Amira Residential Homes Limited

Fairhaven

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out this inspection on 27 April and 3 May 2017. The inspection was conducted in response to concerning information received by the Care Quality Commission. We last carried out an inspection at the service on 4 August 2016. At this inspection we identified serious concerns and several breaches of regulations which put people at risk of harm. As a result we have taken enforcement action against the provider to ensure that improvements are made.

Fairhaven provides accommodation and personal care for up to 21 older people. It does not provide nursing care. At the time of our inspection there were 16 people living at the home.

There was no registered manager in post. The provider had appointed a manager and who had commenced work at Fairhaven on 26 April 2017. However this person at the time of this inspection had not applied to be registered with the Commission. 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.

People were at risk of receiving care and support that was unsafe and did not meet their needs. There were not enough staff deployed by the service to meet people's needs. Risk assessments were not detailed enough to adequately capture risks to people or control measures to minimise these. We also found that the fire risk assessment and fire evacuation records were out of date.

We found people were still not being given opportunities to take part or be offered activities that suited the personal preferences or choices. There were not enough competent and suitably trained staff deployed by the service to meet people's needs. People's medicines were not managed or accounted for correctly and changes to medicines were not identified and included in people's care plans. We also found discrepancies in the recording of people's medicines.
People were also placed at risk from staff who were carrying out unsafe moving and handling procedures.

Some staff did not have valid employment references on their files. Existing staff did not receive regular supervision or appraisal of their performance, training or development needs. New staff had not received an induction or training and there were no systems in place to monitor or plan a schedule to train staff in the future. Not all staff understood the correct way to safeguard people from the risk of abuse or what constituted a safeguarding incident. There was no training provided to help staff to understand the Mental Capacity Act (2005) and people's care plans did not include any information in relation to their capacity to make and understand decisions about their care and support. Staff did not always support people to make decisions and follow the legal requirements outlined in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberties Safeguards (DoLs).

People's consent had not been obtained prior to care and support being delivered. We found that staff did

not understand the principles of the Mental Capacity Act. We found that people's human rights had been unlawfully restricted.

The service did not adequately identify people's needs in relation to nutrition and hydration. There was no assessment or information available in people's care plans to help staff understand the foods and drinks that were appropriate for them. There was only limited evidence that support was being sought from external healthcare professionals as necessary. People were not offered a range of choices at mealtimes and people had no access to snacks or refreshments.

People told us that some staff were kind and caring, and staff had developed positive relationships with people. However we observed staff failed to treat people with dignity or respect. In addition, there was not always enough information in people's care plans to provide staff with adequate knowledge of the person.

People's care plans did not fully reflect the extent of people's needs, and were not always reviewed if the person's needs changed. There was limited evidence of involvement from people or relatives and care plans had not been reviewed since our last inspection in 2016.

The provider's complaints policy was out of date and the service did not fully record or monitor all complaints and the response to complaints was inadequate.

There was inadequate governance and overall oversight which meant that systems were ineffective. There had been no quality monitoring or audits carried out in the home since the last inspection in August 2016. There was no evidence that people and their relatives had been consulted or feedback sought on the service provided.

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.

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.

Risks to people's health and wellbeing were not always managed effectively to maintain their safety.

People's medicines were not always managed safely or effectively.

The recruitment process was not consistently robust due to inadequate checks being carried out on perspective employees before they commenced work at the service.

Staff had not received training in safeguarding and did not know how to report any concerns regarding possible abuse, we observed one person being restrained unlawfully

There were insufficient staff provided to meet people's needs safely and in a timely way.

Is the service effective?

Inadequate

The service was not effective.

Staff did not always receive regular updates to their training and there were no systems in place to monitor this.

Staff did not receive regular supervision or appraisal of their performance.

The information contained within people's care plans in relation to their healthcare, nutrition and hydration needs was insufficient.

No training was provided to help staff to understand the Mental Capacity Act (2005) and therefore staff did not work in accordance with the act.

Is the service caring?

Inadequate

The service was not consistently caring.

People did not always receive personalised care and support that met their individual needs and wishes.

We observed some staff to be kind and caring. However, people were not always given choices.

There was no evidence of the involvement of people or their relatives in the care planning process.

People's privacy and dignity was not protected and maintained.

People were supported to develop relationships with staff when possible.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans lacked personalisation and detail and were not reflective of people's changing needs.

People were not offered opportunities to take part in meaningful or social activities.

Complaints were not being managed or responded to correctly.

Is the service well-led?

Inadequate

The service was not well led.

There was no registered manager in post.

People and staff felt the home was not consistently well managed, due to several changes of management in recent months.

There was inadequate governance and overall oversight which meant that systems were ineffective.

Fairhaven

Detailed findings

Background to this inspection

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

This inspection was carried out in response to concerns we received and was carried out over two days. The first day was conducted by one inspector but due to serious concerns discovered on the first day of the inspection, two additional inspectors attended the second day. We visited the service on the 27 April and 3 May 2017.

We also reviewed information we held about the service including statutory notifications relating to the service. Statutory notifications include information about important events which the provider is required to send us.

During the inspection we spoke with seven people who used the service, one relative, seven care staff, the manager and the provider. We contacted family members and relatives to obtain feedback and also sought feedback from health and social care professional's familiar with the service. We looked at five care plans, eight staff files, complaints, records relating to food and fluid monitoring and other information which related to the overall monitoring of the service.

Inadequate

Is the service safe?

Our findings

People who lived at the home had mixed views with regard to if they felt safe. One person told us, "I don't feel safe, people just walk in to my room, staff don't close the door." Another person we spoke with told us, "They try their best but there just are not enough of them. I press my call bell but on occasions I have had to wait up to 10 minutes by which time it's too late. This make me feel embarrassed." Another person told us, "When I ring the bell I have to wait for a long time and have soiled myself in the past." However one person told us, "I like it here."

We found that the staffing provided during the night time was inadequate in meeting people's needs. We were told by the provider that three people who lived at the home required two staff to support them with all their personal care needs. However the rota seen demonstrated that only two staff were provided per night. One relative told us that their [family member] had complained of being left in a wet bed for a period of over half an hour after pressing their call bell for assistance. We spoke with a night staff member who told us "There is simply not enough staff at night, which means sometimes people are left in wet beds because we cannot get to them in time. It's not acceptable and I have complained about it several times but nothing changes. It's undignified and unsafe. What if there was a fire or another emergency." This meant that people could be placed at risk of harm from not enough staff to support and care for them.

As part of this inspection we looked at the rotas for the months of April and May 2017. We were told by the provider that two of the staff members recorded on the rota were not working at the home any longer and the third person due to work on 27 April 2017 had been suspended by the manager as they did not have a current DBS check in place. However these staff members' names remained on the rota for April 2017. The staffing on the first day of our inspection was only two agency staff and no permanent members of staff. We found that one agency member of staff had only worked one previous shift at the home and the second agency member of staff was working at the home for the first time.

The manager informed us that they had recently recruited three new staff members who were currently on induction training; however we found that all three staff had been rota'd to work on both 27 April and 3 May 2017 supporting people at the home. As a result of this inspection it was discovered that all three new staff members plus the manager had been appointed without the necessary employment checks in place and were subsequently all dismissed from their employment at the home. The home currently has only has three permanent night care staff members employed at the home, and no permanent day staff. This places people at risk of harm from staff who do not know the individual and personal care needs of the people they are supporting.

The failure to provide adequate staffing to keep people safe was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During inspection we observed that people were not always kept safe. We saw two call bells that were out of people's reach. For example, we saw that in one bedroom where the person was being cared for in bed, the call bell was placed behind the person's head. We were told that this person was checked 'hourly' to ensure

their safety. However we found from the daily records this person had not been checked from 8 a.m. up until 1pm on 3 May 2017. When we tested the call bell system we saw that the alarm bell sounded and flashed red, however it then went silent and turned back to green. This implied that the call bell had been answered and responded to. One person told us that, "The staff just turn it off so it goes green but then never come back."

We recorded the response time for one person whose call bell took seven minutes to be answered. When we spoke with the manager they confirmed that they had witnessed bad practice. They said, "Staff turning the alarm off and not attending the call." We found that not all rooms had an adequate call bell system in place for people to use when they needed to call staff for assistance or in cases of emergencies.

There were no moving and handling risk assessments in place. We observed two staff members carrying out an unsafe 'under arm' lift on one person who was seated in the lounge. We found that there was no moving and handling assessment or risk assessment in place for this person. This practice placed the person at unnecessary risk of harm.

Falls were not sufficiently assessed and risks were therefore not well managed. We reviewed the discharge summary for a person who had recently moved into the home which stated, 'This person [name] is at high risk of falls and should not have access to the stairs.' However we found that this person had been placed in an upstairs bedroom and on 19 March 2017 had a fall in their room and were found on the floor. There was no record of the fall in the incident or accident book and this person did not receive any first aid for their injuries. We found no evidence that this person's care plan or any associated risk assessments had been reviewed or updated as a result of this fall. Therefore this meant that this person was at increased risk of a reoccurrence due to no action being taken to help prevent this.

Risk assessments associated with fire and the environment to help to keep people safe were inadequate. There was no up to date risk assessments in place in relation to areas such as personal care, medicines, vulnerability to abuse or behaviour in some of the care plans we reviewed despite these being relevant to people. There was no up to date fire risk assessment in place and the fire evacuation plan included the names of two people who no longer lived at the home. The were no evidence available to confirm that fire drills are carried out in the home. However we saw that the specialist equipment in the home had been serviced within the past 12 months.

Some areas of the home were in a state of disrepair, this included the rear garden area which was inaccessible due to debris scattered across the pathways and an unravelled hose pipe that could have caused people to trip and fall. We saw cigarette ends scattered outside on the patio and a number of broken pieces of furniture left by the fire exit door leading from the conservatory. We were also informed by the provider that the only bathroom on the first floor was out of order. We found that the lift was difficult to operate and the floors were incorrectly labelled. We found that the lack of storage facilities available meant that wheelchairs and specialist equipment was left in the communal areas of the home, which could cause people to trip or fall. This meant that the people lived in an environment that was not always maintained to an acceptable standard.

We were informed by a staff member that on the night of 2 May 2017 three people who lived on the first floor of the home had been smoking in their bedrooms. This information was passed onto the manager the following morning for their immediate attention. However this practice was not challenged or addressed by the provider until a further seven days. The home's statement of purpose states that the home is 'Non-smoking environment.' Therefore this placed at an increased risk in relation to fire safety.

When we looked in the kitchen we found a bowl with mouldy fruit, infested with flies. We also found three jars in the fridge that had not date of opening on them. We found vegetables in the fridge, which included cucumbers and peppers with green mould on them.

Staff did not always demonstrate a good understanding of the needs people living with dementia and how to keep them safe. For example, with behaviour that may place them or others at risk. We observed one staff member who was assisted a person with their lunchtime meal. We saw that this person suddenly became agitated and anxious. However, the staff member failed to acknowledge or respond to this person but simply continued to try and force the food into their mouth. The inspector was therefore had to take immediate action and intervene and tell the staff member to stop immediately. This practice was abusive and placed the person at risk of both physical and emotional harm. We saw from this person's care plan that they had been assessed as at risk of choking and also could display behaviour that challenged. However, the practice observed between the staff member and the person clearly demonstrated that the staff member was unaware of this person's individual needs and associated risks. We saw from the communication record that this person had been admitted to hospital on 15 April 2017 due to an incident of choking in the home. There was no evidence that the risk assessment had been updated as a result of this incident and also this incident had not been reported in the accident and incident book or to CQC. This placed the person at further risk of harm from risk of reoccurrence of the incident.

People medicines were not always managed safely. We found the medicine administration records (MAR) for three people were not up to date. We also found that there was no guidance in place for medicines that may be required on an as needed basis, for example, pain relief medicines.

We looked at the medicine records for one person who had been prescribed an anti-psychotic drug and also the associated 'return' records for these medicines. We saw from this record that half a bottle of this medicine had been returned to the pharmacy on 2 May 2017. We saw from this person's MAR chart that this medicine had been stopped on 14 April 2017 without explanation. The daily records dated 15, 18, 21 22 and 23 April 2017 stated that this person had become agitated, anxious and unsettled. There was no referral to the GP for the increased agitation, behaviour and restlessness. When we spoke with the two staff who were responsible for administering medicines to people they were unaware of the signs of this person's deteriorating mental health needs. This meant that this person had potentially suffered harm as a result of the staff not taking the appropriate action to meet their medical needs.

The manager was unable to provide any records that confirmed staff had been trained in the administration and management of medicines or that staff had their competencies checked since August 2016. The provider told us that they had been trained in the administration of medicines but when we asked them to provide evidence of their most recent training record, we saw that it was dated 2013. This meant that staff had not been trained or were competent to administer or manage medicines to people at the home.

When we looked in the kitchen we found a bowl with mouldy fruit, infested with flies. We also found three jars in the fridge that had not date of opening on them. We found vegetables in the fridge, which included cucumbers and peppers with green mould on them.

The failure to manage people's medicines safely and the inadequate risk management was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was no evidence found that confirmed any staff working at the home had received safeguarding training since 2015. We spoke with three staff and asked if they knew how to identify and report potential abuse. However, none were able to explain the home's safeguarding procedure. Also none of the three staff

we spoke with were able describe the different types of abuse that they may encounter working with vulnerable people. We spoke with a fourth member of staff who was only able to recall one type of abuse they may encounter. We asked three staff where they would locate the information on how to report an incident of abuse but they were unable to confirm where this was located. One staff member told us "I have only been here for a short time so I just ask someone else."

During our inspection we found that there had been two safeguarding incidents that had occurred in the home in the past three weeks that had not been reported to the local authority or to the Care Quality Commission. These related to an incident where a person had choked and had to be admitted into hospital and a further incident where a person's medicine had been stopped without notice and had caused the person to become anxious, agitated and upset.

As a result of this inspection nine safeguarding referrals were made to the local authority.

Due to people not being safeguarded from harm this was a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The process for the safe and effective recruitment of staff was not robust or consistent. We found from the eight staff files we looked at that none of these contained the required and necessary checks that ensured people had been recruited in line with the home's recruitment policy. We found that three staff files had no DBS (Disclosure and Barring Service) checks in place and all three staff were recorded on the rota as working. DBS is a way of employers checking to see whether staff have any prior convictions or concerning information on file to enable them to make safer recruitment decisions. The manager confirmed that all three staff had been working since 27 April 2017. We looked at a further three staff files and found that one file contained no references, another file contained a reference via e-mail with no address or signature of the referee and a third file only had photocopied references that had been obtained after the person commenced working at the home. A further staff file contained only two character references and no references from their previous employer. This meant that the service could not always be certain that staff were fit to be working in a care setting or that they had the necessary skills and experience to carry out their duties.

We found that a new manager had been appointed since the last inspection took place but the provider had failed to ensure that the necessary recruitment checks had been taken before they started working at the home. The manager confirmed that they had commenced working at the home on 26 April 2017. We saw from their file that the references received were invalid and false. One reference was from a 'Hotmail' account and did not provide any information with regard to the organisation or employer it referred to. The second reference provided by the manager was not from their previous employer. When we spoke with the manager about this they told us, "I have been untruthful with [provider's name] but I had no choice but to avoid the references from [employer's name]." We saw that the provider had signed and printed these references off but had not verified these by contacting the named referees.

People were not always recruited with the necessary documentation or checks to provide safe care and treatment to people. This was a breach of Regulation 19 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

People were not always supported to eat and drink a range of healthy and nutritious foods. We observed that snacks were not readily available for people to access freely. Some of the staff said people could have a snack if they requested one. Other staff members said people were given tea or coffee and biscuits mid-morning and mid-afternoon. One staff member told us snacks could not be left out because some people would, "Just take them all." However this practice prevented people from being given the choice to eat and drink when they wished to and meant people were reliant on staff offering them or them requesting a snack or a drink. We saw that people were only served drinks at specific times of the day and at the lunchtime meal, where we saw people were only given orange squash. This did not encourage adequate hydration and nutritional intake.

We observed the lunchtime meal and found that people were not always provided with support in a dignified and respectful manner. The meals were plated up by the cook in the main kitchen area, placed on trays and then carried out to people in the dining room and lounge areas. We saw that there was with no means of maintaining food at the required temperature. This placed people at risk of harm. There were also no pictorial menus in place to assist people who were living with dementia or memory loss with regard to their choice of meals.

We saw one staff member assisted a person with their meal without any interaction or explanation of what the meal consisted of or asking the person if they were enjoying it. On the second day of our inspection we observed one person was being assisted to eat their meal with utensils that were too big for their mouth and for the person to comfortably enjoy the food. On the same day we were also observed a staff member used the same utensils for the savoury meal as for the desert when they supported a person with their lunch. This meant that people were not supported in a dignified and respectful way.

We looked at the menus and choices provided to people. We saw that there was a four week 'rotating' menu in place. However we found that the meal provided on the first day did not reflect the choice displayed on the menu. When we asked the chef to explain this, they told us, "We didn't have any beef in the kitchen so we changed it to chicken." We asked the chef how they monitored people's diets and how they recorded what people had eaten for each meal. They produced a scrap of paper with a series of numbers on it, with no reference to the meal that each person had eaten or the person's name.

We looked at information within one person's care plan in relation to their dietary needs. It stated that they required a 'fork' diet due to them being at risk of choking. However we saw that this person had been given large slices of chicken that could have placed them at risk of choking.

We asked the manager where we could find a record of people's weights. We were told that they were unable to locate these and therefore they (staff member) had started a new record dated 24 and 25 April 2017. We found no evidence that confirmed the home had been regularly recording people's weight, previously to this date.

We also found in one person's care plan that they should be weighed on a weekly basis due to a poor appetite and the risk of malnutrition. The care plan stated that this person should also receive a fortified diet. However the last weight recorded was dated 10 December 2015. We saw from the daily records that this person was admitted into hospital on 15 April 2017 and their weight recorded as low, at 39.4 kgs.The hospital discharge summary stated that this person was 'Dehydrated on admission.' There was no evidence that they had been receiving a fortified diet, receiving meals according to a food or fluid chart or that their weight was being monitored on a weekly basis. This placed this person at serious risk of malnutrition and dehydration.

We found that food and fluid monitoring records were not always completed in a timely way. We found that the record for monitoring one person's fluids was out of date and incomplete. The record showed that from 26 April 2017 to 28 April this person had only consumed 1,825 mls of fluid. The record also showed that on 27 April 2017 this person only consumed 450 mls of fluid over a 24 hour period and on 28 April 2017 the person had only consumed 100 mls of fluid. Four entries out of 11 had not been signed by a staff member. This meant that we could not be assured of the accuracy of the records or if people were being sufficiently hydrated.

Due to people's choices and preferences not being upheld and their nutritional needs not being met we found that this was a breach of Regulation 14 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

On the second day of our inspection we spoke with two agency staff about their induction into the home. We found that neither of these staff members were able to confirm where the fire exits were placed, which people were diabetic or who was at risk of choking or falls. When we asked both these staff members to name the six people who were sitting within the lounge, the first member of staff was only able to confirm one out of six people's names and the second member of staff was only able to confirm four out of six people's names. When we asked each of these staff members if they had received an induction before they commenced working at the home, they told us they had not received an induction or had been asked to sign any documents when they first commenced work at the home. One of these staff members told us, "I just follow what the other staff are doing and pick it up as I go along."

We asked the provider for a training record to demonstrate that staff had been provided with the necessary training to care and support people effectively and safely. However they were unable to provide any evidence that people had received any of the required training. We spoke with four staff members about their training. None of the four staff were able to confirm that they had received moving and handling training, first aid training, safeguarding training, fire training or infection control training in the past year. We also found that the two staff who administered medicines to people on 27 April and 3 May 2017 had received medicine training in the past year. The provider informed us that they administered medicines to people when required but when we asked them to provide an up to date certificate we saw this was dated 2013.

Staff told us they did not feel supported by the provider. One staff member we spoke with said, "There have been so many managers here in the past two years that nothing ever gets done and we just do what we think we should be doing." Another staff member told us that they had not received supervision with anyone, for over a year. We asked for the records for staff supervisions but these failed to demonstrate that staff received effective supervisions or appraisals.

Due to the ineffective training, support and induction of staff we found that this was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We asked four staff members if they could give an example of where a person's liberty may be restricted. Only one out of four staff members were able to provide an example. They told us that, "You cannot use a lap belt without carrying out an assessment as this would deprive them of their liberty, I think, is that right?". There was no evidence that confirmed staff had been provided with MCA training.

We found that people had restrictions applied to their freedom without having DoLS authorisations in place for these. For example, one person had bed rails fitted but there no evidence within this person's care plan that their capacity to consent had been assessed and no consideration had been given as to whether a Deprivation of Liberty (DOLS) application was required to the Local Authority in relation to this restriction. We also saw the front door of the home had an electronic key pad fitted where a code was required to access outside. However we found no evidence that people's capacity to consent had been assessed or that any DoLS applications had been made to the local authority, in relation to this restriction. Therefore people were being restricted unlawfully and their freedom restricted.

Due to people's liberty and choices being restricted we found that this was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service caring?

Our findings

We found people had mixed views about the care they received. One person told us, "The staff have been very good, they have been very patient. They have been very nice I am quite happy." Another person said, "Staff are very kind and caring." However when we spoke with another person they told us, "Some staff can be rude, and sometimes shout."

People's dignity was not always promoted. We saw some examples of staff caring for people but on several occasions throughout the inspection were saw that the care provided was often basic and functional. For example we observed one person who was seated in the lounge area called for assistance to go to the toilet on three occasions, over a period of 10 minutes before a staff member responded to them. We observed two other staff members walk directly past them without acknowledging or responding to their request for help.

We found that people's incontinence pads were stored in an outbuilding next door to the main home. However we found that the pads were not individually labelled and therefore people could have been provided with the wrong size pads to manage their incontinence. This practice is both undignified and disrespectful.

People were not consistently cared for in a way that demonstrated staff respected people's choices or followed their personalised care plans. One person told us, "They put me to bed between 6p.m and 7p.m every night when I would like to go to bed between 9p.m to 10p.m."
We saw in one person's daily record that stated the person had, "Been to the toilet several times and was incontinent of piss and poo." This comment is both degrading and disrespectful.

On the first day of our inspection we observed two staff members trying to 'persuade' a person to go to bed at 7 p.m. We saw the two staff members take the person's arms and try to physically encourage the person to move from their chair and towards their bedroom. The person shouted out twice "No" before they left them alone. This practice is both abuse and disrespectful and demonstrates that the home does not respect or value people's choices or preferences. We spoke with another person who told us, "They like to get us all in bed before the night staff come on duty, but that's too early for me, so I tell them and they leave me for a bit longer."

The lack of attention to detail meant that people were sometimes left in an undignified manner. We saw that two out of six people who were seated in the main lounge area of the home appeared dishevelled, unkempt and with hair that had not been combed. We saw that two people had foot wear on that was ill fitted. We saw another person had not been shaved and had dried food on their clothing.

Private and confidential records relating to people's care and support not always securely maintained as the main office was left unlocked and on occasions we saw the office door propped open. This failed to ensure that people's personal information was treated confidentially and respected.

We found a lack of respect and dignity towards people and therefore this was a breach of Regulation 10 of

the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

Not everyone at the home was able to tell us if they were happy with the support they received. However one family member raised concerns about how responsive the service was to meeting people's needs. One relative told us, "My relative always liked to go out for a walk and enjoyed pottering around in the garden. However this rarely happens as the garden area needs some attention and there are not always people to take them around the garden as there are some areas of the garden that are slippy and could cause my [family member] to fall."

During this inspection we observed no meaningful activities were offered to people. On both 27 April and 3 May 2017 people we seen just seated in the lounge area without any activities being offered or provided. When we spoke with the provider about this and they told us that many people did not want to participate in activities within the home. We found that the activity programme had still not been updated or improved since 2016 and therefore did not necessarily reflect the changing interests of the people who now lived at the home.

Throughout our inspection we observed the television within the main lounge was selected to the same programme that was repeatedly played over and over again. We saw that none of the staff noticed this, offered people the choice to change the channel or offer an alternative activity. The activities primarily offered on a regular basis were bingo and skittles but this was not an activity that was commonly reflected as an interest, within people's individual care plans. We found that the current activity programme did not provide specific activities to engage or support people with dementia. This meant that people were not always provided with a range of activities that reflected their individual interests or hobbies.

We looked at the daily records for one person whose care plan record stated that they liked to attend a local social group on a Tuesday. However when we looked at the daily records for this person we found no information that confirmed they had been offered this activity in 2016 and nothing was recorded for 2017. We spoke with two staff on 27 April and three staff on 3 May 2017 but none were able to confirm when this person last attended this group.

At this inspection we found that there was no information to confirm that people had the opportunity to provide their views or opinions on the service provided. We saw the last meeting held was in June 2016, in which one person had requested a cooked breakfast and another person asked if they could go out for a picnic. We found no evidence that confirmed either of these issues had been addressed or were put in place. The minutes from this meeting failed to reflect any actions taken or how the issues had been resolved by the provider.

The home did not have an effective complaints system in place that recorded complaints, the action taken or the outcome of the complaint. We saw a record of a complaint dated 25 November 2016 that stated "Staff do not treat me well and staff do not come when I ring my bell." In the 'Action taken' section of this record it just stated 'Recorded this complaint' with no action points that stated how they managed this complaint, how the compliant was investigated or how the issues was resolved for the person themselves.

People's care plans did not contain information about how they needed to be supported. The five care plans we looked at did not contain specific information. For example about people's preferred times for getting up and going to bed and whether people preferred their bedroom door left open or preferred it closed.

Five out of seven people we spoke with could not recall having been involved in planning or reviews of their care plan and five knew little about what their own care plans contained. One person said, "I do not know about my care plan." Another person told us, "I don't know what a care plan is so I cannot comment."

People's care plans lacked detail or accurate information relating to people's care and were not subject to regular review, no background or social history to support staff to understand the person better the five care plans we looked at. Each care plan contained a basic list of the tasks that care staff would follow when providing support and some information in relation to continence, mobility, communication and diet. This information was not person-centred and did not provide enough detail to enable staff to carry out tasks consistently and safely.

From our observations we saw that staff often provided only basic and functional care and this was not always in accordance with their care plans. For example we saw one staff member approach a person who was seated in the lounge, without any conversation or explanation with this person before they fitted a handling belt around the person's waist. They communicated only with the other staff member who was assisting them and spoke over the head of the person they were assisting.

Although people were asked whether they preferred baths or showers when they moved into the service, the daily records failed to confirm if people had been provided with this choice. We looked at one person's care plan which stated that they preferred a bath to a shower. However their daily records failed to confirm that this person had been offered or given a bath from 27 August 2016 to 2 May 2017. When we asked the provider about this they told us that it was a recording error.

We looked at the daily records for a third person from 14 December 2016 up to 24 December 2016 but there was no information that confirmed that they had been provided with any personal care during these dates.

The provider failed to ensure that people's preferred choices with regard to their personal care needs were respected. We looked at the daily records for another person and the records failed to confirm that this person had been provided with any personal care from 16 March 2017 to 3 May 2017. When we asked the provider about people's choices with regard to if they wished to have a bath or shower they stated "Well, the bath is broken so people can only have showers."

We found that the environment, in particular for people living with dementia, was inadequate with regard to providing any visible prompts or signage to assist people in locating their bedrooms or the communal areas of the home. There was also no dementia friendly colour schemes or memorabilia provided, which can assist people in becoming more relaxed and less anxious, when in large communal areas of the home .No efforts had been made to personalise people's bedroom doors, with either photographs or pictures. We observed two people during our inspection who spent the majority of their day wandering along the ground floor corridor, with no staff interaction or being offered an activity or any meaningful engagement, except being constantly asked if they would like a cup of tea.

Due to the lack of meaningful engagement for people living with dementia, poor care delivery and ineffective care plans we found that this was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

The management of the service lacked leadership and was not transparent or open. We found during our inspection that people had been placed at risk of harm due to unsafe practices and ineffective systems that monitored people's health and safety. For example, where people were at risk of falls and at risk of choking, there was no documentation in place to identify or reduce the risks to these people. These issues had not been identified by the provider, prior to this inspection taking place and there had been no lessons learned as a result of these incidents.

We found that people had their liberty restricted unlawfully with regard to the use of bedrails and leaving the home. This practice had not been appropriately assessed and monitored by the provider as they were not complying with the MCA. We observed unlawful practices of restraint being carried out, during our inspection. For example we saw one staff member try to force a person to eat their food and one person had bedrails fitted without a record of consent in place or an application of deprivation of liberty safeguard being made to the local authority.

We found that people's nutritional and dietary needs were not monitored which placed people at risk of harm from consuming food that was both inadequate and against their wishes.

We asked the provider for any quality monitoring records that were in place for the home but they were unable to provide these. We also found that there were no audits in place that monitored people's records in relation to hourly call bell checks, fluid balance charts, personal care being given and weight records. This placed people at risk of harm from dehydration, malnutrition, lack of personal care and risks to their personal safety.

Feedback from staff failed to demonstrate that they were being provided with the appropriate training, induction or supervision to carry out their role effectively. For example, three staff we spoke with could not confirm when they last received training in moving and handling, infection control, first aid, the administration of medicines or safeguarding. Two agency staff who we spoke with told us that had not received an induction into the home and they were unable to recall the names of the people who lived at the home or recall where the fire exits were placed. We found that staff had administered medicines to people without the required training or competency checks in place. We found that the provider had also administered medicines to people without being trained in medicines. This placed people at risk of receiving unsafe care.

We found serious concerns in relation to the recruitment process in place. This placed people at risk of receiving support from staff who were not fit to do so.

We spoke with staff about the management of the home. Staff gave us mixed feedback about the support they received from the senior staff. One person told us, "There have been so many changes that it's hard to know what's going on." Another staff member told us that the provider had shouted at them on several occasions and had used offensive and derogatory language.

We found that there were no systems in place to obtain feedback through the completion of annual surveys. This meant that the provider was not able to formally receive feedback about the service people received.

Governance systems were not robust and as a result we found that this placed people at risk of harm, unsafe care and a poor quality service. Therefore this was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.