Four Seasons Homes No.4 Limited

Dove Court Care Home

Inspection report

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15 June 2017
21 June 2017

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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

This unannounced inspection took place over three days on 14, 15 and 21 June 2017.

At this inspection, we identified a number of Regulatory Breaches. The overall rating for this service is 'Inadequate' and the service has therefore been placed into '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.

Dove Court Care Home is registered to provide residential and nursing care for up to 58 people, including people living with dementia. At the time of this inspection there were 55 people living in the home. Three of these people were in hospital during our inspection. 38 people using the service required nursing care. There were people using the service who could not always express their needs and wishes because they had a mental health condition or because their ability to communicate was impaired. Many of the people using the service were nursed in bed. Many of the people using the service were very frail and had complex needs requiring a high level of support.

There was a registered manager in post at the time of our inspection. 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. During our inspection the registered manager left the service due to the concerns raised through our inspection.

At this inspection we found breaches of five regulations of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014. The breaches we identified posed a significant risk to people who used the service due to the complexity of their care needs. Many of the people using the service were extremely vulnerable, and highly dependent on the care and nursing staff supporting them. Our observations of peoples' needs during our inspection showed that they were not always receiving the necessary support to ensure risks to their health, safety and wellbeing were being effectively managed. There was a lack of care delivered to meet people's individual needs and maintain their dignity.

Due to the breaches we identified during our inspection and the risk that these posed to people, some of whom had experience harm as a result, we made a number of safeguarding referrals to the Local Authority as we were concerned about people's safety and well-being.

We found there to be insufficient numbers of staff working at the service to keep people safe. There was a high reliance on agency staff and a lack of clinical leadership within the home. People had experienced and were at risk of experiencing unsafe care and treatment as a result. Staff training and performance was not being effectively monitored and staff lacked knowledge about people who used the service.

We found the premises to be unclean and unsafe. Risks posed by the premises had not been identified and as a result had not been resolved. This put people at risk.

We found that medicines were not always safely stored and managed and that there had been a lack of follow up when medicines had been unavailable.

Care was not always planned and delivered to ensure people's safety. People at nutritional risk and those at risk of developing pressure sores had experienced unsafe care and treatment and there was a lack of monitoring in relation to people's nutritional intake.

People's dignity was not being maintained at the service and their privacy was not always respected. People's personal preferences in relation to their care was not always considered and people lacked stimulation and choices about how they spent their time.

We found some staff to be caring and compassionate towards people, however, due to staffing levels at the service they lacked time to be able to spend with people. Care being delivered was task focussed.

There was a lack of effective monitoring in place at the service and this had resulted in poor outcomes for people using the service. Ineffective quality monitoring systems had failed to pick up and address the failings we identified during our inspection.

The principles of the Mental Capacity Act 2005 were followed at the service and people had assessments and best interest decisions documented when needed. However, there was not a clear oversight of who may need a Deprivation of Liberty Safeguard in place. We were told that this would be addressed following our inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People did not feel safe at the service and there were insufficient numbers of staff and an inconsistent staff group which put people at risk of unsafe care and treatment.

Medicines were not being managed safely and people could not be assured that they would receive their prescribed medication.

Risks associated with people's care and treatment were not adequately assessed and care wasn't planned to ensure their safety.

The environment people were living in was unclean and unhygienic and did not protect people from the risk of infection. The premises were not being adequately maintained to keep people safe.

Is the service effective?

Inadequate

The service was not effective.

There was a lack of support for staff. An inconsistent staff group meant that people lacked the required knowledge about people's needs. There was no oversight of staff training needs and staff lacked an understanding of the Mental Capacity Act.

People were not adequately supported to have enough to eat and drink.

Mental capacity assessments had been completed where necessary but people who may have needed a Deprivation of Liberty Safeguard (DoLS) did not have one in place.

People's health and well-being was not being adequately monitored.

Is the service caring?

Inadequate

The service was not caring.

People's dignity was not maintained and their privacy not always respected.

Staff lacked time to spend with people.

People did not have choice in how they spent their time due to a lack of equipment and low numbers of staff working at the service.

Is the service responsive?

Inadequate

The service was not responsive.

People did not receive care to meet their individual needs and there was lack of consideration around how people would like their care and treatment delivered to them.

People were not offered stimulating ways in which they could spend their time and many people were cared for in bed.

People and their relatives weren't involved in the planning and delivery of their care and treatment.

Complaints were logged when these were identified, however, relatives we spoke with felt that issues they had tried to raise had not been adequately responded to by the registered manager.

Is the service well-led?

Inadequate

The service was not well-led.

The registered manager and provider did not have oversight of the care and treatment being delivered at the service and there was a lack of communication between staff and management.

There were not effective systems in place to assess the environment people were living in or to ensure that people experienced safe care and treatment.

People and their relatives told us about a lack of management presence within the home and staff performance was not being effectively monitored.

Dove Court Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was 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 14, 15 and 21 June 2017 and was unannounced. The inspection team consisted of two inspectors, an expert by experience and a specialist advisor. Our advisor was a registered nurse. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection we reviewed the information we held about the service, including statutory notifications that the provider had sent us. A statutory notification is information about important events which the provider is required to send us by law. We had also received information from commissioners who had raised some concerns about the service with us. We used this information to formulate our inspection plan.

Over the course of the three day inspection, we spoke with 14 people who used the service, five relatives, three nurses, the clinical lead, a unit manager, an activities co-ordinator, five care staff, the registered manager, the regional manager and a member of the 'Residents Experience Team'. We viewed eight records about people's care and treatment which included their daily care records, risk assessments and medicines records. We did this to ensure that they were accurate, clear and up-to-date. We made observations of the care being delivered to people and looked at people's care from planning through to delivery.

We looked at the systems the provider had in place to monitor the quality of service to ensure people received care that met their needs.

Inadequate

Is the service safe?

Our findings

At our last inspection in January 2017 we found that there were insufficient staff working at the service to meet people's needs. At this inspection we found that this was still the case and that the provider had failed to make the required improvements in relation to staffing levels. Although a dependency tool was being used, we observed people waiting for long periods of time and people left with little or no staff interaction. We found that some of the people using the service remained in bed and it was not clear why this was the case. One person using the service told us, "I needed help one night for something that fell on the floor, the care assistant said I was selfish and there are other people needing help and I cried myself to sleep". Another person who used the service said, "Some of the staff are good but some are not. When I ring my bell it takes ages for them to come. There's not enough staff here." Of the six relatives we spoke with, five raised concerns about staffing levels at the home. One relative said, "I can't find any staff, corridors are empty of staff - there's no one around for help." Another relative told us, "Carers are not consistent they don't listen to you - they have no communication skills." During our inspection we saw a staff member tell someone they would have to wait for 10 to 15 minutes for assistance as they were doing people's medication. Another person had to wait for 90 minutes to be assisted into bed due to a lack of staff. There were not sufficient numbers of staff to meet the needs of people using the service.

Staff were task focussed in their work and all of the staff we spoke with told us they struggled at times to meet the needs of the people using the service as there were not enough of them. One staff member said, "It's not good. We don't have nurses. Most are agency day and night. Agency nurses is the thing that I'm worried about." A care worker told us, "If anyone needs any help we're a little bit limited." Another care worker said, "We just haven't got the staff. We don't want to compromise the residents so we are running around." Staff were very busy and stretched during our inspection and lacked any time to spend with people. We asked to see call bell response times in order to assess these, however, these were not analysed at the service.

The above evidence indicates an on-going breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

People did not always receive care that ensured their safety. We found that risks to people's health had not always been adequately planned for and this put people at risk of harm. For example, seven people at the service had a pressure sore, six of these had been acquired at the service. When we looked at pressure care we found that the care and treatment being provided did not protect people from developing pressure areas and that when people did develop pressure sores, this was not managed effectively.

We found one person who had been assessed as high risk of developing pressure sores when they first moved in to the service. This person had not been provided with the mattress they required for several days. The person had been placed on a broken airflow mattress (mattress designed to reduce the risk of pressure sores) for seven days and then moved to a foam mattress which would not have been appropriate or safe for them. No care plan had been written for this person for nine days following their admission to guide staff on how to minimise the high risk of them developing a pressure sore. We looked at their food and fluid charts,

as well as their repositioning charts and found gaps in recording and no totals made of amounts of food and fluids this person had received. There was no monitoring of this person's care to ensure their safety. This person's relative had requested a shower for this person three days after their admission. Notes made recorded that, "Family not happy as [person using the service] smelt of urine, they requested a shower; it was explained to them how the shower schedule worked, he was scheduled for a Thursday but they would do their best to slot him in." This person was not getting the personal care they needed to keep them safe and comfortable. This person developed a pressure sore which was identified 11 days following their admission. This person had suffered harm due to the lack of safe care and treatment at the service.

People at risk of dehydration we looked at throughout our inspection visits did not have target fluid amounts in place. One person had only drank 170mls of fluid on 20 June 2017. This person's low fluid intake had not been adequately recognised or responded to by the staff team, placing them at risk of dehydration. None of the people we reviewed during our inspection had a record of urine output. This meant that staff could not properly monitor people's fluid balance or identify dehydration. We found this to be the case when we visited the service on 14 and 15 June 2017. We identified several people who were having insufficient fluids to the provider during these two days of inspection. When we returned to the service the following week, we found that people were still not having sufficient amounts to drink. One person using the service had been admitted to hospital with dehydration. People's nutritional risk was not being effectively managed and this posed a significant risk to people using the service.

We found that people's risks were not adequately assessed and planned for and that this put people at on-going risk. One person was assessed on admission as being at a high risk of choking. No care plan was written for this person in order to guide staff on minimising this risk until three days after their admission. As people were being cared for by an inconsistent staff group this put people at significant risk of harm. No referral was made to address this risk until 12 days after the person's admission.

People could not be assured that they would receive their medicines as prescribed by their doctor. We found that some people's medicines had not been given to them because they were not available at the time people needed them. We found that one person had not been given their medication for 17 days, the explanation noted on the back of the Medicines Administration Record (MAR) was "medicine not given as not available." Another person had not been given their insulin on one day due to the pen to administer this "not being available." This person's blood sugar had not been monitored as required on several occasions. We found several photographs missing from the MARs. As many of the people using the service were unable to express themselves and were being cared for by an inconsistent staff group, this put them at risk.

Some people were prescribed medicine to be taken 'when required.' When this is the case there should be a protocol in place that informs staff in what circumstances this medicine should be given but there were no protocols in place. We found that temperatures of the medicine room and fridges in which medicines were stored were not always monitored. We observed a medicines round during our inspection and found that the nurse administering the medicines did so safely and ensured that people took their medicines as needed. However, we found two instances of people in pain and this was not being effectively managed at the service as staff and management were unclear about people's needs.

We found the service to be unclean and unhygienic during our inspection. We found communal toilets and bathrooms to be unclean, with toilets covered in faeces and plug holes filled with congealed dirt. We found unpleasant odours throughout the home and areas, where food was prepared, which posed a risk to people using the service due to their unhygienic state. We found clinical waste to be disposed of in communal general waste bins and found that staff lacked an understanding about infection control procedures. We asked to see an infection control audit and were no told that no such audit took place at the service. We

asked to see cleaning schedules for cleaning staff and found that staff were not working to these. We were told that bedrooms were "deep cleaned," however, we found the home to be in a dirty and unhygienic state. Some of the furniture in the communal lounges of the home were covered in stains and one had what looked like faeces on it. We found radiators which were full of dirt and dust and found one person's soiled underwear on top of a bin in a communal toilet. People were not being protected from the risk of cross infection due to the lack of infection control processes at the home.

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

The premises were not safe for people living at the service. We found nails protruding from people's bedrooms walls which posed a risk to people who used the service. We found one bedroom which had an ill fitting call bell which meant that live wires were exposed above this person's bed. We found some light fittings which were coming away from the wall. When we raised these concerns with the registered manager and the regional manager they told us that they had been unaware of these areas of concern within the service. The registered manager told us that the maintenance man was away from work and told us that this was why the premises were not being maintained.

During our inspection three people using the service raised concerns about their safety to the inspection team. Two people described being fearful of staff who delivered care to them and one person described being treated as "a piece of meat." One person told us, "My son visits six days a week but I still feel neglected here. I can't get out of this place sooner. I am fed up to death here as I am always complaining and I am fed up with it." Another person using the service told us that staff referred to them as a "dirty mare." People were not being protected from the risk of abuse as the registered manager was not aware of incidents that occurred at the service. During our inspection we found people who were at risk and made safeguarding referrals as a result.

Staff were recruited using safe recruitment procedures. Pre-employment checks were carried out to ensure prospective new staff were fit and of good character. These checks included disclosure and barring service (DBS) checks for staff. DBS checks are made against the police national computer to see if there are any convictions, cautions, warnings or reprimands listed for the applicant. This meant that the manager could be sure that staff were of good character and fit to work with vulnerable people.

Inadequate

Is the service effective?

Our findings

People were not cared for by a consistent and permanent staff group. This meant that staff lacked the knowledge about the people they were caring for. Both staff and people using the service expressed concerns about the impact this was having on people. At the time of our inspection the clinical lead had resigned and two care staff had left their employment at the service. We spoke with an agency nurse who was concerned about the levels of staff and their ability to safely meet the needs of people using the service. They told us, "You can see things aren't right."

We found that staff lacked information about people's needs as there was a high reliance on agency staff. We spoke with two agency nurses on duty during our inspection and found that they were working from a list of tasks handed over from the last shift. Staff did not understand people's needs well enough to ensure their safety. For example, when we asked who needed re-positioning because they were at risk of developing pressure sores, nursing staff were unable to tell us.

When we visited the service on 21 June 2017, we found that all clinical staff on duty were supplied by an agency and that there were no permanent nurses working at the service. When we spoke with care staff they described lacking time for supervisions and said that these had not been done for some time. One member of the care staff team told us, "You only get pulled into the office when something's gone wrong." When we asked another staff member about support from the registered manager they said, "I don't have conversations with her. She doesn't seem to have time for me." The registered manager told us, "We are behind with supervisions." Staff were not being adequately supported and there was a lack of consistent, permanent staff who had the required knowledge about people's needs to provide the care and treatment that people needed.

When we asked the registered manager for an overview of staff training at the service they were unable to provide this. We asked to see any gaps in staff training and, again, the registered manager was unable to tell us where these were. Although the registered manager was able to produce individual training records for staff, they were not able to provide an overview and were not sure of any training which was due or out of date. Staff training needs were not being effectively monitored at the service.

People using the service also raised concerns with us about the staff team and the lack of communication with them. Relatives of people using the service expressed similar concerns when raising issues around the quality of the care their relative received. One person's relative said, "I have been to seen the Manager face to face but nothing happens. The carers agree with me, there is a communication break down between nurses and they are ineffective." A person using the service told us, "Some staff I feel confident in but others not." Some people we spoke with described staff providing the care they needed, however, people were not cared for by a consistent staff team and that caused several people using the service, and their relatives, anxiety about them getting the care and treatment they required.

People were not supported to have sufficient amounts of food and drink. There were several people we looked at who were underweight and at nutritional risk during our inspection. People were regularly

weighed where possible and these records showed some people consistently losing weight during their time at the service. One person was eating and drinking very little. Food and fluid charts were in place and these documented as little as 250ml of fluid in a day and some days documented that no food had been eaten at all. When we spoke with this person's relative they told us that the staff were not offering their relative the kind of food that they liked and so they were repeatedly refusing it. This person had lost a lot of weight as a result. During our inspection staff brought the person something that they would like (at the relatives request) and they ate it all. People were not being offered food to meet their dietary likes and dislikes.

We found two people who were unable to drink thickened fluids from a beaker provided to them. Two relatives raised this with us during our inspection. This had not been addressed by the service. One person who used the service was unable to eat unless they were sat up in bed by staff. This person told us, "I need to sit up to eat but the staff haven't time to do that." Another person required fortified milk on their breakfast cereal. This had not been provided to them during our inspection. During our inspection we observed people being unable to eat their meals due to a lack of support from staff.

There was a choice of food available to people to each day, however, as the majority of people remained in bed, they relied on staff to know their personal dietary preferences and for sufficient amounts to be provided for them. We found that this was not always happening and that people had suffered from a lack of food and drink as a result. We raised this with the provider who took steps to review people's nutritional needs following our inspection.

People can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). We checked whether the service was working within the principles of the MCA. We found that capacity assessments were being carried out but that care staff lacked a knowledge and understanding around this. The 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.

Mental capacity assessments had been carried out when needed and best interest decisions were documented. However, we found that the management were unclear about who had a Deprivation of Liberty Safeguard (DoLS) in place and who didn't. We observed one person who used the service asking to leave the unit they were on. The person wanted to go out and staff were advising the person that the door had to remain closed for "safety reasons." When we asked whether this person had a DoLS in place nobody knew. When the temporary manager looked into this, they found that this person did not have a DoLS in place and that one had not been applied for. The temporary manager stated that a full review of DoLS was needed at the service.

We saw that health professionals had been involved with people when this was identified as being required. However, as we identified issues with people's health and well-being during our inspection that the registered manager had not been aware of, we could not be assured that this was happening in all cases. For example, one person's relative raised concerns with us about their relative's decline in health since being admitted to the service. They felt that they had become dehydrated and had developed a pressure sore. This decline in this person's well-being had not been picked up by the registered manager or the provider and this person continued to be at risk.

Inadequate

Is the service caring?

Our findings

People's dignity was not being maintained at the service. People were unkempt, in dirty clothes and we found that staff were working to a schedule when it came to people's personal hygiene. We found evidence that people had been refused showers as this did not fit into the schedule that staff were working to and people and their relatives told us of times when their personal hygiene had been neglected at the service. For example, one person had been admitted to the service two weeks prior to our inspection. There were no records of them having had a bath or a shower during this time. Their relative told us, "I wasn't happy with their care when they arrived, I asked them to give them a bath Wednesday and it wasn't until Sunday they still didn't get a bath so I asked for some gloves to bath them myself which they recorded. When I took their clothes off I was shocked to see them red raw on their bottom and lower area and they smelt." This relative had brought in cleaning products to clean this person's room as they were concerned about the lack of hygiene at the service. Another relative told us, "My [relative] has a sore back side and needs creaming with Sudocrem. They don't always look at it. The pads are the wrong ones and they never have the correct ones in. They are just loose and vulnerable. I changed them myself today." These people's dignity was not being maintained at the service as they were not getting the care and treatment they needed.

We visited the hairdressing salon in the home as were told that this was a room where people regularly had their hair done. We found this room to be unhygienic with an unpleasant odour. This would not have been a pleasant place for people to be. We looked at the hairdresser's trolley and found hair rollers covered in hair, dust and dirt. We identified these to the registered manager and the regional manager at the service who had been unaware that these were being used.

We found that pads were in short supply at the service. We were told that this was due to the fact that staff had been "double and triple padding people." It was not clear why staff had been doing this. This approach to personal care was not dignified or safe for people.

We observed people in an undignified state during our inspection. One person was wandering the service in their underwear with their pad on display. This was not dignified for this person. Another person was found outside their room, alone in their wheelchair for 15 minutes. When we asked staff why this person had been left alone in an empty corridor they told us that this was where people were "put" whilst staff cleaned their rooms. This person was not sure why they had been left in a corridor as staff had not taken the time to explain this to them. We found unpleasant odours in people's bedrooms and found communal bathrooms to be dirty and unhygienic. The home did not provide a dignified environment for people to live in.

Several people we spoke with were in their bedrooms during our inspection and we found several people who were dressed only from the waist upwards and that some people had only underwear on their bottom halves. Staff could not explain to us why this was. Care was not being delivered to ensure people's privacy and dignity.

The provider had computer systems available for people who used the service to provide feedback about their care, however, as many of the people using the service stayed in bed, it was not clear how people were

supported to provide feedback. People we spoke with expressed concern about staff's communication skills and some people felt as though they placed a burden on the staff who were very stretched with work at the service.

During our inspection we observed staff walking into people's rooms without knocking. On one occasion this happened whilst someone using the service was having personal care delivered to them in bed. This was not dignified for the person and was not respectful of their privacy.

Two people using the service had belongings which had gone missing during their time at the service. One person had enjoyed listening to the radio, however, this had gone missing from their room and nobody working at the service knew where it had gone. Another person's relative reported a number of their personal possessions having gone missing from their room. They told us that pictures, clothes and a watch had gone missing from the room and that other people using the service often came in and out of their relative's room. During our inspection we saw people wandering into other people's rooms. Staffing levels meant that it was difficult to manage this and that people's privacy was not always respected.

Many of the people using the service were cared for in bed and when we queried why this was, in some cases we were told that there was insufficient suitable equipment to move and seat them safely. We found that a shower trolley that had been used for people who were unable to get up and shower had been broken for some time and that because of this people had been told they could not have a shower. When we raised this with the registered manager, they had been unaware that the shower trolley was broken and unaware that staff had been refusing people a shower on this basis. The provider took steps to resolve this during the course of our inspection, however, people's independence and autonomy was not promoted at the service and people's choices had been reduced due to how the service was being run. Some of the people using the service would have liked to have moved around the home more freely but were unable to do so due to the constraints with staffing and available equipment within the home.

Several people we spoke with during our inspection were afraid of staff and felt that they placed a burden on them. Two people were anxious and raised concerns about how staff spoke to them. Some people did not feel respected by staff caring for them.

The above evidence indicates a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Dignity and respect.

We observed some positive interactions between staff and people who used the service which were warm and compassionate. For example, one person was being repositioned and staff spoke with them quietly, explaining what they were doing. Staff were observed and heard to be discreet when people needed assistance. They reassured people and responded promptly, calmly and sensitively, this was observed with one person who was calling for help to the toilet. However, throughout our inspection we observed the care to be task orientated with no additional time for social interactions or emotional support. The meant that people lacked any quality care which focussed on them as individuals.

Inadequate

Is the service responsive?

Our findings

At our last inspection in January 2017 we found that people and their relatives were not consistently consulted and involved in their care and that people's personal preferences were not respected due to the task focused approach to care. At this inspection we found that these issues had not been resolved and that the provider had failed to make the required improvements.

People's personal preferences were not respected at the service and this meant that people were not able to spend their time in the way they would have liked. One relative told us, "I have asked that the bed be moved against the wall as it would make the room easier to live in and have their chair to watch TV better, but it hasn't been done. I never see any staff around and when they do come they have no bedside manner. They have no communication skills and are not effective. When I asked the staff to look at cleaning the carpet and could they smell anything they replied saying they were immune to the smell." People's personal preferences were not respected at the service, often this was due to the fact that staff lacked time to consider these and to cater for them. One person who used the service told us, "I would like more help with sitting up in bed to eat my food but there's not enough staff." Another person who used the service told us, "The staff keep you waiting a long time and sometimes they don't come. Sometimes you are waiting for an hour. I would like to eat in the dining room but they just put my TV on today and I had it in bed. I am fed up with the staff." People were not able to do the things they enjoyed and many people using the service remained in bed in their rooms. There was little interaction between people using the service and staff lacked any time to engage with people and to consider their personal preferences.

There was little on offer for people to do at the service. The activities co-ordinator working at the home during our inspection explained that some of the people using the service liked to be taken out into the local community but this was limited depending on their availability. Staff we spoke with told us that they felt there was little on offer that people would enjoy doing. Several staff members described the activities as "childish" and felt that they would not appeal to many people who used the service. One staff member described flower arranging being offered and that one person at the service had been particularly looking forward to this. However, the flowers that were brought into the home were made of paper and so people were disappointed about that as an activity. There was little focus on ensuring people were engaged in activities they enjoyed due to the task focussed nature of the care and treatment being delivered to people. One staff member said, "I think the activities are very childish." Another staff member told us, "I love working here but things do need to change. We've got so stuck into a routine."

People who used the service described being bored and many people stayed in bed or in their rooms. When we queried why this was with staff they told us that some people could not be moved due to a lack of suitable equipment at the home to do this safely. We asked people and their relatives how they spent their time at the service. One person who used the service told us, "There are no activities for me. I am bored stiff and I would love to get out of this place sooner - fed up to death here." Another person said, "No, I cannot get out of bed as I am disabled." The relatives of people felt that there was a lack of activities. One relative told us, "There are no activities here for them and the garden here is unkempt and a hazard. The patio doors are rarely opened but today is hot." On the first day of our inspection the garden presented a hazard to

people using the service due to unsafe equipment and rubbish being stored in it. The provider did address this during the course of our inspection, however, when we initially visited the service this space had been unpleasant and unsafe for people to access. Another relative we spoke with said, "Generally staff are limited, only two on at night. My mother doesn't get any activities, she hardly gets out of bed."

There was an inconsistent staff team working at the service which meant that staff lacked the knowledge of people's personal preferences and were therefore unable to provide care to meet their individual needs and preferences. Staff working at the service throughout our three day inspection were a mix of permanent staff and agency care staff and nurses. There was a high percentage of agency usage and this was impacting significantly on people's care. For example, when we asked staff about a person's interests and hobbies they were unable to tell us what these were. One person using the service was very anxious and yet their care records held no details of these anxieties and staff we spoke with were unaware of them. Staff lacked knowledge about what people liked to eat and drink. One staff member told us, "There isn't enough staff as most residents need two staff for their personal care, working with agency staff is hard because you have to keep telling them what to do as they don't know the residents. I don't feel safe on shift when it's an agency nurse. I don't feel confident that they will respond if you need them or a resident needs them." During our inspection visits the majority of nurses on shift were agency nurses.

Care records we looked at lacked evidence that people were involved in the planning of their care on an on-going basis. We identified individual preferences for people, for example, in relation to their nutritional likes and dislikes which had not been identified or planned for at the service. People's personal histories were recorded in some cases, but this was not consistent across the service. One relative told us, "There has been no assessment or review about my husband. I would have liked one."

The above evidence indicates a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care.

Complaints had been logged by the registered manager and there was a system in place to ensure that the complaints which were identified and dealt with were adequately recorded and responded to. However, we spoke with a number of relatives who felt that the concerns they had raised about their relative's care and treatment had not been adequately responded to by the management at the service. One relative told us, "I was waiting to have a meeting today to discuss his care at 11am but the manager says it's tomorrow." Another relative we spoke with told us of numerous issues they had raised with the registered manager that they felt had not been dealt with adequately.

Inadequate

Is the service well-led?

Our findings

At our last inspection we found that the quality of the service was not being effectively monitored and that this had resulted in failings within the service. We asked the provider to make improvements in this area. At this inspection we found that these failings were continuing at the service. We found that there continued to be a lack of management oversight and that issues and incidents we identified during our inspection had not been addressed by the registered manager or by the regional manager who had been working at the service. These failings posed a significant risk to people who were using the service at the time of our inspection.

The environment people were living in posed a risk to them and this had not been effectively monitored. When we arrived at the service we found the premises to be unsafe. We found light fittings which were not securely attached to the wall, we found a call bell above someone's bed which was coming off the wall with wires exposed and we found nails protruding from bedroom walls, where people could have caught their skin. We found tools which had been left in communal corridors, including a set of secateurs and we found broken and dirty equipment being stored in communal bathrooms. When we pointed these areas of concern out to the registered manager, they told us that they had been unaware of these risks and that they did not regularly walk around the home. The registered manager told us that the handyman had been away from work and that this was why the home was in an unsafe state. The provider did not have effective systems in place to monitor the safety of the environment people were living in.

People were not being cared for in a clean and hygienic environment. We found several areas of the home to be unclean and unhygienic. This put people at risk of infection due to the lack of infection control systems and processes at the home. We found clinical waste in general waste and found the service to be dirty and malodourous. We walked around the service with the registered manager and the regional manager, both of whom expressed surprise and shock about the state in which we found the home. Radiators which were full of dirt and dust had not been cleaned for some time and we found furniture to be covered in stains and dirt. We asked to see the last infection control audit which had been carried out and were told that no such audit took place at the service. We were told that the cleaning staff had cleaning schedules to assist them in their work and to ensure that the home was fully cleaned. However, when we asked the cleaning staff if we could see these, we were told that these were not carried around the home and that they had not seen them. There were not effective systems in place to effectively monitor infection control at the service and this put people at risk.

People could not be assured of safe care and treatment as this was not being effectively monitored. We found that some people's care plans had not been completed in a timely manner and that this had put them at risk of unsafe care and treatment. For example, one person who was at high risk of developing pressure sores had not had a care plan written for nine days following their admission to the service and no preventative measures put in place prior to the care plan being written. Once some skin damage was identified a care plan was then written. This lack of monitoring and oversight had resulted in this person experiencing harm as a result. The person was placed on a faulty mattress for several days which meant that they did not receive the care and treatment they had needed. This person went on to develop a pressure

sore. When we spoke with the registered manager about this, they had been unaware of the events surrounding this person's care.

People who were at nutritional risk were not being adequately monitored. We found that people using the service who should have had their food and fluids monitored were having very little to eat and drink, despite them being identified as being at risk. Fluids had not been totalled and clinical staff and the registered manager were not monitoring how much or little people were having. For example, on one day of our inspection we identified that one person had taken 250mls of fluid and no food at all. Several people did not have any targets in place for their fluid intake and so it was not possible for this to be monitored by staff as they would not have known what the person should have been having. The registered manager was not reviewing people's nutritional intake and nor were the clinical staff on duty.

Some people we spoke with were positive about the registered manager and described being able to approach her should they need to. However, two people who used the service and three relatives we spoke with raised concerns with us about the registered manager's visibility within the service. One person who used the service told us, "I don't know the manager and I have been here 12 months." One relative said, "I know the manager, she should be walking around this care
home looking at her staff working." Another relative commented, "I know the manager. She stays in her office most of the time." There was a lack of management oversight and presence within the service and this was impacting on the quality of care that people received.

We asked the registered manager about staff training at the service and how they managed staff performance. We were told that they were behind on staff supervisions and that these had not been held for some time. We were not shown any records in relation to these. When we asked to see an overview of staff training, we were told that this was not possible and that staff were looked at on an individual basis. There was not an effective system in place to monitor staff training and performance at the service.

Staffing levels weren't assessed or monitored to ensure people's safety. Although a dependency tool was in place, this had not effectively measured staffing needs as we found staffing levels to be inadequate during our inspection. Staff were unable to deliver safe care and treatment due to the staffing numbers and skill mix, however, this had not been identified as an issue.

During our inspection we identified several incidents which had occurred at the service involving the conduct of staff who had worked at the home. Some of these incidents the registered manager had been aware of but others they did not have any knowledge of. These incidents involved a lack of care and treatment to people who used the service. There was a lack of communication within the service which resulted in a lack of management knowledge and effective oversight in relation to staff performance and the quality of care being delivered. For example, one person had been unwell during a night shift. This person had a type of feeding tube known as a percutaneous endoscopic gastrostomy (PEG) in place and the fact that they had been unwell was significant. The registered manager had not been aware of this incident on a night shift and only became aware when we advised them on our inspection. The person had not been given adequate care and treatment that night and this had put this person at risk. Steps had not been taken following this incident as the registered manager had been unaware that it had happened. There were not effective monitoring systems in place to ensure people received safe care and treatment.

Although the provider had a number of quality assurance processes in place at the service, these had not been effective in identifying the number of widespread and significant shortfalls in safety and quality. Where issues had been identified they had failed to make improvements. These failings posed serious risks to people using the service. Management oversight had not been robust or effective.

The above evidence indicates an on-going breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

We found that where the registered manager had been aware of the incidents which needed to be notified to CQC they had done so. However, we were not assured that all incidents which had taken place at the service had been notified to us due to the lack of management oversight we found at the service.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure that people received individualised care to meet their personal needs and preferences.

The enforcement action we took:

We took urgent action to restrict admissions to the service and required the provider to supply assurances to us about management of the service on a regular basis. We asked the provider to ensure that people received the food and fluid they required and that this was monitored.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's privacy was not always respected at the service and people did not receive dignified care.

The enforcement action we took:

We took urgent action to restrict admissions to the service and required the provider to supply assurances to us about management of the service on a regular basis. We asked the provider to ensure that people received the food and fluid they required and that this was monitored..

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people using the service had not been adequately assessed and planned for to ensure people received safe care and treatment. The premises was not safe for people to use. The provider had failed to protect people from the risk of infection due to inadequate infection control processes being in place. Medicines had not been safely managed.

The enforcement action we took:

We took urgent action to restrict admissions to the service and required the provider to supply assurances to us about management of the service on a regular basis. We asked the provider to ensure that people

received the food and fluid they required and that this was monitored.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to assess, monitor and improve the quality and safety of the service and the risks relating to the health, safety and welfare of service users.

The enforcement action we took:

We took urgent action to restrict admissions to the service and required the provider to supply assurances to us about management of the service on a regular basis. We asked the provider to ensure that people received the food and fluid they required and that this was monitored.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient staff to safely meet the needs of people using the service.

The enforcement action we took:

We took urgent action to restrict admissions to the service and required the provider to supply assurances to us about management of the service on a regular basis. We asked the provider to ensure that people received the food and fluid they required and that this was monitored.