Croft Carehomes Limited

The Croft Care Home

Inspection report

17 Snydale Road
Normanton
West Yorkshire
WF6 1NT

Tel: 01924223453
Website: www.croftcaregroup.co.uk

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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

The inspection of The Croft Care Home took place on 8 and 9 October 2018 and was unannounced on both days. The home had previously been inspected in January 2018, rated requires improvement and found to be in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which assesses the suitability of premises and equipment. Following the last inspection, we asked the provider to complete an action plan to show what they would do, and by when, to improve the key questions in the safe and well led domains to at least good.

The Croft is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The Croft accommodates 29 people in one adapted building and provides personal care support, but not nursing care. On the days we inspected there were 20 people living in The Croft.

There was no registered manager in post. They had left the service in June 2018 and an acting manager had been appointed to provide interim cover. The provider had appointed a management consultancy firm to assist the acting manager. However, the acting manager had left the service on 5 October 2018 and there was no operational management cover in place when we arrived on the first day of our inspection. The provider advised us mid-morning on the first day the management consultancy firm had been requested to provide operational management cover. 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 not safely supported in the home as there were insufficient, experienced staff. Staff did not work as a team and did not effectively manage risk. Risk assessments were out of date and incidents were not analysed to reduce the risk of potential harm being repeated. It was unclear if all safeguarding concerns had been reported or investigated properly due to a lack of records.

Medicines were managed, for the most part, safely but there were issues with 'as required' medication where there was insufficient guidance for staff.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service did not support this practice. The service was not working in line with the requirements of the Mental Capacity Act 2005.

Staff were not adequately supported as they did not receive regular supervision and due to lack of records, it was difficult to determine how current training was. Staff were overworked and some displayed a complete lack of empathy for the people they were supporting. There was little promotion of dignity or respect as people's needs were openly discussed. There was limited evidence of people deciding how to spend their

day and there was insufficient activity to engage them.

As stated above, the service had no registered manager and the acting manager had also left. There was limited quality assurance and what audits had been completed, were not followed up with actions to resolve the issues. The management consultancy firm had been appointed from 8 October 2018 to provide operational cover but this was limited due to their availability.

We found nine breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: 9 (person-centred care), 10 (dignity and respect), 11 (need for consent), 12 (safe care and treatment), 13 (safeguarding service users from abuse and improper treatment), 14 (meeting nutritional and hydration needs), 15 (premises and equipment), 17 (good governance) and 18 (staffing).

Following the inspection, the provider agreed to a voluntary restriction on admissions and provided us with some reassurances regarding management and staffing cover. The local authority commissioning team has also suspended placements at the home.

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 Care Quality Commission is considering the appropriate regulatory response to resolve the problems we found. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not always safe as there were insufficient staff to support them and staff on duty did not show they understood the risks to people.

Safeguarding concerns and other incidents were not investigated robustly and risks were not effectively managed. There were still some issues with medication.

The environment was poor, with areas of uncleanliness and untidiness. Fire doors were propped open with chairs on both days of the inspection.

Is the service effective?

Inadequate

The service was not effective.

We did not observe current best practice being followed and there was no evidence of teamwork.

Although there were some mental capacity assessments in place, these were not current. Staff did not show they understood their roles and responsibilities well.

People's nutritional and hydration needs were not always met safely, and one person was at risk of choking before we intervened.

Is the service caring?

Inadequate

The service was not caring.

Staff displayed insensitivity to people's needs and some were abrupt in their attitude.

People's dignity was not promoted as people were left in soiled clothing and continence care was not pro-active. Feedback from relatives also indicated they often found their relation in wet

clothing.

There was insufficient bedding available and no effective laundry system. People were left in rooms with doors wide open despite being in their nightclothes.

Is the service responsive?

Inadequate

The service was not responsive.

The provider had instigated an electronic care record system which some staff did not have access to, and others who did, were not aware of how to record properly on it.

Records were not completed in full and there was no oversight of care delivery. One person who was staying at the service for a period of respite care did not have any care documentation in place despite having stayed in the service over two weeks.

There were no activities in place as the activity co-ordinator was deployed to provide care tasks. People were bored and disinterested.

Is the service well-led?

Inadequate

The service was not well led.

There was no management oversight on the first day and the home was chaotic. The staff did not know each other's names and there had been no effective handover.

There was no effective quality assurance process in place although the management consultants had begun this. However, the immediate needs of the service required strong leadership and this was not evident.

The Croft Care 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 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.

The inspection of this service was brought forward due to a number of concerns received about this service and due to the Commission being dissatisfied with the responses received when asking for further information regarding incidents such as falls.

This inspection took place on 8 and 9 October 2018 and was unannounced on both days. The inspection team consisted of two adult social care inspectors, a medicines inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The provider had not completed a Provider Information Return as the inspection was brought forward. This 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 spoke with eight people using the service and four of their relatives. In addition, we spoke with eight staff including four care assistants, two senior care assistants, the care co-ordinator, and a member of the domestic staff. We also spoke with both management consultants and the provider, along with a visiting health professional.

We looked at seven care records including risk assessments in depth, four staff files including all training records, minutes of resident and staff meetings, complaints, accident logs, medicine administration records and quality assurance documentation.

Inadequate

Is the service safe?

Our findings

At the last inspection we found a breach relating to premises and equipment and on this inspection found this had not been addressed. We identified further significant concerns in addition to this.

The home had a malodour which was a combination of the smell of urine and smoke. Although attempts had been made to limit the fumes from the smoking room through opening windows and keeping doors shut, the smell pervaded the home. The smell of urine increased during the day as people's continence needs were not met and one domestic member of staff was insufficient to clean the whole home and manage the communal areas.

The kitchen was in an unacceptable state with dirty, tepid water was left in the sink which was blocked. The floor was dirty and there was a green mop in a bucket full of dirty, smelly water. We could find only four slices of bread in the kitchen although we were advised later in the day that food was stored 'over the road'. We saw a plate on the cooker top with a piece of meat in gravy and a large plastic bowl of tepid beans on the worktop uncovered. The health and safety assessment, which had been reviewed in January 2018, stated no people were able to access the kitchen area and yet the broken digital lock on the door meant there was no restriction in place.

We found the hot water temperature was very hot. We could not keep our hand underneath it in some communal bathrooms. However, we could find no evidence of regular checks. The last check we found was dated 28 September 2018. We spoke with the management consultant about this and they assured us they would 'deal with it'. We received a copy of a water temperature check dated 19 October 2018 which concluded there were some issues, but this did not indicate what action had been taken.

Premises and equipment were not clean. The lounge had armchairs which were stained, and sometimes damp cushions. Pressure cushions were in place but these were not visibly clean. The toilet nearest the lounge had a dirty raised toilet seat and bowl. We found some people's rooms were in a poor state, with a malodour and with clothes, papers and other sundries discarded on the floor. We walked around the home several times on both days and found bedding missing. Not all people had sheets on their mattresses or duvet covers due to the disorganised state of the laundry. This is a breach of Regulation 15 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were supplies of personal protective equipment for staff to use such as aprons and gloves in bathrooms. Premises safety checks in areas such as gas and lifting equipment had taken place as required.

Risks were not effectively managed. At least two people who were independently mobile were at significant risk of harm due to falls. Both were repeatedly told to sit down at regular intervals during both days by staff and other people living in the home. No diversions were offered from staff to provide a distraction, or to seek clarity as to what the person wished to do. One person was without their walking aid for part of the day which increased the likelihood of harm, despite this being part of their falls risk assessment. Other people were supported incorrectly to stand by being asked to hold onto their wheelchair to get their balance,

resulting in them leaning forward and posing a heightened risk of losing their balance.

We raised our concerns about fire risk as a number of people smoked. We saw one person playing with a lighter in the dining area. We later found the same person was deemed to lack capacity as the management consultant had applied for a deprivation of liberty safeguard authorisation. We asked for an urgent risk assessment to be completed as there was none in place. This was received post inspection but did not sufficiently identify the risks posed or the actions in place to mitigate the likelihood of harm. We also saw, on both days, fire doors propped open with armchairs which would have rendered them useless in the event of a fire.

We looked at accident and incident records and found these had been completed only up to 5 September 2018. The management consultant confirmed none had been reported to them since they started on 10 September 2018 up to the time of the inspection. Of those logged, although there was detail of the incident, there was insufficient analysis to indicate consideration had been given to measures to reduce the likelihood of future incidents. Incidents had occurred when staff had been transferring people, yet there was no evidence to show staff practice or the appropriateness of the transfer had been reviewed. One record showed the person needed to be on regular observations, but we could find no evidence these were taking place. We did not see staff check on the person in their room or complete any records to indicate this. On another record it was noted a care assistant came into the lounge and found the person on the floor after being assisted by a colleague. The record stated, "It looked like [name] had fallen while being transferred." The manager's comment said, "All actions were taken at the time of the incident by staff." This did not show an effective approach to reducing the likelihood of harm. This is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 safe care and treatment as the assessment and mitigation of risk was insufficient to reduce the likelihood of harm.

Staffing levels were insufficient to meet people's needs safely. A relative said, "Some [staff] are good but dangerously low on staff, often only two on." We were advised early on the first day of the cook's absence which meant the care co-ordinator cooked the main meal for people that day. Staff advised us no one was covering the laundry and they had to take it in turns to complete this. There was no system in place and staff had been taking laundry home to manage which posed an infection control risk as they had no time during their working shift to complete this task.

Staff told us, "There's not enough staff, we are all rushed off our feet," and, "There's hardly any staff." We looked at staffing records and found this was accurate and the service was relying heavily on agency staff. One care assistant said, "Staff have come and gone. They don't seem to stay more than a couple of shifts." Another care assistant told us, "We don't feel supported as there are not enough staff, we are not able to meet people's needs or do our work as well as we ought to." They spoke with us about offering to do extra shifts to cover shortfalls, but one care assistant said, "But that was in May, and it's gone on too long." The management consultant advised no permanent staff had been recruited to the service recently.

There was a clear divide between permanent and agency staff with neither party willing to work with the other and blaming each other for unfinished tasks. The staff working on the first day did not know the name of the agency care assistant, and when we asked for the records of this staff member, the management consultant did not know their name either and no checks had been undertaken. The agency profiles we were shown revealed most staff's training had lapsed and there was no evidence to show the manager or provider had sought any reassurances around this. Some profiles identified where people's visas had expired and therefore they were not permitted to work in Britain. For the two staff working from abroad and living in the care home, there were no records to show they had been mentored, shadowed any colleagues or had their competency checked. The management consultant was unable to locate any information to

evidence this. On the second day we heard the management consultant request further details about specific agency staff who were due to work in the home later in the week.

We looked at staffing rotas and found these were not completed sufficiently in advance and staff complained to us about the difficulties of planning childcare or other caring support required. On the first day we were shown the rota for the current week as no others had been planned at this point. Staff complement consisted of one senior and two care assistants during the day and two care assistants during the night, one of whom may be a senior. This meant if people required medication during the night and there was no senior on duty, this medication could not be administered. The last dependency tool we found was dated 8 August 2018. We were given a copy after the site visit dated 9 October 2018 which did not reflect the level of need we found as most people needed two staff to transfer safely. This is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 staffing as there were insufficient numbers of competent and skilled staff working in the home.

Medicines were stored securely in a locked treatment room and access was restricted to authorised staff. There were appropriate arrangements in place for the management of controlled drugs and staff regularly carried out balance checks of controlled drugs. We checked the quantities and stocks of medicines for 14 people and found the stock balances to be correct. This meant that medicines had been given as signed by staff.

Written guidance was not always in place to enable staff to safely administer medicines which were prescribed to be given only as and when people required them, known as 'PRN'. On this inspection we found that in five of the 14 records we checked, guidance was not available. Some medicines were prescribed with a variable dose i.e. one or two tablets to be given when required. We saw the quantity given had not been recorded, meaning that records did not accurately reflect the treatment people had received.

Staff had received medicines handling training. However, there was no documented evidence to establish their competencies were assessed regularly to make sure they had the necessary skills. We found room temperature checks were sporadic as were those for medicines which required cold storage. No action had been taken by staff to address this. This meant we could not be assured that medicines requiring refrigeration were safe for use.

We saw medicines audits which had been developed since the last inspection which included regular checks by managers. However, the audit tool was limited in scope and detail and had failed to identify the issues we found. In addition, action plans were not always produced following an audit. This is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 safe care and treatment as medicines management was not completely safe.

Personal emergency evacuation plans did exist for people but were not always reflective of current need or accessible as stated on them as they were stored in the office.

Of the people and relatives we spoke with, most told us they did not feel safe due to the lack of staff and a lack of oversight by staff. We were unable to locate any safeguarding records and the management consultant advised this was because they were referred directly to the local authority. They confirmed there were no records of recent events or evidence of what action had been taken about them. We did see in an incident log reference to two separate incidents where the acting manager had offered the relative a choice of a full investigation or to be managed in house. There was no evidence the incident had been reported to the relevant bodies as required under legislation. This is a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 safeguarding service users from abuse and improper

treatment as potentially abusive situations were not being reported or investigated in accordance with requirements.

Staff were not always aware of external agencies they needed to report such concerns to. Staff knowledge around safeguarding was basic as evidenced in the poor practice we observed and in their inaction when situations were escalating. We had received some notifications in line with reporting requirements but it was difficult to determine if this was an accurate reflection of events.

Inadequate

Is the service effective?

Our findings

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. We found some capacity assessments in place but not all were decision specific. In one example we read the decision was 'general daily living' but referred to falls reduction equipment, which we observed was in place. The decision for the equipment had been made with a social worker and district nurse and so followed the best interest guidance. However, others were not correct and needed reviewing such as the process for agreeing covert medication.

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). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found many of the DoLS had lapsed but the management consultants had submitted renewal applications. For those still authorised, we found there was inconsistent evidence of conditions being followed as records of visits by the relevant person's representative were not always recorded. This is a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 need for consent as the requirements of the MCA were not being followed.

Many of the policies and procedures we found referred to out of date guidance, and the practice we observed did not reflect current models of safe care.

When we arrived on the first day there were nine people in the lounge area but it was unclear who had eaten breakfast. There were no cups on the dining tables and no evidence of breakfast. When we asked staff who had had breakfast they were unsure. This was because the senior care assistant, who was administering medication, was also serving breakfast while in the lounge. The other two care staff were assisting people to up. There was no record of who had eaten or was yet to have any breakfast. One person did not enter the lounge until 10.10am but was not offered any breakfast or a drink when they did so.

People had access to drinks mid-morning but not everyone was asked their preference. At lunch time the agency care assistant was directed by the other staff where to place people at the dining table. People were not asked their choice, and referred to in the third person, i.e. "She can sit there" and "Sit her over there." People were sat at the dining table from 12.15pm but no food was brought out until 12.40pm.

The cook was not present on the first day of the inspection and so the lunchtime meal was prepared by the care co-ordinator. It was plentiful and served hot, and people did have plate guards to assist in their independence. The dining room was well presented with tablecloths, condiments and cutlery. One care assistant offered people a choice of juice by showing them the two different types of drink in jugs. The senior care assistant directed the care co-ordinator as to people's meal choices, which had been obtained earlier

that day, but when asked if there were any specific dietary requirements we were advised there were not, which was incorrect based on the care records we had seen.

There was insufficient dietary guidance for staff to follow and staff were not aware of who was at risk due to certain health conditions. One person with capacity advised staff themselves of what they were able to eat due to their physical health needs. However, other people were not able to do this. We found one person who was supposed to be on a special diet have been given incorrect food groups on a daily basis according to their food chart.

On the second day we heard one person say how appalling it was there were no teabags. Teabags were not provided at the home until 12.15pm that day and the person refused to drink any other beverage. They told us they had not had a drink since getting up. On the second day we noted one person in their room with a full plate of food in front of them but they were fast asleep. The food remained uneaten. This is a breach of Regulation 14 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people's nutritional needs were not being met.

We had to intervene in one instance where a person was laid in bed, not upright, being served food of an incorrect consistency. This could have resulted in a choking incident. The care assistant who was working in the home for the first time had not been made aware of the risks to this person as no one had spoken with them about people living in the home before they had begun their shift. We looked at this person's care record and found incorrect information in their care plan as it stated the person needing their food cutting up but also referenced they needed food to be of a 'fork mashable' consistency.

For people at risk of weight loss records were poor. One person only had two entries for 7 October 2018 which stated they had had a banana, soup and banana whip and 200ml tea. No other food or fluid intake was recorded. We heard on the second day staff shouting at each other various fluid quantities for people so this could be recorded on the system. This was not based on any written records and was questionably accurate. This is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 safe care and treatment as the assessment and management of risk was ineffective.

There was no evidence of a handover on the first day we inspected. The agency care assistant was working their first shift in the home and advised us they had not been introduced to anyone or received any induction. When we queried this with the management consultant, they confirmed there was no evidence an induction had taken place. Another agency worker told us they constantly had to ask for information and guidance as they had no access to any records and information was not freely shared. We heard on the second day a discussion between a senior care assistant and the management consultant about the importance of agency staff being inducted but the request was challenged by the senior care assistant, saying they had no time to perform this role.

Staff were not receiving appropriate support or supervision. Staff told us they had not received regular supervision and training was delivered via e-learning and booklets. When we checked staff files we found a lack of supervision records since the previous inspection and the training matrix had not been updated since February 2018 which meant it was difficult to determine if staff training was up to date. Some of the training schedule indicated training had been undertaken but we could not always find corresponding proof in staff's files. In one staff file we found a number of training courses had expired and there was no evidence of further training having been undertaken. Most of the courses were undertaken at three yearly intervals although moving and handling was annually. This is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We heard one person say they were in pain and they asked a care assistant why they had not arranged for the doctor to visit as they wanted to see one immediately. They were told, "Tomorrow, you can have the doctor. I haven't had time today." The person was not happy and said, "It's not good enough, I asked first thing."

We spoke with a visiting health professional who advised they felt not all staff followed advice which had been offered. However, we found records did indicate external health professionals were contacted as needed in most instances such as the dietician or dentist.

Inadequate

Is the service caring?

Our findings

We heard one person tell a care assistant, "I've had this horrible smell. I've just sniffed the cushion I was sitting on and someone's peed on it. I'll have to go and get changed now." The care assistant said, "I'll sort it" and a different care assistant took it and said, "I suppose I'll wash it then." Relatives spoke with us of having to provide personal care support themselves. One relative said, "We had to clean [name] up as they were plastered [with faeces]." Another told us, "The residents are not getting the care they need." They spoke with us about many incidences of their relative not receiving continence care or support with personal care. They explained these issues had been raised with the provider but nothing had changed.

One person was quite vocal in the lounge and a few people appeared to find this distressing. During this time a care assistant was sitting at the computer but did not intervene or show any acknowledgement of the person crying out or the other people showing annoyance. A number of comments were made which were not stemmed to avoid escalation. Staff were not pro-active in managing situations which led to people acting a way which showed they were distressed.

When we arrived on the first day we saw people in their nightclothes in full view as doors were propped open. One person was lying across their bed exposing their underwear and a care assistant went into the room and came out again, without closing the door or adjusting the person's clothing. People were not wearing their own clothing as this had not been laundered. Some people openly complained about wearing clothing which was too tight and we observed people wearing ill-fitting clothing, such as trousers which were too small. One person told us, "My trousers are hurting me, they are too small. They are not mine." One relative said, "Everything goes missing, so we are now taking their clothes home and washing them."

During the morning on the first day we heard one care assistant state loudly, "Let's get you to the toilet, [name]." No regard was given for this person or others sitting in the same area who could clearly hear what was said.

During lunchtime on the first day we witnessed a conversation between a person and a care assistant about another person living in the home. This involved discussing the person's continence care needs in front of the person and others sat in the dining room. The care assistant said very loudly, "Oh, you're not going to the toilet? You've got 20 minutes before dinner." The discussion had no regard for the person's dignity. A bit later the same care assistant was told by the person, "I don't want to go for a wee" and they replied, "Oh I thought you would." Another person living in the home then started taking part in the conversation at full volume across the dining room about the consequences of drinking lots and needing to use the toilet. Other, more senior staff, were present in the lounge at this time, and did not make any effort to halt this discussion.

One person was asked by a care assistant loudly, "Are you wet? Let's go and change them I'll go and get you some," referring to the person's trousers. When this person stood up their clothes were clearly soaked through and the cushion on the chair was visibly wet. This cushion was not cleaned during the whole lunchtime period.

People's signs of distress were ignored, people's privacy was not respected and there was little regard for discretion. On the second day we heard an exchange between two care staff where one advised the senior the person had not wanted to get up with them, and so the senior replied, "Either, [name] will get up with you, or it'll be a long wait." No attempt was made by the senior care assistant to determine what the issue might be or whether an alternative care assistant might help. They dismissed the person's feelings and did not support the care assistant to manage the situation differently or offer any other support. This is a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 dignity and respect.

Inadequate

Is the service responsive?

Our findings

We observed people sat passively in the lounge for much of the day. Although the radio was playing from the TV, four out of eight people were asleep. One person kept calling out but no staff responded. Mid-morning on the first day there was a 15-minute period where no staff were in the lounge at all. Although the activity co-ordinator had come in on their day off, they were unable to perform their role as they were assisting with care tasks. They managed to hold a short game of skittles after lunch.

A number of people remained in bed in their rooms all day and we saw very little interaction from staff with these people. There was a lack of recorded checks and staff spent most of their time in the lounge area. We asked one care assistant about one person who kept crying out and they admitted they did not know how to support the person as they had been told nothing about them. When we asked another care assistant what was happening with the person, they said they did not know either. We had to advise the person needed repositioning as their head was pressed against the wall. However, they were supporting another person who they said needed support first and said, "I'll see to them, it must be about time now."

The care assistant admitted they relied on their memory to make notes on people's care delivery as they did not have time to write them at the time. This meant there was no contemporaneous record of any repositioning check or continence management for this person. We checked the records and found entries were ad hoc. The previous day, 7 October 2018, had only four entries starting at 2pm and there were only three more with no evidence of any checks having taken place since 8.10pm that day. The next recorded check was 7.30am the following day. According to their care plan the person was supposed to be supported with repositioning at two-hourly intervals.

The records for this person also provided inconsistent guidance for staff saying they could be transferred using a hoist or a turntable. However, it also stated they were on bed rest due to a fall in May 2018. When we questioned a senior care assistant it was evident there was no clear understanding of this person's current needs.

We looked for records of another person who was on respite and had had a number of falls. While the falls were logged, there was no evidence of any care plans in place to support this person effectively.

During our last inspection we found paper records to be mostly person-centred but during this inspection we found many had not been updated to reflect current need. Care records were in the middle of being transferred onto an electronic system. However, this transfer did not appear co-ordinated as some people had more records then others and it was not always easy to find records. It was understood all 'progress notes', or daily records, were to be added onto the system. However, we found not all staff had access to this which meant they relied on colleagues to record on their behalf or it was left unrecorded as there was no alternative process in place.

Records from the night shift were written on a scrap of paper which was left in full view in the dining area. It was incomplete and unclear as to what care had been provided. One care assistant admitted, "The night

shift write on a piece of paper but I can't understand it. I can't do the checks [on the computer] for last night as I can only do what I know I've done today." We sampled the progress notes of one person at 9am on the second day of inspection and found no entries had been made on the system since 2.30pm the previous day. This is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as care was not person-centred.

One family we spoke with raised some issues regarding the neglect of their relative, which they later shared directly with the provider. The provider assured us they were looking into the circumstances and would be responding to the concerns. We saw the home had received two complaints between November 2017 and April 2018, both of which had been investigated thoroughly and apologies offered by the then registered manager. Three further complaints had been made since June 2018 where the outcomes were not recorded as clearly.

The home had received six compliments during 2018 including many offering grateful thanks to all the staff.

Inadequate

Is the service well-led?

Our findings

We found the home to be in a chaotic state when we arrived on the first day to inspect. There was no evidence of any leadership as staff did not know their colleagues' names or who was supposed to be performing which tasks. On the second day, the atmosphere was slightly calmer but still poor, as people were shouted at by staff to sit down and not supported in a person-centred manner. None of the staff had been informed of the acting manager's departure and were unclear who had managerial authority.

One relative advised us, "A handful of staff are OK but it's like talking to the wall." Staff advised the provider did visit the service but focused on tasks which were uncompleted rather than considering the welfare of staff. We asked staff about the management of the home and one care assistant told us, "It is zero - there is no management."

We spoke with the provider on the first day of the inspection and outlined our initial concerns. They explained the acting manager had recently left and the cook had rung in sick so they had had little time to put any management plans in place. However, they did state they wanted the home to be more settled until they advertised for a manager. They acknowledged there had been a significant staff turnover and were struggling to recruit. They were using an agency they had contracted with in their other services to fill vacancies.

The management consultancy firm had been in the home since 10 September 2018. Their role had initially been to support the acting manager with establishing systems to effectively manage the home but since the manager had left the home the previous week the provider had to ask them to provide some operational management cover. They were initially each providing three days' cover each during the week with an overlap on Wednesday but this was increased to four days each, with the mid-week days overlapping to provide extra support. This meant there was operational cover during the week. There was an on call rota outside of these hours for staff to contact in an emergency.

Since the management consultancy had commenced they had instigated a daily walkaround which was thorough. We found repeated issues were recorded including reference to the dirty kitchen but there was little evidence of resolution to these. We found the latest had been completed on 4 October 2018 where significant environmental issues were noted. During our numerous walkarounds on both days we found little of the concerns noted had been addressed.

The quality assurance system which was in progress at the last inspection was still not fully implemented. Although there was a yearly timetable of planned audits, we found many of these had not been completed. Resident and staff annual surveys were due to be sent out in October 2018. There were a few 'respect and dignity' audits which focused on the dining experience but these were tick box audits and provided only basic information. The mattress and bed rail audit was supposed to be completed monthly but we only found audits for June and September 2018. Not every mattress was listed as checked, and where issues were noted the action taken was not noted.

The assessment, monitoring and mitigation of risk and quality were insufficient to provide safe care. This all demonstrates a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 good governance.

Evidence of staff and resident meetings were submitted after the inspection as they were not available on the day.

The management consultants had completed a thorough home audit along with a health and safety audit. These reflected many of the issues we found on this inspection. They had implemented an action plan which they were beginning to work through while now commencing with operational management of the home.

The ratings from the previous inspection were on display as required under legislation.