Croftacres Limited

Croftacres Residential Home

Inspection report

15 Hibberd Road
Hilsborough
Sheffield
South Yorkshire
S6 4RE

Tel: 01142340016

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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 took place over two days on 26 October and 10 November 2016 and was unannounced. The home was last inspected in February 2015, when it was found to be requires improvement in all the key lines of enquiry.

Croft Acres is a home offering accommodation over two floors for up to 25 older people and people living with dementia who require personal care and support. At the time of the inspection there were 19 people living at the home.

There was no registered manager in post at the time of the inspection. There was a manager who was absent from the service, and an interim manager who was responsible for the day to day running of the home in the manager's absence.

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.

The provider was not meeting the requirements of ten regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and one requirement of the Care Quality Commission (Registration) Regulations 2009. We are currently considering our options in relation to enforcement and will update the section at the end of this report once any action has concluded.

The service was not recognising incidents which put people at risk of harm and was not taking all reasonable measures to keep people safe.

Risk assessments where they were in place were not correctly filled out and did not identify specific risks or demonstrate the measures needed to mitigate those risks.

Medicines were not managed safely. People were not all receiving their medicines as prescribed.

There were not always sufficient staff on duty to meet people's needs safely. Staff were not well-trained or supported.

Recruitment processes were not adhered to and the required pre-employment checks were not always carried out prior to people commencing work.

The service was not protecting people's rights and working within the Mental Capacity Act 2005.

Food was not always of good quality and people did not all receive the required support to help them eat

and drink adequately.

Staff were kind and caring, however did not always recognise when people were not being treated with dignity and respect.

People were not encouraged to be independent. Care was task orientated and had some institutionalised elements.

Care plans were not person centred. There was very little evidence of personal information being gathered and available for staff. Care plans were not reviewed to ensure they were up to date and included all current information.

There were activities in the home, however these did not meet the needs of some of the people in the home and were not helpful to people living with dementia. There were no opportunities offered for people to leave the home on outings.

The management of the home had been unstable and people and their relatives had lost confidence. People were not sure who the current manager was.

There were no processes in place to monitor the quality and safety of the service. The registered providers did not have any oversight of the performance of the home or the staff who worked there.

Records were of very poor quality and did not fulfil their purpose.

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 five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The service was not recognising incidents which put people at risk and was not reporting these to the relevant bodies for investigation and action to be taken to ensure the safety of the people in the home.

The management of medicines was not safe. People were not receiving their medicines as prescribed in all cases. Risk was not always identified or appropriately managed.

The recruitment process was not robust and did not ensure that people who were employed were of good character and suitable to work with vulnerable people.

Is the service effective?

Inadequate

The service was not effective.

Training was not up to date and the induction process which was in place was not adequate to ensure staff were competent and able to carry out their roles effectively.

Mental capacity assessments and best interest decisions were not carried out in line with the Mental Capacity Act 2005. Deprivation of Liberty Safeguards were not in place to ensure restrictions which were in place were lawful.

People did not enjoy the food they were being given and were not being monitored to ensure they were maintaining a good level of nutrition or hydration.

Is the service caring?

Inadequate

The service was not caring.

Staff were mostly kind and caring in their approaches to people; however they were not recognising people's needs and ensuring these were met.

Staff did not always maintain and protect the dignity of the people in the home.

People were not encouraged to be independent or involved in the running of the home and decision making relating to their care and support.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans were not reflective of people's needs. There was conflicting and contradictory information contained within care plans we reviewed.

Care plans were not person-centred and there was no evidence people had been involved in the creation or review of their care plans or risk assessments.

Complaints were not being recorded, investigated or resolved in line with organisational policy.

Is the service well-led?

Inadequate

The service was not well-led.

There had been inconsistent management for a period which had led to a decline in the standards in the home; these standards were not being monitored by the registered provider.

There were no processes in place to monitor the safety or quality of the service. This meant the registered provider did not have any oversight of the performance of the home or its staff.

The home was not meeting the terms of its registration, as they were failing to display their previous rating on their website, and they were not notifying the Care Quality Commission of incidents which is a requirement under the Care Quality Commission (Registration) Regulations 2009.

Croftacres Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 took place over two days on 26 October and 10 November 2016 and was unannounced on both days. The home was last inspected in February 2015, when it was found to be requires improvement in all the key lines of enquiry. The home was inspected as there had been serious concerns brought to our attention from the commissioning authority in relation to the safety of the care which was being provided in the home.

The inspection was carried out by two adult social care inspectors and an expert-by-experience on the first day, on the second day there were two adult social care inspectors. 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 expert had experience of adult care settings and people with dementia.

Prior to the inspection we reviewed all information we hold on the home, and sought feedback from the commissioning authority and other professionals who worked with the home. We did not request a provider information return due to the inspection being brought forward in response to information of concern being received.

During the inspection we spoke with 11 people who lived at the home and six relatives who visited the home. We spoke with five members of care staff, one senior care worker, the interim manager and the owners of the home.

We reviewed records relating to all areas of the service including, the care files for eight people, staff

recruitment files for four staff, training and supervision records, safeguarding records, complaints, risk assessments and medication administration records for every person who lived at the home. We also examined safety certificates, policies and procedures which were in place.

Inadequate

Is the service safe?

Our findings

People who lived at the home did not all feel safe. People told us, "I have lived in another home, it felt safer than here", "I don't feel safe at night, a male resident wanders into my room during the night. I use my buzzer but they are ages coming", and "I feel I live in a safe place, but I feel so insecure".

Relatives we spoke with echoed what people had told us and said, "I believe my relative is at risk, it is not safe here at times", "The people who live here are too challenging, the staff cannot keep them all safe" and "I have never seen so many staff on duty, it's because you are here, they have clearly called extra staff in".

Staff we spoke with told us they had undertaken safeguarding training and were able to explain what safeguarding was and what their roles were in relation to keeping people safe. However, we found there had been incidents which had taken place which had not been recognised as safeguarding and action had not been taken to report these incidents to the relevant authorities for investigation and for actions to be put in place to ensure the safety of people in the home. For example we identified there had been an issue with how a person at the home was assisted to move from their chair to their bed, this was not done in accordance with up to date moving and handling guidelines, or no risk assessment had been carried out to determine the safest way to assist the person
the management of the home was aware of this, yet had not reported it appropriately.

This was a breach of Regulation 13 Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to our visit we had been made aware of concerns about the premises, these were predominantly about the laundry area of the home which was in a poor state of repair. We found action had been taken to rectify the areas which had needed improvement and there had been a new washing matching purchased to replace one which was not working.

There were some risk assessments in place; however these were not in place for all the people we reviewed and were not adequately completed. We found there was a lack of understanding about assessing risk and the use of the forms which were in place. For instance we found cases where a judgement of risk was required for each section which, when added together gave an overall score to indicate the level of risk (from low to high risk), however more than one judgement had been selected which gave an incorrect score and overall risk rating. We found instances where key information was missed from risk assessments, for example in some cases there were no recent weights or body mass indexes (BMIs) recorded, which meant where a person's size and build was judged as part of their risk assessment this was not based on the right information.

We found risk assessments were not reviewed to ensure they were up to date, for example we found a bed rails risk assessment which had been carried out in November 2015, this has not been reviewed until November 2016 at which time 'still relevant' was recorded, there was no evidence the assessment had been carried out again to ensure this was the case.

This was a breach of Regulation 12 safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered provider was not taking all reasonable measures to ensure people were protected from risks.

We looked at how the home recorded accidents and incidents. We found that whilst there were records made of accidents and incidents, these were stored in individual care files and there was no register kept of accidents or incidents to allow the home to analyse the information they had to gauge whether there were any emerging patterns or trends. For instance analysis of falls that may indicate more staff were needed at a certain time of day, or if particular obstacles may cause a trip hazard.

We observed the staffing levels in the home, during both days of the inspection. We found there were more staff available in the home on the second day. There was no dependency tool in use to help the manager calculate the number of staff needed to safely meet people's needs, this meant the home could not be sure they had the correct number of staff on duty. We noted there were times where there was a shortage of staff available. This was particularly evident on the first floor during lunchtime and during the afternoon. People and relatives we spoke with confirmed this was the case, "Staff rush around a lot - there aren't enough of them", "There are not enough staff, especially at weekends" and "We don't see many staff up here (first floor) during the afternoon". We noted that on the first day from 15:00 there were no staff visible on the first floor, and a staff member prepared a bath for someone then left the bath unattended until the person was escorted up from the ground floor level, putting other people at risk of harm as they could access the unattended bath and hot water.

This was a breach of Regulation 18 staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had been made aware by the commissioning authority prior to the inspection there were concerns that staff were not being safely recruited and did not always have a Disclosure and Barring Service (DBS) check in place. The DBS is a service that identifies people who may be barred from working with children and vulnerable adults, and informs the service provider of any criminal convictions recorded against the applicant. These checks help the manager to make informed decisions about a person's suitability to be employed in any role working with vulnerable people.

We reviewed the recruitment records of four members of staff including a senior member of staff. We found there were gaps in the employment histories of staff and that the references which had been gained were not adequate, for example, it was unclear in some cases whether references were from previous employers or were character references, and references had not been verified to assure they were genuine. We found there had been at least two cases where staff did not have a DBS check in place prior to commencing work, although this had been rectified by the time of the inspection. We found another instance where a member of staff had brought a DBS from their previous employer; this showed the person had multiple convictions from a number of years earlier, but there had been no risk assessment carried out to ensure the person was suitable to work with vulnerable adults.

This was a breach of regulation 19 fit and proper persons employed of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed the management of medicines within the home. The home had a process for the handling of controlled drugs; this included a controlled drugs register and a secure controlled drugs cupboard. Controlled drugs are medicines which have a high risk of being misused if not strictly controlled. On the first day of the inspection we found there were a number of controlled drugs stored in the home belonging to

one person, none of these medicines were recorded in the controlled drugs register. We asked the manager about this and they told us the drugs had been prescribed pre-emptively for a person who had been very ill but had since made a full recovery. This meant the controlled drugs should have been returned to the pharmacy as they were not required. We raised this on 26 October 2016, we noted on the second day of the inspection 10 November 2016, these drugs had not been returned until 2 November 2016. On the second day of the inspection we found there were non-controlled drugs being incorrectly stored in the controlled drugs cupboard, this was again discussed with the manager who advised this would be rectified.

We reviewed the administration of medicines within the home. We found there was a large quantity of small plastic packets of medicines stored in the medicines room. We found these were dated and named and were identified to be medicines which had been refused by the people in the home. We checked the medication administration records (MARs) which corresponded to the packets dates and times and found the medicines had been recorded as being given and taken by the people they belonged to. This meant that records were inaccurate, and people were not receiving their medicines as prescribed. This was not recognised or reported to the prescribing physician to ensure there was no detriment or harm to the person as a result of them not taking their medicines. We found there were a large number of packets belonging to two people. The packets were labelled 'all a.m. medicines', however we found there were anything from five to 13 tablets contained within the packets, some of which had been wet or were broken, which meant it was impossible to know what medicines the person had and had not taken.

We found on the first day of our inspection in one case the person had not been taking their medicines as prescribed for a number of weeks as they had been regularly refusing them. We asked the home to refer this matter to the local authority safeguarding team, and to contact their physician to ensure they were aware of the situation and could make necessary arrangements to reduce any risks to the person. We saw on the second day there had been a change to the time of day medicines were prescribed, however the records for two days since this change showed the person had been asleep when the medicines were given out and staff had not made any attempt to return to the person or to wake them to ensure they received their medicines. This meant the person was still not receiving their medicines as prescribed.

We reviewed the processes which were in place for 'as and when required' (PRN) medicines. We found on the first day of our inspection there were no protocols in place to inform staff what the medicine was for, the signs they would need to look for to show a person may require the medicine or the desired effect the medicine would have. We saw on the second day some PRN protocols had been put in place; however these were generic to the medicine and not specific to the person.

We looked at the usage of PRN medicines and whether the records matched the amount of medicines in stock for people. We found there were discrepancies in the numbers recorded and the actual stocks for PRN medicines. We discussed this with the senior care worker who told us staff are not always careful about whose sock of medicines they used.

On the first day we found the medicines fridge was not working, as a result of this creams which needed to be stored below 15 degrees Celsius were being stored above this temperature and were kept in the medicines trolley. This meant the creams would not be as effective as they could have been.

The above demonstrated a breach of Regulation 12 safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We noted the home was generally clean, and staff had access to personal protective equipment (PPE) for example plastic aprons, gloves and hand sanitiser.

Inadequate

Is the service effective?

Our findings

People who used the service had mixed views about the food and told us, "They over cook all the food, and it is cold when I get it", "The evening meals are appalling, it is nothing but beans on toast or cheese on toast - things like that" and "The food is good, but they give you too much; I cannot eat it'.

Relatives told us, "My [relative] will not eat the food here, it is a real problem. [Relative] is not getting the nutrition [relative] needs", "I worry that [relative] is getting enough to eat. [Relative] turns their nose up at it" and "Sometimes they give [relative] a really big plate of food, [relative] hates it, they like small portions".

We spoke with people and their relatives about the food which was available in the home. There had been concerns raised to us by the commissioning authority that there were no snacks or drinks available to people between meals, we saw there were some snacks offered to people when drinks were served and there was some fruit available to people in the communal areas. We found people had very mixed views about the food. The general opinion however was that the meals at teatime were poor as they tended to be toast based. A number of people felt the food was of poor quality and there was variation in the standard of the meals dependent on which staff were on duty. People complained they were over faced by large meals which put them off. People told us, "The teatime food is so bad I have resorted to bread and jam everyday", "It is not what I call home cooked food it is all out of packets" and "I leave most of the food, I end up eating chocolates most of the time".

We observed there were issues with the level of staffing over lunchtime particularly on the first floor, and whilst there were efforts made to interact with people during lunch service this sometimes distracted people who were living with dementia from eating their meals. We noted a person who was not able to eat as they had very poorly fitting dentures, there had been no action taken to ensure this person could eat the meal supplied to them. We observed that whilst people were supplied with a meal of their choice, there was not sufficient staff or focus to ensure people were encouraged and supported to eat and there was little evidence of monitoring and recording of the amounts people had consumed to ensure they were achieving a good diet.

We saw drinks trolleys were brought into lounges. Staff were observed to encourage people to accept a drink; however we saw several instances where drinks were placed on tables and people wandered off not having consumed their drink. This meant several people were at risk of not maintaining adequate hydration.

This was a breach of Regulation 14 meeting nutritional and hydrations needs of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed the home's records in relation to the training staff had undertaken. We found training in the home was poor and that all staff had training which was out of date and needed to be refreshed. We found the induction process was inadequate, we were told by the registered provider they had sourced a new induction process, however this consisted of booklets which were to be read and completed. The registered provider told us the staff that were starting work had training from their previous employers. We explained

that it is not adequate to accept training from staffs previous employments as they cannot be assured of the quality of the training.

Staff we spoke with told us they had received one to one supervision, although they could not remember when or how often this took place, there was little written evidence of supervision sessions having taken place. There was not matrix in place to show when staff had been supervised or when the next session was due to take place. We did not see any evidence that staff were appraised each year to review their performance and identify areas of training and development.

The above demonstrated a breach of Regulation 18 staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as staff were not adequately trained or supported in their roles.

The Care Quality Commission (CQC) monitors the operation of the Mental Capacity Act 2005 (MCA) and specifically on the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. 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 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 looked at the care records for eight people. We found on the first day there was no evidence that any mental capacity assessments had been carried out. We spoke with the manager and asked which people currently had a DoLS in place; they were unable to tell us, as there was no central file which allowed this information to be easily accessed. The manager told us the information relating to DoLS would be in each person's files. We found in one case there had been an urgent application made to deprive a person of their liberty, however there had been no mental capacity assessment carried out. As part of the DoLS application an assessment of mental capacity was carried out by an independent best interest's assessor and the person was found to have capacity to make their own decisions. We found in other cases people were being unlawfully deprived of their liberty as they were not free to leave the home but they did not have DoLS in place to ensure their rights were protected.

We found there was a poor level of understanding of the Mental Capacity Act 2005, and this led to people being unfairly restricted where their decisions were judged to be 'unwise' by senior staff. For instance one person who did not have an authorised DoLS in place had restrictions placed on their movement around the home which meant that they were unlawfully deprived of their liberty.

We reviewed whether consent was being gained from people for the care and support they received. We found there was no evidence in people's care files to show their consent had been sought or gained, we also did not hear staff requesting verbal consent before approaching people to assist them. There were no signatures seen to show any agreement to care plans, there were no contracts or consent forms.

This was a breach of Regulation 11 need for consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We noted from people's care records they had access to other health professionals including dentists, chiropodists, district nurses and general practitioners.

We noted from the home's website that they advertised they were offering specialist care for people living with dementia. However, we found staff were not specifically trained to understand the needs of people who had been diagnosed with any form of dementia. We found the environment was not adapted to meet the needs of the people who lived at the home, as there had been no thought given for instance to effective use of lighting, colour or clear signposting to help people navigate the building more easily.

Inadequate

Is the service caring?

Our findings

People who lived at the home told us, "There are some smashing staff", "I have just got used to being told what to do, I feel as though I have no say in my care" and "Not all the staff seem to understand my condition".

We observed staff interacting with people in the home throughout the inspection. We found staff were mostly kind and caring. Staff spoke to people in a friendly and considerate way. There were positive relationships between some of the staff and people who lived at the home. However people told us staff did not stay long at the home, which made it difficult for them to get to know the staff. One person said "I miss staff that have recently left".

We found that whilst staff were attempting to offer compassionate care, they were rushed and this resulted in interactions being task led, with no time for social interactions. Relatives told us, "The care really picked up recently, and then went downhill again", "The staff do their best to care for folks, they are just too busy rushing around" and "You can see that people are not always cared for properly".

People we spoke with told us "They [staff] don't always knock on the door when they enter" and we observed this to be the case, as we saw staff walked into people's rooms uninvited whilst we were speaking to people during the inspection. We noted there were other issues with dignity for example we observed ladies were not wearing any tights, stockings or socks in a lot of cases, other people had clearly not been shaved for a period of time, and people's dignity was not protected during mealtimes when people were left to struggle to eat their meals which caused them to spill food on themselves. A relative said "The care and respect leaves a lot to be desired".

This was a breach of Regulation 10 dignity and respect of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found there had been no resident and relatives meetings held to ensure people and their relatives were aware of what was happening in the home. This was particularly important as due to the recent concerns, there had been a large number of visits to the home from health and social care professionals. People had found this worrying and had become anxious as they had not been told what was happening. People and relatives told us, "There has been a high turnover of staff, it makes us feel unsettled" and "My relative is really worried about the future - we are not sure what is happening".

We reviewed whether the managers and staff at Croft Acres recognised where people needed support to ensure their thoughts and wishes were considered, either where they had a power of attorney (POA) or they needed an independent advocate. We saw one file where there was a copy of a POA; however there was no mention of this within the care plans. We did not see any evidence of the use of independent advocates.

People we spoke with told us they were not encouraged to be independent. One person told us they were restricted from being able to do things for themselves as they used a wheelchair and their room was not

arranged to allow them to get to all areas including the en-suite bathroom. We saw little evidence of people being encouraged to be independent.

The home offered care and support to older people, some of who would inevitably end their lives at the home, however there were no end of life care plans in place in the files we reviewed. It is essential to gain people's wishes and preferences for the end of their lives whilst they are able to give them to ensure those wishes are met.

Inadequate

Is the service responsive?

Our findings

People told us, "The activity person is lovely, but they do not understand what I need", "I need the activities planning around my needs and abilities" and "I would happily just go out for a ride, for a change of scenery".

Relatives said "The things they do not always seem to be right for people who have dementia they get agitated", "I think the activities need to take place in a different room, then people can make a real choice if they want to join in" and 'It would be lovely if my relative could get out, they have not been out since they have lived here".

We reviewed the care files for eight people. We found there was a variation in the formats of the care files, we were told this was due to the home being in the process of re-writing people's care plans as they had identified the older system was not adequate. We reviewed some of the new format and some of the older style; we also compared one which had been re-written between days one and two of the inspection. We found that the content of the care plans however was not improved despite the work which had been carried out.

We found there were some care files for people who had been in the home for several years which had sections that had not been completed despite the time the person had been in the home, for example in one case we found there were blank records relating to eating, drinking, nutritional risk, weight monitoring, continence, personal care and pressure damage prevention. This meant there was no information available to staff to understand the needs of the person in relation to their care needs.

We found the newly completed care plans were also incomplete. Information which would assist care staff to meet needs had not been sought and added to their records. We found care plans were not person centred and the language used in some of them was disrespectful to the person about whom they were written, for example '[person] is incontinent by choice'.

There was no evidence staff who had carried out care planning had attempted to gain information about the person's life history or background which would give staff insight into the person and their needs. We saw in one file there was a detailed background description, however this had been supplied by family as they wanted staff to understand the reasons why their relative presented the way they did.

We saw no evidence that care plans were reviewed and in cases where we saw a pre-admission assessment this had been carried out as part of the new care planning process and was not completed 'pre-admission'.

This was a breach of Regulation 9 person centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw there were activities taking place on both days of the inspection. However on both days the activity consisted of an activity coordinator singing along to a karaoke machine they had brought in. On both occasions the same songs were sung and these songs were modern and very loud. It was evident some

people were not enjoying the activity and some people confirmed this was the case, one person told us "I find the singing too much for me. I come away back to my room".

At the time of the inspection we were told there were two sessions of organised activities per week. Other than the singing we saw a game of bingo was played after lunch on the first day. Not everyone found this meaningful, some slept through it and some could not hear. Relatives we spoke with said the activities could be more varied and suitable for people living with dementia. Other people felt the activities did not suit their needs, when asked what they would like people told us, "I would love it if they got people in to do talks like history societies" and "It would be marvellous to have more involvement from the church in here, maybe a bible study".

There had been no outings available for people. Everyone we spoke with felt they wanted the opportunity to go out. People said "It would be lovely to get out from time to time".

People and their relatives gave mixed feedback about whether they would know how and to whom to make a complaint. Some people said they would and others said they did not know who to complain to since the manager changed again. One person said, "They know I do not like the food, but nothing changes". Relatives told us "Well, there is new person in charge, not sure who I would complain to now", "I just don't know who to turn to improve my relative's life" and "I have complained about things without any action". We asked to look at the complaints records, there were none available. This meant the service was not recording, investigating or acting on complaints in line with their organisational policy.

This was a breach of Regulations 16 receiving and acting on complaints of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

The service did not have a registered manager in post. There was a manager who was absent from the service and there was an interim manager who was responsible for the day to day running of the home.

We were concerned throughout the inspection that people we spoke with were worried about the home knowing what they had said to us and requested anonymity; one person said "I am worried about what I tell you they might find out".

Some staff told us they were not happy about the recent changes to the management of the home and staff were not confident in who to approach with their concerns. Staff told us, "Having no consistent manager spoils the communication", "We don't even know the new manager very well" and "The sudden changes in the management make staff morale low".

Most people and relatives we spoke with were unclear and dissatisfied with the management of the home. People told us, "I have heard that they have sacked the Manager. I have no idea who's running things", "Well led? Don't make me laugh" and "I would leave this place tomorrow if I could". Relatives told us, "It is ridiculous the management is in a shambles", "If it was not for the Local Authority this place would not still be open" and "I see only one solution, move my relative out".

There were no processes to gain the thoughts and opinions of the people who lived at the home, their relatives or professional visitors to the home. People told us, "It makes me laugh. I live here and nobody asks me how it's going", "I have not been asked to fill in a questionnaire" and "I would happily go to any meetings or give my opinions about how things might be improved, no-one has ever asked me".

Relatives we spoke with said, "I have never ever been asked what I think about the quality of the service offered here" and "It might have helped to have relatives meetings over the years". Staff also felt that communication was poor and they were not kept informed of what was happening in the home. One staff member said "I wish there were more meetings to tell us what was happening with the management and social services".

The home had features of institutionalised care, as staff worked to task rather than meeting the needs of people as individuals. This was evidently a cultural issue within the home as staff were not recognising that institutional care was in place and was consequently of poor quality.

The communication in the home was not open or transparent, people, relatives and staff all agreed they were not kept informed of what was happening in the home, and people were feeling insecure and worried about the future of the home as a result.

The home was not meeting the requirements of their registration, as the manager was unaware of the need to notify the Care Quality Commission of incidents, which affected people in the home or the running of the home, for instance safeguarding concerns. The home was not making appropriate notifications as a result of

this lack of knowledge.

This was a breach of Regulation 18 Notification of other incidents of the Care Quality Commission (Registration) Regulations 2009.

There were no processes in place to monitor the quality and safety of the care and support being delivered in the home. We found there was no evidence that checks were in place to ensure documents were adequate or up to date, for example there had been no audits carried out on medicines. There were no processes to bring together key information in the home, for instance falls which had occurred to allow the registered provider to analyse the information and make improvements to the home as a result of patterns or lessons learnt.

We spoke with the registered provider and it was clear there were no processes in place which allowed them to know what was happening in the home and to ensure they had clear oversight of the performance of the staff or the home as a whole.

Records which were in place were of very poor quality and did not fulfil their purpose. For example the purpose of daily care records is to allow the reader to gain insight into the way in which a person is occupied and how they present on any given day, this is critical information for social workers and health practitioners to make their assessments and make valid judgements about whether the needs of the person are being met or whether they may be unwell for instance.

The above demonstrates a breach of Regulation 17 good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Notifications were not being submitted to inform us of significant events in line with the registration regulations.

The enforcement action we took:

Home closed voluntarily

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans were not person centred and did not reflect the needs of the people who lived at the home.

The enforcement action we took:

Home closed voluntarily

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect.

The enforcement action we took:

Home closed voluntarily

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Mental capacity assessments were incorrectly completed, there were no Best Interest decision processes carried out where people were not able to make their own decisions and people were being unlawfully deprived of their liberty.

The enforcement action we took:

Home closed voluntarily

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not managed safely, there were no risk assessments in place to identify specific risks and put measures in place to ensure the safety of people who lived at the home.

The enforcement action we took:

Home closed voluntarily

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding incidents were not being recognised, reported or followed through to ensure people were protected from harm.

The enforcement action we took:

Home closed voluntarily

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People did not have free access to food and drink throughout the day. There were not sufficient staff to assist people to eat their meals which led to people not having enough to eat. There was evidence of weight loss as a result of this.

The enforcement action we took:

Home closed voluntarily

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints were not being recorded, investigated or responded to. People and their relatives told us they had complained repeatedly, there was no record of their complaints or any action having been taken to address their concerns.

The enforcement action we took:

Home closed voluntarily

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were no processes or systems to monitor the safety and quality of the service. There was no oversight of the service by the registered provider.

The enforcement action we took:

Home closed voluntarily

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Staff were not appropriately vetted before commencing work in the home to ensure they were suitable to work with vulnerable adults.

The enforcement action we took:

Home closed voulntarily

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient staff to meet people's needs safely and in a timely manner.

The enforcement action we took:

Home closed voluntarily