Care Quality Commission

Bethesda Care Homes Ltd

Pinglenook Residential Home

Inspection report

229 Sileby Road
Barrow Upon Soar
Loughborough
Leicestershire
LE12 8LP

Tel: 01509813071

Date of inspection visit:
12 June 2018
13 June 2018
28 June 2018

Date of publication:
17 September 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place 11, 12 and 28 June 2018 and was unannounced. This was the provider's first rated inspection since they bought the home in August 2018 and registered with us. We brought the inspection forward due to concerns we received from a whistle blower and the subsequent visit by the local authority, following our safeguarding referral about the concerns shared with us. The concerns we received were in relation to allegations of abuse, unsafe care, and poor facilities.

During the first two days of inspection we found a number of areas of concern. After these visits we liaised with the police and local authority who had undertaken their own investigations and checks on the service. Following this liaison we returned for a third visit on 28 June 2018 to check whether any of the necessary improvements had been made since our initial two visits.

Pinglenook Residential Home 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. The home provided care for a maximum of 16 older people. Thirteen people lived at the home at the time of our inspection. The home comprises of a communal lounge and dining area; and some bedrooms on the ground floor; with more bedrooms on the first floor along with the manager's office. There is some outdoor space for people's use at the rear of the home.

At the start of our inspection there was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. By the third visit a manager was in post although had not yet applied to be registered with the CQC.

People were not always safeguarded from harm. Safeguarding authorities had determined that some people in the home had been neglected and acts of omission had occurred.

People did not always receive timely referrals and reviews of their care when their needs changed. For example, peoples' weights had not been monitored despite some people requiring nutritional supplements.

Accidents and incidents, such as falls, were not analysed and used to help identify how to reduce the likelihood and make improvements. Risks related to people's care had not been updated since the registered manager left and staff had not always taken appropriate action to manage new and emerging risks.

Risks associated with the cleanliness of the premises were not effectively managed and dealt with appropriately. Some areas of the home had fallen into a state of disrepair as no monitoring had taken place or action taken in a timely manner.

Infection prevention and control practices did not protect people from the risks associated with infection.

The management of medicines did not follow best practice as set out by the Royal Pharmaceutical Society Guidance for Care Homes. Not all external creams or ointments had dates of opening recorded or body maps in place. Errors were not being identified or acted on when people missed their medicines that were due at set times.

Staff had not received all the training considered essential to provide safe and effective care. Management checks to determine whether staff were competent to carry out specific tasks had not taken place to assure them staff knew their responsibilities.

There were not enough staff employed or deployed to meet people's needs in a timely manner, and to provide people with emotional support when they needed it. Following the concerns identified, the provider contacted an agency to provide staff cover, however, appropriate checks had not been completed by the provider to ensure they had the right skills and training to meet people's needs.

Staff did check people's consent to care before they provided it. However, appropriate assessments had not been reviewed on a regular basis and care had not always followed the Mental Capacity Act 2005 (MCA). Staff knowledge on the MCA and Deprivation of Liberty Safeguards (DoLS) varied and staff did not always understand how this legislation applied to the people they cared for. DoLS and any conditions in place had not been reviewed and some had expired nearly a year ago.

The CCTV in the communal areas had not had any review to ensure it was in the best interests of people within the home.

There was a lack of meaningful activities for people to enjoy and to provide purposeful lives. People's personal care needs had not always been met in a personalised and responsive manner.

People enjoyed their food, however they did not always receive food that met their preferences.

People's privacy and dignity was mostly respected but staff sometimes acted in a way which did not consider this. People and relatives were not always involved in the development and review of care plans.

Systems and processes designed to assess, monitor and improve the quality and safety of services, and reduce risks were not effective.

Following the first two days of our inspection we were informed that a new manager had been appointed and started working at the home on the 18 June 2018. A number of improvements have taken place in a short period of time. These have been reflected in the main findings of this report.

The provider did not have enough expertise and knowledge of the Regulations to manage the care home when a manager was not present. They had not provided sufficient staff support to ensure people's care and safety needs were met, and the premises and equipment were safe.

At this inspection we found six breaches of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. 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 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 time frame so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.

Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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.

People had not always been safeguarded from harm. Risks related to people's care were not always recorded, updated, and acted on, when needed.

People did not always receive their medicines as prescribed and the management of medicines was not always safe.

There were not enough staff to meet peoples' needs. Recruitment processes had not always been safe and robust.

The premises were not clean and infection control and prevention measures insufficient to protect people from the risk of infection.

The safety and security of the premises was compromised by insufficient maintenance and fire checks.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not received all the training considered adequate for the home and were not skilled in moving and handling or safe medicines practices.

The home was not working fully within the code of conduct for the Mental Capacity Act and Deprivation of Liberty Safeguards.

People received meals they enjoyed and had enough to eat and drink. However, they did not have choices.

People had access to other healthcare professionals when required, although staff did not always act on changes to people's condition. The manager had arranged a review of all the people living in the home with their GP.

Is the service caring?

Requires Improvement

The service was not always caring.

Some people had not experienced a caring service because they had not been safeguarded from harm.

Most people and relatives thought staff were kind and caring. Sometimes staff did not consider the dignity and privacy of people when undertaken their duties.

Visitors were welcomed into the home.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Records did not always provide staff with up to date information to help them respond to people's current needs.

There was a lack of any meaningful activities and people were not supported to have purposeful lives.

The complaint register showed a complaint had been addressed appropriately but we could not be sure whether others had been received.

Is the service well-led?

Inadequate

The service was not well-led.

At the beginning of our inspection there was no management at the home and the provider did not have sufficient knowledge and understanding of the Regulations to ensure the safe running of the service.

On our third visit to the home, a new manager had started to make improvements.

Care Quality Commission

Pinglenook Residential Home

Detailed findings

Background to this inspection

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

This comprehensive inspection was brought forward due to concerns received from a whistle-blower and the local authority and was unannounced. The inspection took place on 11 and 12 June 2018 and was conducted by one inspector. We returned for another day on the 28 June 2018 to check whether the necessary changes had started to be made. This was undertaken by one inspector and inspection manager. Whilst the inspection was prompted in part by notification of an incident following which a person using the service sustained harm; this incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident. The information shared with CQC about the incident indicated potential concerns about the management of risk.

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

This comprehensive inspection was brought forward due to concerns received from a whistle-blower and the local authority and was unannounced. The inspection took place on 11 and 12 June 2018 and was conducted by one inspector. We returned for another day on the 28 June 2018 to check whether the necessary changes had started to be made. This was undertaken by one inspector and inspection manager. Whilst the inspection was prompted in part by notification of an incident following which a person using the service sustained harm; this incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident. The information shared with CQC about the incident

indicated potential concerns about the management of risk.

We reviewed information that we held about the service such as notifications, which are events that happened in the service that the provider is required to tell us about, and information that had been sent to us by other agencies.

During this inspection we spoke with three people who lived at the service during our first two visits and three people during our third visit. We also spoke with three members of support staff and the manager and provider.

We did not use information from the Provider Information Return (PIR) as we did not request one for this inspection. A PIR is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We looked at three people's support records to see if they reflected the care that was being provided. This also included individual medication administration records and three staff recruitment files. We looked at other information related to the daily running of the service including quality assurance audits, staff training and the management of any complaints or concerns. Following the inspection, we requested information to be sent to us from audits conducted by the local authority community Infection and prevention team and an independent fire inspection. All the information we requested was sent to us in a timely manner.

Inadequate

Is the service safe?

Our findings

There were not enough trained and knowledgeable staff to meet people's needs. Prior to our visit, we were informed by the local authority there was only two care staff on duty to meet the needs of 15 people who lived at the home. They told us staff experienced real challenges in meeting people's needs and as a result some unsafe moving people practices such as 'drag lifting' people (lifting a person under their arm pits increasing the risk of damage to the person's spine, shoulders, wrists and knees) were witnessed. When we visited the service on the 11 and 12 June 2018 the service was chaotic with a number of external stakeholders visiting and no manager in place.

The local authority had requested the provider ensure there was one more staff member covering each of the day time shifts to ensure at least three care staff were present each day, seven days a week. A member of staff told us, "We are understaffed; last week [person's name] kept falling down. We were constantly running to [person] when their bell went off." Staff had also reported to us that when they requested additional staff this had been refused.

When we visited, the providers were present at the home providing support to staff and people; however, they demonstrated limited knowledge as to what was needed to provide safe care. On both days they acted as the third member of staff required for each shift, and did not have the necessary training to do this safely. They also provided the management cover. A new manager was due to commence work with the home and provider on 18 June 2018.

One member of staff on the rota had received no training, and others had not received the training they should have to support safe care. For example, a member of staff who was considered 'trainee staff' and who had received no training for their role, was counted in the numbers of qualified staff. Another member of staff was considered 'trained' in medication administration, but their training was given by the local pharmacy rather than appropriate and robust safe administration of medication training. Staff from an employment agency had started to be used by the second and third days we visited. However, the provider had failed to ensure they had a proper induction to the service or that they were adequately trained in safe medicines administration or moving and handling.

The provider had failed to ensure that all staff working in the service were adequately trained and supervised to meet the needs of people. This meant the provider was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014; Staffing.

A new manager was in post when we visited on the third day. They had worked hard in a short space of time to review the staffing rotas and ensure all shifts had the appropriate numbers of staff in place. They were still faced with a number of challenges such as managing agency staff, however, they had identified a different agency that was more responsive to their requests. The manager ensured that for each member of staff used they received a profile from the agency about the staff member's skills and experience; and the agency staff member was inducted to the home's policies and procedures when they arrived on shift. However one of the agency staff we spoke with on the third day had not received an induction and not been told what to do in

the event of a fire. The new manager had also identified the standards of cleanliness in the home were not adequate. They were working with the housekeeper to make the changes required.

The provider did not always undertake robust staff recruitment procedures which minimised the risk of employing unsuitable staff. During our visit we spoke with one member of staff who, when asked, confirmed their Disclosure and Barring Service (DBS) check had not been returned for the provider to check they were safe to work with people (a DBS check informs the provider if a person has a criminal history). We discussed this with the provider, who told us the member of staff was 'training' and they did not think this was necessary. We informed the provider it was important they knew staff were safe to work with people, and the provider said they would ensure the person did not work until the DBS check had been undertaken. The next day we were contacted by social services who told us when they visited the home that day, the member of staff was still working unsupervised with people.

This meant the provider was in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014; Fit and proper persons employed.

During our third visit, the new manager was aware of the issues identified during the previous two days of inspection and was in the process of ensuring that all checks had been completed prior to staff commencing work at the service. Recruitment for the staff vacancies took place the week of our inspection. The manager's description of the process they would follow to ensure all staff were suitable for employment at the service, gave assurance that robust procedures would now be followed.

People were not always safeguarded from abuse. Prior to our visit, we received information of concern which we passed on to the local authority safeguarding team. The investigations concluded that people had not been safeguarded in the home, and some had experienced abuse. The safeguarding authorities opened their safeguarding concerns to all people who lived at the home. During the investigation the safeguarding authorities did not feel the provider had acted in people's best interest to protect people from staff who had allegations made against them. This was because they had not considered the potential risks to people by having these staff continue to work in the home whilst an investigation was being carried out. The investigation is on going and we will monitor the situation over the coming weeks.

This meant the provider did not always safeguard people from harm and was in breach of Regulation13 of the Health and Social Care Act 2008 (Regulated Activities) 2014; Safeguarding service users from abuse and improper treatment.

People's risks were not always appropriately acted on. Most people who lived at Pinglenook did not have high dependency needs; however for those that did, staff were not working with those people to reduce the risks. For example, one person was at risk of falling. The person's care record demonstrated they had multiple falls. Body maps and other documentation showed extensive scratches and bruising which was possibly due to poor moving and handling techniques. Social workers found the person did not have appropriate equipment to support the person in their movement; and found staff were using moving and handling techniques which could cause injury to the person.

We found an incident and accident record for one month which recorded a number of incidents in different parts of the home and at different times, but there was no other information to tell us if this was the same person and in what circumstances the person had fallen. There was also no analysis of these falls to identify the cause or review ways in which to reduce the number of falls the person was experiencing.

Since the previous manager left the service in April 2018, there had been no reviews of people's care to

determine whether their needs had changed. We found by looking at one record that a person had lost over 3kg in weight. Their care plan said they should be referred to the GP if they lost 3 kg or more but this had not been carried out.

The premises were not clean or well-maintained to prevent or control the spread of infection. The sinks and toilets used by people were clean but the other parts of the home had not been cleaned. There was no cleaning schedule in place to ensure areas of the room such as skirting boards, pull-cords, pipework, radiators, and bathroom tiles were clean. They were all dirty and in a state of disrepair.

There was no cleaning audit to check that the home had been properly cleaned and people were safe from the risk of infection. During our visit we saw stained pillow cases and quilt covers, with dried in blood on one of the pillow cases. We saw that one of the pressure relieving cushions a person used to keep their skin safe from breakdown, and a mat used by a person's bed in-case they fell, had tears, exposing the foam underneath. This was an infection control risk as it meant potential infection could not be wiped away from the surface. One bed had been stripped and we could see the mattress underneath which was in a poor and dirty condition.

The premises and equipment were not always kept in a good state of repair or clean. We checked the provider's systems to ensure the safety of the premises. Some of the expected checks had been completed such as legionella checks and gas safety checks. However, not all of the expected fire checks had been carried out. For example, the weekly fire alarm checks had not been undertaken to ensure in the event of a fire, the system worked to alert people to fire. None of the staff had undertaken recent fire drills to ensure they were aware of what to do to evacuate people.

People's personal emergency evacuation plans were not always up to date or contained sufficient information to support emergency services in knowing how best to evacuate people safely. The provider did not have a contingency plan for a place of safety if people required evacuation. This meant people might be put at risk in the event of evacuating the premises.

Medicines were not always managed safely. We spoke with two staff who administered medicines to people. Both said they had undertaken the right training to do this safely and competently. We later found that whilst staff thought they had undertaken the right training, this was not at a level expected to protect people from medicine mismanagement.

We did not do a full medicine audit as medicines were stored in the kitchen, and work was being done to the kitchen at the time of our first two visits. But we found in the small sample checked that staff had not written the opening dates of some boxed medicine; the amount of medicines left over did not always correspond to the written record; the handwritten records did not follow good practice guidance to ensure they were written correctly. Medicine administration charts were difficult at times to decipher because staff signatures to say a person had received medication looked very much like the code 'NR' for medicines 'not required.

By the third day the kitchen was fully operational and working well. We found where medicines were stored was not appropriate as the area was accessed by staff several times a day; and there was not enough space for storage.

We fully reviewed the management of medicines and checked the records of all people who lived at the home and found a number of concerns. Previously the external creams and ointments were not being dated when opened. This continued to be a concern but we found that the creams had recently been dispensed by the pharmacist so were in date.

We had been informed there had been a number of incidents of people missing their medicines or medicines being delayed. On closer inspection we established that this was on one day,15 June 2018, when agency staff had been employed to undertake medicines administration. The agency staff care worker was not familiar with people who lived at the home and had taken longer to administer the medicines on that day. Whilst most people received their medicines as prescribed, one person did not receive all their prescribed medicines for their medical condition. This meant they missed one dose that day. When looking at this person's prescription we found it was confusing for staff to understand. The new manager requested a GP review of their medicine as there was a potential for this to occur again.

We found that another person had received the wrong dose of medication on one day. The prescription was confusing and the manager had also arranged for the GP to review this person's medication as it appeared they did not need this different dose.

The provider failed to ensure that people received their care and treatment in a safe way. This meant the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014; Safe care and treatment.

After our first two inspection visits, the local authority Community Infection and Prevention Team visited the home and provided us with a copy of their report. The new manager and provider were in the process of reviewing the report and had started to action the points highlighted as a priority. New bedding and mattresses had been ordered that week and some had arrived by the time we visited on the third day.

Prior to our visit we were informed that staff were not routinely using 'personal protective equipment' (PPE). During our visit we saw that staff had access to gloves and aprons and were using them.

Arrangements were in place to commence appropriate training for the housekeeper and deep cleaning of some of the area's most in need. The manager confirmed, following the inspection, arrangements were in place to change some areas of the home as they were not fit for purpose. For example, the downstairs wet room was to be decorated with appropriate flooring and tiles to ensure it was suitable for people to use as and when they wished.

By the third visit of our inspection the provider had commissioned an independent fire safety audit. The report was sent to us by the manager. We observed fire safety checks being completed throughout the service. The new manager was in the process of completing new personal evacuation plans for each person as the current ones were not detailed. We were shown an example of two already completed. The fire brigade was due to visit the following week to check all the changes had been completed and conduct an assessment of fire safety in the home.

Fire checks were now being carried out on a weekly basis. A full fire drill and evacuation was carried out the week prior to the third day we visited. The fire alarms were tested on the day of our visit with people in their rooms being warned beforehand. Actions had been taken to ensure the fire safety procedures were working effectively.

Requires Improvement

Is the service effective?

Our findings

Staff did not have all the training considered essential to support people's health and well-being, and had not put into practice the training they had received. In December 2017, staff had received training to move people safely, and to use equipment to support the safe movement of people. Prior to our visit, social care professionals had attended the home and found staff were moving a person unsafely by 'drag lifting' them. This is where a care worker re-positions a person by placing their arm or hand, under their armpits. This can potentially cause injury to a person. The provider had been informed of this and had arranged further training to ensure staff understood how to move people safely. During our visit we saw no-one being moved unsafely but we were told that unsafe practice was again witnessed by social care professionals when they visited after our inspection.

By the third day of our inspection the provider had arranged practical moving and handling training for all the staff. The new manager also conducted observations of staff throughout the day and identified areas of poor practice. This was being addressed through checks and supervision.

During the first two days of our visit staff told us they had received medication training. This training was undertaken by the pharmacist, but was not training at a level which could provide staff a comprehensive understanding of what constituted safe medicines practice. The manager told us they had booked 'safe handling of medicines' training for staff in July 2018. On the third day of the inspection two senior care staff had undertaken on-line training and had passed the course. The manager undertook a competency check with a member of staff the morning of our third visit to ensure the staff member was administrating medicines safely.

Many of the people at the home lived with dementia. Whilst staff training for dementia awareness had been arranged, none of the staff had received this training at the time of our visits. One member of staff told us they had missed a couple of the training sessions because they had to work with the people who lived at the home. The manager sent us the training matrix and it identified a number of areas that required improvement to ensure staff were trained to a standard to care for people living in the home.

One of the new members of day staff told us they had received no training since starting work at the home three weeks prior to our visit. This was the first time the member of staff had worked in a care home. The member of staff was preparing sandwiches for people but they told us they had not undertaken any food hygiene training.

Care homes are expected to provide staff new to care with Care Certificate training, or training which is of the same rigour. The Care Certificate is expected to help new members of staff develop and demonstrate key skills, knowledge, values and behaviours, enabling them to provide people with safe, effective, compassionate, high-quality care. We saw the previous manager had worked with a member of night staff to achieve the 15 standards set out in the Care Certificate but on the manager's departure this had not been completed. The provider was not familiar with the Care Certificate when we spoke with them about this.

Whilst staff training was being organised by the provider; by the third day of our inspection visit, the provider had not ensured that all staff received the training and supervision they required to care for people to the standard expected. This meant there was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014; Staffing.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Staff had not received training to support their understanding of the MCA however explained to us they would always check with a person whether they consented to care and support tasks staff wanted to carry out, before they did so. Staff said if a person declined to receive this support, they would not force the person to do so, but would try to gently persuade people to have the support.

The previous manager had added information to care plans to determine whether people had capacity to understand information and make their own decisions, although these were not specific to each decision. One person's care plan informed us the person had good memory and understanding; however their Deprivation of Liberty Safeguard said the person did not have capacity and was unable to recognise why they lived at the home and what staff did for them.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The provider had applied for DoLS for people who lived in the home with dementia. However, DoLS have expiry dates, and the provider had not ensured further applications had been sent to the safeguarding authorities once the expiry date had been reached. For example, on person's DoLS expired in July 2017. This meant they had been unlawfully deprived of their liberty for almost a year without a review. Since our inspection all the DoLS in place had been reviewed, updated and referrals sent to the local authority. To date, two applications had been confirmed and returned to the provider.

The provider had failed to ensure people were legally being deprived of their liberty. This meant the provider was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014; Safeguarding service users from abuse and improper treatment.

The home had CCTV to the communal areas of the service and outside areas. This was in place with the previous provider when they sold the business. However, the provider had not considered the rights of people who did not have capacity to make an informed decision as to whether the CCTV would be in their best interests. No appropriate assessments or best interest meetings had taken place with people or their relatives to ensure this was an appropriate safeguard for people.

The CCTV had been removed by our third visit. We advised the provider to consider all the interests of people living in the home before they put this back in place. The CCTV remained on the outside areas of the home to ensure security of the premises as they were situated by a main road with different entrances into the home.

People's care was not always delivered in line with current legislation, standards and evidence based

guidance to achieve effective outcomes. The provider had not used research on living with dementia to support the staff work more effectively with people at the home live purposeful lives. People mostly sat in front of a television and appeared bored for most of the day. Their activity was a red ball which was thrown to them when staff had some time available to support them.

At the time of our inspection visit the home's kitchen was out of use for two days because a new kitchen was being fitted after an environmental health inspection identified some issues with some of the equipment. We asked people and relatives what they thought of the food provided by the cook when they were able to use the kitchen. People were satisfied with the food provided. However, people did not have a choice of meal at lunch time. After lunchtime on our third visit we overheard one person telling a member of staff that they did not like pasta. The staff member replied, "I know you don't." No alternative had been offered or provided.

Whilst there were no issues identified with the quality of the food provided, it was reported to us that there was a lack of available snacks for people throughout the day to help them maintain or gain weight. By the third day we saw people eating fresh fruit. The manager had also arranged for afternoon tea and cakes for people. Some people were on food supplements which were taken by people as prescribed. This was to be reviewed by the GP as to whether people still required them.

We found that some people had lost weight and steps had not been taken to identify why this was. For example, one person's care plan informed that if the person lost more than 3kg in weight they needed to be referred to the person's GP. We saw they had lost just over 4kg between February 2018 and May 2018, but no referral had been made to the GP, and no further weight check had been undertaken since the beginning of May.

By the third day of our inspection, the new manager had arranged for all people to be weighed and records completed on a weekly basis. They had also arranged for the GP practice to visit and review all people living in the home. The manager had identified that people had not had a medicine review or health review for some time. They gave examples of concerns they had identified regarding some people's prescribing regimes which needed a healthcare professionals input.

Whilst staff were not always pro-active in referring people to the appropriate healthcare professional in response to checks which demonstrated a person's needs had changed; they were responsive in supporting people's requests to see their GP. People and relatives told us staff would contact the GP if they had concerns a person was unwell.

The premises were not specifically designed to meet the needs of older people and people with dementia. The furniture in the lounge area was tired and worn, and some of the coffee tables were chipped. The chairs in the dining room were also worn. A first floor communal toilet did not have a sink to enable people to adhere to good hand hygiene practices. The bedrooms did not always have good quality furniture. One person's chest of drawers in their room was broken; another person had a broken radiator cover. In one bedroom, a bedside table was made of chipboard – this was a rough surface and would not have been cleaned easily; as well as potentially being a risk if a person had paper thin skin and caught themselves on it.

The provider told us they recognised that improvements to the décor were needed. They said they had already changed the dining room tables to improve the environment, and were in the process of having a new kitchen equipment installed. They said they were looking to improve the bedroom and living room furniture as part of their future plans for the home. We asked if they had a written improvement plan but they did not. However, we were sent a plan following our visit and an update as to when work was to

commence on these areas.

The side garden was paved and had some plant pots with flowers. However, there was no inviting, or suitable garden furniture to encourage people to sit outside and enjoy the fresh air. A lot of people in the home had DoLS to restrict their liberty from going outside on their own. To provide a more enticing outdoor space would give people more opportunity to have fresh air.

Requires Improvement

Is the service caring?

Our findings

People and relatives told us staff were mostly caring. One person told us there was a happy atmosphere in the home, and another said it was a small and friendly place and would recommend it. One visitor said the person they were visiting thought their care was 'excellent' and staff were 'very kind' to them. One of the people we spoke with said that one member of staff could at times be domineering, however also said that other staff were caring and got things done.

However the systems in the home made it difficult for staff to provide a caring service. The systems had not always kept people safe from harm, and had not provided sufficient staff to ensure people were provided with care that met their emotional and social needs as well as their physical needs. The provider had not provided staff with the training to meet people's needs.

Staff all told us they thought the staff at the home were caring and wanted to provide good care to people. However, we found instances where staff had not considered people's dignity or privacy. For example, one member of staff was providing support to a person in a communal bathroom. Another member of staff needed something from the bathroom and knocked on the door, walking in saying, "It's only me". They got what they needed and then walked out again. This was not dignified for the person being supported with personal care.

During our visit we saw staff sometimes spoke about people in front of them as if they could not hear them. For example, instead of speaking directly to the person; two staff spoke in front of a person about the person. They were saying to each other, "She's in a good mood," "She's in a jolly mood."

We were in a person's bedroom checking their room record to see whether they had been repositioned in bed as required by their care plan to ensure their skin was not put at risk. It looked like the person was not repositioned in the way the room record said they were. We asked the member of staff about this. They went up to the person who was lying in bed, and without asking, pulled back the person's bedclothes, to show us the position of the person. After they had done so, they apologised as they realised they should have checked with the person first.

When checking medicines we found that some people had prescribed external cream put on their legs in the lounge with an aid of a privacy screen. We asked the staff member whether if it was them, would they prefer to have cream put on in the comfort and privacy of their bedroom or in the lounge area. They said they would prefer this in their bedroom.

We saw one instance where a person stood up, and their trousers began to fall down. Staff were quick to support the person in pulling their trousers up so their dignity remained intact.

Staff also showed warmth and affection to people. When they had time, they chatted with people and enjoyed a joke and a laugh with some of them. Visitors were free to visit the home when they wanted and to stay for long periods of time. We saw good relationships between staff and visitors.

The home had a small office on the first floor where confidential records were kept. However, because the office was small, and because staff had limited time to undertake tasks, we saw staff talk on the phone in front of people to other professionals about confidential information of people.

Requires Improvement

Is the service responsive?

Our findings

The previous manager of the service had worked on people's care records to reflect people's needs from a physical, social and emotional perspective. They also informed of people's communication needs. For example, one person had a hearing impairment and their care record reminded staff to check the person wore their hearing aid, and to ensure the aid was working.

However, since the manager's departure, there had not been sufficient review of the care records to check to see whether the person's needs had changed and the actions staff needed to take to support those changes. This meant where people's needs had changed, they had not been identified and acted on. Where a person had a specific health condition, there was no care plan that made reference to this or identified what additional information or actions staff should undertake to support this person.

Records did not clearly indicate whether people had been involved in their care planning. A relative told us they were in the process of going through their relation's care plan when the manager left and they did not have a chance to complete the process.

We looked at other records which should have identified the care people received. These again had not been updated. For example, we looked at people's bathing and shower records. On the days of our visit we saw people looked clean and well presented, but this had not been the experience of other professionals who visited the home. A relative told us their relation had high standards of personal hygiene but more recently had sometimes looked a bit 'grubby'.

The shower and bath records indicated that people had gone over a week without a bath or a shower. We asked staff if this was the case. The staff we spoke with told us that people had at least one bath or shower a week, or at the very least had a 'bed bath'. They said this was a recording issue as staff had not had the time to record when a person was showered or bathed.

Care plans had information about people's past lives, likes and dislikes, but this information was not used effectively to provide good outcomes for people. This was particularly so in response to people's emotional and social needs. During our visits, people were mostly sitting in the lounge with the television on.

Staff engaged with people as they completed their tasks but there was no time for them to support people to lead purposeful and meaningful lives. One person told us, "There's nothing to do here." We saw a couple of people read books or newspapers but apart from that, the only activity we saw was when a care worker engaged some people with a ball throwing session. We saw very few other activities available to people.

On a wall in the hallway by the notice board, we saw an activity programme. One person told us they had never seen these activities being undertaken, and a visiting professional told us the same. A relative told us their relation had not undertaken many activities since living at the home.

The home had a garden at the side of the building. We were informed that people did not like to go out into

the garden; however, whilst there were some plant pots on the paved surface, it was not an enticing space for people to use. People and staff told us there was little time for staff to support people with activities outside of the building such as trips to the local shop, and this meant that people who lived at the home received very little fresh air or time away from the home unless relations or friends could take them out.

The provider had failed to provide a service which met people's individual needs and reflect their preferences. This meant the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014; Person centred care.

There had been one complaint registered in the complaints register at the home. This had been managed appropriately. However, we could not be sure whether smaller complaints which might be addressed by senior staff were logged in the complaints record to check whether there were patterns or trends in complaints which emerged and whether they had been addressed. For example, the person who complained about not liking pasta.

The home did not specifically provide end of life care, and care records provided limited information about people's wishes and priorities as they moved towards the end of their lives. The provider had booked training for care workers on end of life care, for the week after our inspection visit.

Inadequate

Is the service well-led?

Our findings

This was the first inspection of the service since the new provider had taken ownership of the home in August 2017. This was the provider's only care home and their first registration with the CQC. Since registration, we had only received one concern in November 2017 about this home prior to the safeguarding alert we raised in June 2018. This complaint was addressed by the registered manager. The local authority had undertaken their own checks in December 2017 and found the home compliant with their standards. Prior to this there had been no concerns with the service.

There was a lack of appropriate governance and risk management framework and this resulted in us finding multiple breaches in regulation and negative outcomes for people who used the service. There were no effective systems in place to develop and improve the service, based on the needs of the people who used it, their families and staff. The provider had not sought the views of people who lived at the home, their relatives, and staff to support them in improving the home.

There had been an inconsistent level of management in the service with a turnover of four managers in the space of six months. The registered provider was regularly in the home but had a limited understanding of the Regulations which needed to be met to keep people safe.

Prior to our visit, the local authority had visited the home because of our safeguarding referral. They had serious concerns with what they saw, and had already worked with the provider to improve some aspects of the service prior to our arrival a few days before. However, since the 18 June 2018 a new manager has started working at the service and with the support of the local authority quality team, a number of improvements had taken place and systems established.

Prior to our first visit, and local authority involvement, there had been no maintenance worker to support maintenance of the building and checks of the premises. Since then, the provider recruited a person to undertake maintenance and fire safety checks, but this was recent and not all fire checks had been completed. These issues were being addressed when we visited on the third day. However, it was clear that maintenance had not been a priority for the provider until outside services became involved. This placed people and staff at risk of harm from an unsafe environment.

The provider had not increased staffing when people's care needs changed, and there was no dependency tool to determine what dependency levels people had and how that translated into the number of staff required to support their needs. Staff had not received the appropriate training to support them to provide good care to people; and there were insufficient audits and checks in place to ensure people's safety. For example, medicine, hygiene, care plan, and staff recruitment checks.

The provider acknowledged to us they had left too much of the running of the home to the previous registered manager, and they did not have sufficient understanding and oversight to ensure good practice. They told us of plans to improve the service, but there was no record showing how and when they hoped to deliver the improvements.

The provider failed to ensure that there were sufficient systems and processes in place to assess, monitor and improve the quality and safety of the service. This meant the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014; Good governance.

Staff had felt supported by the previous managers but felt the most recent manager had spent too much time in the office undertaking paperwork rather than supporting them in the home. They commented to us that there was a lack of clear leadership and issues were not being addressed when they raised them. For example, they told us that there was a lack of staff and they needed further support, especially during the day. The provider had responded by ensuring they were in the service more often and part of the staffing for the days they were short. However, this was not sufficient to support people or the staff.

By the third day of our inspection, the new manager had ensured that a review of the agency staff they were using was undertaken. They found staff from the agency, were not trained to a level they required so sought another agency. Profiles for each member of staff sent to them were received and checked by the manager. They also ensured the staff member had the skills required and a short induction to the service. This still posed some challenges but was monitored by the manager on a daily basis who also worked with the staff.

The new manager had introduced a daily meeting with the staff team to discuss any issues and resident of the day was to be implemented from 1 July 2018. This would enable the staff team to look at all areas of a person's care and support, including the care plan documentation, the environment in which they lived and the nutritional support they needed. They had also introduced a written handover file, which staff were required to sign to confirm they had received the necessary information when they came on shift.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure that people were supported to lead meaningful lives. Staff did not have the time to support people to undertake activities or hobbies which might interest them and give purpose to their lives.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure that people were safeguarded and their rights protected

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 had failed to ensure that people were protected because they had not carried out the appropriate checks to minimise the risk of employing unsuitable staff, prior to staff working without supervision.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure that there were sufficient numbers of suitably qualified, competent, skilled and experienced staff employed at the service.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure that people received safe care and treatment that met their needs and kept them safe from harm

The enforcement action we took:

We took enforcement action by issuing a warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure they had systems and processes in place to assess, monitor and improve the quality and safety of services provided to people.

The enforcement action we took:

We took enforcement action and issued a warning notice