Loven Larchwood Limited

Larchwood Nursing and Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Larchwood Nursing and Residential Home provides nursing and accommodation for up to 48 people. At the time of our inspection, 42 people were living in the home.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 home is run.

We had previously inspected this service in August 2016. We found that the provider was meeting the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the service was rated 'Good'. During this 2017 inspection, we found the registered provider was in breach of eight regulations. These included those for safe care, staffing, safeguarding, nutrition, mental capacity, dignity and respect, person-centred care and good governance.

The service was not safe. Individual risks to people had not been identified or managed in a safe way. People's risk assessments were not reviewed regularly and assessments to determine people's risk of pressure ulcers and malnutrition were not carried out frequently. Where people were at risk of developing a pressure ulcer, records around repositioning were incomplete, and there were no clear plans in place to minimise this risk. This included for people who had already developed serious pressure ulcers.

People's level of dependency was not assessed appropriately and staffing levels were not calculated to support people in the safest way possible.

People's medicines were not managed or administered in a safe way. The service had no records of any topical creams. People did not always receive a GP review in a timely manner when they needed it and people's 'as required' (PRN) medicines records were not always accurate.

Some staff demonstrated a lack of knowledge around safeguarding people and how to report concerns The registered manager had not reported pressure ulcers to safeguarding when they should have.

Risks relating to eating and drinking were not managed appropriately or mitigated. People did not receive a diet according to their dietary needs. Records relating to food and fluids were inaccurate. Choice was not always offered to people at mealtimes.

People's mental capacity assessments were no longer relevant and had not been updated. There were no best interests decisions for some people, and staff did not have good knowledge of the Mental Capacity Act 2005 (MCA).

Staff did not always treat people with dignity and respect, and people were not involved with their own care.

People did not receive individualised care based on their own preferences and needs.
Care records were incomplete, out of date and did not contain adequate guidance for staff.

The registered manager did not know people or their needs, and people did not know who the registered manager was. There was poor leadership in place, and there were no systems in place to identify concerns or drive improvement.

People's preferred hobbies, histories and interests were not always recorded or known by staff. There were some activities on offer but for people in their rooms, this was limited. No trips outside of the home were available to people.

There were practices in place which ensured suitable staff were employed with checks in place. People were supported to access healthcare services.

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.

Full information about CQC's regulatory response to any 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.

Risk assessments were not always carried out according to people's needs and their environment, and therefore risks were not mitigated appropriately.

Medicines were not managed and recorded safely.

Staff did not always know about reporting safeguarding concerns, and not all safeguarding concerns had been reported by management.

There were not enough staff to ensure people were kept safe.

Is the service effective?

Inadequate

The service was not effective.

People's mental capacity was not always fully assessed appropriately for specific decisions, and best interests meetings were not always completed or recorded.

People did not receive appropriate diets and they did not always have a drink available to them.

People did not always have access to healthcare services when they needed.

Is the service caring?

Inadequate

The service was not caring.

Whilst some staff were compassionate and reassuring towards people, they did not have time to spend with people.

People were not always given choice and were not involved in their care.

People's dignity and privacy was compromised.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There were not enough staff available to ensure that staff had time to spend with people in order to meet their needs and deliver individualised care.

Care records were out of date and not relevant, and they did not contain appropriate guidance for staff. Accurate contemporaneous records were not kept about people.

People knew who to talk to if they had any complaints.

Is the service well-led?

Inadequate

The service was not well-led.

The registered manager did not know about people's needs, and had not reported concerns when they should have.

There were no systems in place for monitoring and improving the service which resulted in concerns about people's care not being identified.

Staff were not aware of whistleblowing.

Larchwood Nursing and 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.

This inspection took place on 19 September 2017 and was unannounced. The inspection was carried out by two inspectors, a medicines inspector, a specialist advisor 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.

Before the inspection, we reviewed the information available to us about the home, such as the notifications that they had sent us. A notification is information about important events which the provider is required to send us by law. Prior to the inspection, the provider also completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before the inspection, we also obtained feedback from the local authority.

During the inspection we spoke with eight people using the service and two relatives. In addition we spoke with three care staff, two nurses, the head of care, the activities coordinator, the chef, the registered manager and the new manager. We looked at care records for eight people, and the Medicine Administration Records (MARs) for all people within the home. We looked at how the service managed people's medicines and how information held in records and care notes supported the safe administration of people's medicines.

Inadequate

Is the service safe?

Our findings

The service was not safe.

Risks to people were not adequately assessed, reviewed or mitigated. We had serious concerns about the management of pressure care in the home. The registered manager was unable to provide us with information about people living in the home who had pressure ulcers. We were given inconsistent information about the pressure care needs of people in the home by three different members of staff.

We identified two people as having serious pressure ulcers, and others at high risk of developing these. The records relating to these two people's pressure care over the last two months were inaccurate, incomplete and in some cases illegible. Therefore the provider could not assure themselves that the people were being treated appropriately. We were unable to identify accurately all of the people who had pressure areas and how they were being treated, because of inadequate records and inconsistent staff feedback. Where records were available which recorded how staff supported people to reposition, there were gaps of up to twelve hours where people were recommended two hourly repositioning for pressure care. This meant that we could not be assured that people were receiving safe and effective care in line with their assessed needs.

We were concerned about how people were being protected from harm. Where there were risks to individuals there were not always comprehensive plans in place which described how to ensure the person's safety or to guide staff on supporting people's needs. For example, a relative confirmed to us they were concerned about one person's treatment, "This is the first time I've visited [relative] and I was a little shocked at the state of [relative's] leg. I noticed straight away and went and got a [staff member]. To be fair I think they're taking it quite seriously and they've got a dressing which looks right to me but how come they didn't notice it needed dressing?"

Another person who was new to the home was diabetic and had a foot ulcer. There was no risk assessment or care planning around this. We were concerned that there was no guidance for staff about the care that needed to be provided in relation to the foot ulcer.

Risks to individuals were not adequately assessed and planned for. For example, one person's care records showed that they had a history of urine infections and acute kidney infections. They were at high risk of developing further urine infections; however, there was no specific care plan in place to detail signs and symptoms, prevention and management. For another person, there was not an individualised care plan in place concerning kidney failure.

People's risk of malnutrition was not adequately assessed, reviewed or mitigated. For example, one person was at risk of malnutrition and had their weight reviewed monthly but no review of the malnutrition screening tool (MUST) had taken place since 25 October 2016. This is a tool which was used to assess the risks associated with not eating enough. Another person's MUST had identified they should have been weighed weekly but this continued to be completed monthly. This meant that the service was not proactive in reviewing risk as frequently as needed, and weight loss was not always identified quickly.

We reviewed the systems in place to manage people's medicines and found this required improvement. We had serious concerns about the management of topical external medicines, such as creams. We were unable to identify people who were in need of these medicines. Therefore we could not see whether people were having creams as prescribed or not. For some medicines prescribed for external use, there were no records showing where they needed to be applied. Staff informed us that some external medicines such as barrier creams and emollients had not been available. This meant there was a risk that people were not receiving their creams as prescribed, some of which related to pressure area care and prevention.

Before the inspection visit, we received a concern that people were left with their medicines, and staff were signing to say that they had seen people taking them. One person we spoke with told us, "Mostly they give me my pills and watch while I take them but sometimes they leave me to take them." This posed a risk to people who may be living with dementia and who may not realise they need to take their medicines. It also meant that the staff could not be sure people took their medicines as prescribed.

We found that there were gaps and discrepancies in records which did not always confirm that people living at the service received their medicines as prescribed. This included important cardiovascular medicine which must be given accurately and appropriately to ensure the safety of people using it. We noted that staff were not following safe procedures in relation to dating medicines when they opened them to ensure they did not pass the expiry date.

Staff did not always refer people to be reviewed by a GP when they needed it. For example, one person told us they were in 'agony' because of their pressure area. The person's care plan said that they had additional 'as required' (PRN) pain relief, but we found they did not have these available. Their care plan referred to a PRN pain relief medicine being used when they were in pain but we noted this was not currently in use and without any recorded explanation. The systems in place to ensure people received medicines when they needed them were not accurate and effective, so people did not always receive appropriate medicines or a GP review in a timely manner.

We noted areas of the home where toiletries and prescribed fluid thickeners were not securely stored and therefore people could access them placing themselves at risk of accidental harm. This was a potential danger to those living with dementia in the home who may not realise such substances could be harmful if consumed. The service had not assessed the risks relating to this.

We had concerns about the assessment and management of risks around infection control. During our visit we noted that there were slide sheets (used to move people safely) left on a floor in a bathroom, which also represented a falls hazard. The bathroom floor was sticky and unclean. We noted that not all wheelchairs were kept clean and one was ingrained with dirt. One person had a soiled carpet in their room and we were told that there were plans to replace the carpet with hard flooring. However, in the meantime the carpet remained heavily soiled which posed an infection risk.

These concerns constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were concerned about staffing levels. A relative said, "Sometimes they're [staff] very busy, I think they're understaffed." The service used a dependency tool which was inappropriate for the environment. People were not always accurately assessed in terms of their dependence on staff, and the layout of the building was not taken into account, where many people stayed in their rooms across the home over two large floors. The registered manager had not reviewed staffing by assessing whether there were enough staff independently of the tool. The calculations did not reflect people's needs accurately, and staff told us they

were often short staffed. One staff member said, "Morning times are hard. People can wait until past 11:00 am." We confirmed this with one person who told us they were still waiting to be supported with washing and dressing at 11:00 am.

We saw that people sat in communal areas for long periods of time throughout the day with no staff around. Several people were left without access to call bells, within their rooms and in communal areas and therefore had no way of calling for assistance. In the afternoon we saw that several people on the second floor were crying out for help, and one person was sliding forwards out of their chair. There were no staff around to help them. We saw that people had not had baths regularly in recent months, and the head of care confirmed that this had occurred as a result of not having enough staff.

Not all staff had the necessary skills for their job role. For example, one person told a nurse they were in pain, but the nurse was unable to understand what they were telling them because they did not understand English. This was the nurse in charge of that floor. The registered manager had not identified there could be an issue with this which put people's safety at risk.

There were no checks of some important staff competencies, including those around pressure care. Therefore the provider could not assure themselves that staff had the appropriate knowledge and skills to carry out their roles properly and safely.

These concerns constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager did not use systems for ensuring the appropriate teams were involved in monitoring risks associated with keeping people safe, and they had not reported serious concerns. For example, there had been two grade four pressure ulcers which had not been reported to the safeguarding authorities by the registered manager. Another person had presented with behaviour which could present a risk to their safety, and this had not been reported to safeguarding. This is important because the safeguarding authorities can assist with putting plans in place to ensure people are protected from the risk of harm as well as ongoing monitoring.

We had inconsistent feedback from staff about their knowledge of safeguarding. Whilst they were aware of different types of abuse, not all staff knew how to externally report safeguarding concerns.

These concerns constituted a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were employed with safety checks in place, such as the Disclosure and Barring Service (DBS) checks and references.

Staff authorised to handle and give people their medicines had recently received training and had their competence assessed. We observed part of the morning medicine round and observed that staff giving people their oral medicines did so safely and in a caring manner.

Supporting information was available for staff to refer to when handling and giving people their medicines. There was personal identification, information about known allergies and medicine sensitivities. There were additional records in place for high risk medicines to ensure safety. For people prescribed skin patches there were also additional records showing they were applied to people's bodies in a rotational manner and also confirming they were later removed before the next patch was applied.

Medicines were stored securely for the protection of people who used the service and temperatures of storage were monitored to ensure they stayed within a safe range.

There were risk assessments in place for people's environment which mitigated risks, including checks of electrical equipment and lifting equipment. Fire safety checks were in place and each person had an evacuation plan. There were also water checks and a risk assessment for legionella. There was a plan to improve the flooring throughout the home.

Inadequate

Is the service effective?

Our findings

The service was not effective.

The service was not meeting people's needs in relation to eating and drinking. We found that people's dietary recommendations were not followed. For example, for three people we found that they were assessed as needing a fortified diet. This means that food is made using high calorie ingredients such as cream and butter to increase calorie intake. However, we spoke to the kitchen staff and they were not aware of this and told us they did not fortify any foods and everyone had the same food served. One person was recommended to have a high calorie milkshake provided daily, and they had not received this. We saw they had been seen regularly by a dietician since December 2016 and they had been last visited in July 2017. For people who had been deemed to be overweight, no conversations had taken place with them about their diet in order to ascertain whether they could have a lower calorie diet.

One person who was deemed to be at risk of not eating enough and had lost weight, was not being properly supported. When they received their food, they asked staff what it was, and they were not offered any choice. Their care plan suggested they needed prompting at mealtimes and we observed that they did not receive this until the food was cold. Weekly weights had been recommended for this person and these were not being carried out to identify reductions in weight promptly. For another person, their nutrition care plan had not been updated in line with supplement drinks that had been stopped. We looked at people's records in relation to risks associated with not eating enough and found that these had not been reviewed and updated since 2016. This meant that the provider could not be sure how people were supported with their nutrition, and had not checked that people were receiving the nutrition they needed.

One relative expressed concerns to us, "There has been concern about [relative's] weight and there are two issues. First [relative] has to have a soft diet but I worry [relative] isn't having a balanced diet because they don't seem to understand that food doesn't all need to be pureed. If vegetables are properly cooked and not hard they're fine but they don't seem to understand that. The other thing is [relative's] supposed to be weighed every week. Well we've had three weeks this month and there's only one weight on the chart so I think it's being missed." They stated they had raised this with staff and no action had been taken.

People confirmed to us that they received no choice of meals. We saw that people were not always offered a choice of meal. We saw on one floor that two people asked what they had been given as they had not been told or chosen the food themselves.

People did not always have a drink available. For example, one person was calling out for a drink and banging on their table to get assistance. We spoke with them and saw that their mouth was extremely dry. We could not find a staff member immediately, so informed the head of care that the person needed a drink. The person was unable to move from their chair to access fluids themselves. Fluids had not always been recorded when people were on fluid charts to ascertain how much they had drunk. For example, for one person there were only two entries in a 24 hour period. Therefore the systems in place to ensure that people were receiving enough to drink were ineffective. The home did not always give people a choice of drink if

they did not have their own supply. One person told us, "Normally I have squash which I prefer but I've run out so will have to wait until my family visit, they'll bring me a new bottle."

These concerns constituted a breach of Regulation 14 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 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).

People's mental capacity assessments had not been effectively reviewed and updated. For example, one person had a mental capacity assessment which had been carried out in April 2015. The person was living with dementia and we spoke with their relative. The capacity assessment had found that the person had full capacity. The relative told us the person no longer recognised their family members and their cognition had greatly deteriorated during the last two years. There was no updated assessment and no best interests decisions about the person's care. Therefore the provider could not be sure they were meeting the requirements of the MCA.

For another person, they had signed a consent form to consent to their care when they had been deemed to have no capacity to do so. Therefore they were not able to meaningfully consent, and there were no best interests decisions recorded. This demonstrated a lack of understanding of the MCA. The registered manager agreed that this area required improvement.

For people with limited mental capacity to make decisions about their care or treatment and who would refuse their medicines there were records of assessments of their mental capacity and best interests decisions to give them their medicines crushed and hidden in food or drink (covertly).

The registered manager had applied for DoLS for some people living in the home, but for one person who had a DoLS authorisation, there was no initial capacity assessment available to ascertain that a DoLS application was needed. These concerns showed a lack of understanding around the MCA. Staff did not all have good knowledge of the MCA and DoLS, one saying, "I don't really know what that is." Therefore we could not be sure the staff sought consent for people's care as there was limited understanding and up to date records around people's capacity.

These concerns constituted a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they had received supervisions. These are meetings where staff can discuss their role and any concerns and training requirements with a senior member of staff. We looked at records of supervisions and found that these were not regular, as the majority of staff members had not received supervision since March 2017. This supervision had been people's annual appraisal. Not all staff had received an additional supervision, and there were none planned on the yearly supervision planner. This meant that training requirements had not been identified or discussed, and staff had not discussed their responsibilities.

Although staff carried out some training in areas relevant to their role, this was not always followed up with competency checking and was not always effective. Four staff we spoke with were not able to tell us details about the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguarding (DoLS), one staff member saying, "I forget what that means, not sure", and another saying, "I can't answer that." We saw that tissue viability training was overdue for 23 members of staff, and that no staff had undertaken equality and diversity training.

There was an induction procedure in place, but the registered manager had not closely monitored people when they started work. We identified that one new member of staff was not able to converse in English. However, one person told us, "I think [staff] know what they're doing, I've got confidence in them."

People were supported to access some healthcare, however there were not always notes recorded so that staff could follow healthcare professionals' guidelines if they visited someone for treatment. The registered manager had not always called healthcare professionals such as a GP in, in a timely manner when needed.

Some people were under other services such as the diabetic foot clinic, and received other healthcare such as a chiropodist.

Inadequate

Is the service caring?

Our findings

During our inspection visit we found that dignity was compromised. For example, we saw several people were lying on their bed naked with the doors open in the afternoon. One staff member we spoke with referred to people who required support with their meals as, "Feeds", which did not reflect a respectful approach or uphold people's dignity. During the morning, we heard one person shouting out for help as there were no staff around and the person did not have a call bell within reach. We saw this was also the case for several people after lunch, whose dignity was compromised because there were no staff around and they required assistance.

People were not always clean and could not always have baths and showers when they needed which compromised their dignity. One relative also told us they had raised concerns about their relative not always being supported to change their incontinence pad when they required. People were not always called by their preferred name, One person told us, "Most of them call me 'love' and are in a bit of a rush, I don't think some of them are very patient but they don't have much time."

Staff did not always properly respect people's privacy. One person told us, "They [staff] normally knock but by the time I've answered they're already in the room, they don't have time to hang around."

Some people had unclean rooms and equipment which did not uphold their dignity. We saw for example that one person had a used urine bottle resting on their carpet all day without being cleaned.

People were not given choice and were not involved in planning their care. One person said when they had moved into the home, "No [staff] didn't ask me about my care or what I need help with." The other people we spoke with told us they were not involved in making any choices or decisions about their healthcare, and that it was up to the carers to make those decisions. Relatives were not always consulted and involved in people's care when appropriate. One relative told us, "I might only find out about a new pressure sore if [relative] mentions it."

These concerns constituted a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had mixed feedback from people about whether the staff were caring or not, one person saying, "It's just that some people are genuinely caring where some of them here are just doing it as a job, that's all I mean." One person we spoke with told us, "I think that on the whole, they treat me with respect."

Staff did not have time to foster effective positive relationships with people using the service and people were not protected from the risk of social isolation.

Requires Improvement

Is the service responsive?

Our findings

The service was not always responsive. The service carried out pre-admission assessments to ascertain whether they could properly meet people's needs when they came in to the home. However, these did not always have the most important and accurate information. For one person we saw that the initial assessment had not included information for staff about how to meet the person's needs with regards to a foot ulcer.

We found that whilst care plans contained detailed information about people's clinical conditions, they were generic and not person-centred. For example, one person had a specific medical condition, but there was no information about how this manifested itself with the person or guidance for staff on how to meet their needs. Care plans we looked at had not been updated, some since 2015. Evaluation forms were completed by staff to record how the person had been each day, but the assessed needs were no longer relevant in some cases. We found many records that were not legible so we were unable to ascertain the needs of people.

Staff were not responsive to people's needs. We observed during our inspection visit, two people were in their rooms without access to a call bell. On both occasions there were no staff available and we supported the people to ask for assistance from staff. We saw that another person had fallen asleep on their bed with their lunch in front of them, which had not been consumed or taken away. This was some hours after lunch. We saw that another person had fallen asleep with their head on a dining table in the dining room. We noted that there were several other people who sat in a communal area all day with very little interaction. This demonstrated that people did not have assistance when they needed it.

There were life history books included in people's care plans but we found not all of these had been completed for people, therefore knowledge about individuals was limited. Whilst care plans contained some information about food people disliked, there was limited information about what people's preferences were, for example, what music they preferred. We spoke with the activities coordinator, who told us they tried different activities with people. There were two members of staff employed for activities, and they worked two and a half days each. However, they supported care staff with mealtimes and taking the tea trolley round, which meant they did not always spend the allocated amount of time on activities. They told us about activities and games they did with people in communal areas, for example bingo and arts and crafts. They also had visiting entertainers such as singers on occasion.

We saw that some people had activities recorded very seldom, for example, one person had received 'one to one' time just twice in July, and three times in August. Another person told us they wanted to leave their room but did not have the opportunity to do so. There were no opportunities for trips out. One person said, "We used to go out on trips but we don't anymore. I'd really like to go out, into the city, even if it was just for a couple of hours; that would be nice." Another said, "I do get bored. There's not much to do and I will get involved but I'm in here a lot of the time." They followed on to say, "Gardening, cooking. I'd like to do both, or either if it was possible."

People were not supported to have a regular bath or shower if they wanted one. One person said, "I prefer a shower but I haven't had one for ages, [staff] give me a body wash." Another person told us, "I think I've been here about a fortnight and I've not had a bath or a shower yet, just a wash." A family member told us, "[Relative] is supposed to have two baths a week, Sunday and Wednesday but sometimes they're a day late."

We saw in one person's care plan that they liked to bath every week, and we saw this had not been completed during May and June 2017. One staff member told us that the bathing and showering support had suffered as a result of being short staffed. Therefore people's personal care needs and preferences were not always met and they did not receive individualised care.

These concerns constituted a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us they were supported to have a bath every week. Another person explained that they chose for themselves what they wanted to do as they were able to do them independently. They said, "I sort myself out. I get up when I want and get washed and dressed. I choose to have breakfast in my room, that's what I like. Sometimes I go to the dining room for lunch, other days I'll eat in my room, it's up to me." Another person felt that staff met their needs, "Even when they're really busy they'll find time to do what I need."

There was a complaints procedure in place. However, one relative told us they had brought concerns to a staff member's attention about their relative's weight, but they had not responded proactively. This was also echoed by a person we spoke with who did not feel that care staff were responsive. Another relative said they felt comfortable to make a complaint, "I speak to the manager or a member of staff." One relative told us they felt an aspect of their relatives' care they had concerns about had improved since raising it. We saw that formal complaints had been investigated and recorded.

Inadequate

Is the service well-led?

Our findings

The service was not well-led. One person said, "It isn't as good as it was." This was closely reflected by another person. A relative referred to the care home in general saying, "I think it's all a bit neglected and needs improving." We saw that during our inspection, the registered manager stayed in their office throughout the day. None of the people we spoke with knew who the registered manager of the home was. The registered manager gave us inaccurate and inconsistent information about people's needs, and demonstrated to us that they did not know about people or their needs. The registered manager could not demonstrate to us that they knew anything about risks to individuals who were living in the home, especially in relation to pressure care.

The registered manager had very little oversight of the service and the systems in place were ineffective at picking up concerns we found during our inspection visit. They had not acted on previous feedback they had received from the safeguarding authorities and the clinical commissioners with regards to areas of safety which needed improving. We identified that these serious concerns had remained unresolved.

There were no systems in place to check staff competencies and that people were safe. There were no observations carried out to check whether staff treated people with dignity and respect.
The registered manager had not ascertained that there were not enough staff to meet people's needs and keep them safe. Additionally, we saw no evidence of recent oversight systems carried out by the providers.

Daily records of people's care were inaccurate. Some people's pressure care records were undated or unnamed and therefore we could not ascertain their treatment. Some records were illegible and all of the care plans had not been updated and were no longer relevant. Therefore there were not contemporaneous accurate records kept of each person's care. There was no system in place whereby people's care plans were checked for quality and accuracy. It had not been identified and dealt with that people were not receiving the correct diets, or when they were at risk of social isolation. It had not been identified that people's rights were not always upheld because their mental capacity assessments had not been reviewed and there were no best interests' decisions where people no longer had capacity. There were medicines audits in place, however it had not been identified as a problem that there had been no way of overseeing the use of topical applications, such as creams.

There were relatives meetings, however one person told us, "Relatives meetings are about every three months with only about four of five people turning up. Things are talked about but in my opinion, not much seems to change." People and relatives told us they were not kept informed of any changes to the service. One person said, "I learn what's going on through the grapevine", which was closely echoed by another relative we spoke with.

The lack of oversight constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had not notified us of all serious injuries which they are required to do, including

grade three pressure areas. Therefore they were in breach of regulation 18 of CQC Registration Regulations 2009.

We had little confidence in the registered manager. We obtained feedback from the commissioning authority prior to the inspection. We were aware that they had already raised some of the issues we found during our visit, a month before. We found that adequate improvements had not been made. The culture of the staff team was task-focused and not centred on people's individual needs, desires or preferences. The registered manager was leaving the week of our inspection, and the new manager was also in attendance during the day of our inspection visit.

We saw that staff meetings took place, however these were not effective at ensuring the smooth running of the service because issues were not brought to the attention of the registered manager, and where they had been, no action was taken. For example, a 'Clinical Governance' meeting took place on 28 June 2017, where care plans were discussed. This had not resulted in any improvement in the care plans. Medicines were also discussed but we continued to find concerns with them during our inspection visit.

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
Treatment of disease, disorder or injury	The provider had not always notified CQC of serious injuries and safeguarding concerns.

The enforcement action we took:

Urgent letter of concern and NoP to impose conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	There were not enough staff available to spend time with people and ensure that people received person-centred care. Not all steps had been taken to ensure people received good care and people's changing needs were not always met.

The enforcement action we took:

Urgent letter of concern and NoP to impose conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	People were not treated with dignity and respect, and their privacy was not upheld.

The enforcement action we took:

Urgent letter of concern and NoP to impose conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	Best interests decisions were not always made in line with legislation. MCAs were not reviewed and were not always relevant.

The enforcement action we took:

Urgent letter of concern and NoP to impose conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Staff had not recorded and reassessed pressure areas consistently to ensure ongoing risk assessment and appropriate treatment. Risks to individuals were not always assessed or mitigated.

The enforcement action we took:

Urgent letter of concern and NoP to impose conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered manager did not refer to safeguarding authorities as appropriate.

The enforcement action we took:

Urgent letter of concern and NoP to impose conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People were not receiving diets recommended to them. People received no choice of meals and did not always have a drink available.

The enforcement action we took:

Urgent letter of concern and NoP to impose conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place for monitoring the service were ineffective because no concerns had been identified. The provider had limited oversight of the service.

The enforcement action we took:

Urgent letter of concern and NoP to impose conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff to meet people's needs and provide person centred care. The staff had not received adequate training and had their

competency checked.

The enforcement action we took:

Urgent letter of concern and NoP to impose conditions