The Willows Care Home (Worcester) Limited

Orchard Court

Inspection report

3A Orchard Gardens
Thurmaston
Leicester
Leicestershire
LE4 8NS

Tel: 01162640086

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This unannounced inspection took place on 23 November 2017. It was the provider's first inspection at this location since registering with CQC.

At this inspection we found breaches of five regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Registration Regulations 2009. 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 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 well-being were effectively managed. There was a lack of care delivered to meet people's individual needs and to promote and encourage their independence.

Due to the breaches we identified during our inspection and the risk these posed to some people, we made a safeguarding referral to the Local Authority as we were concerned about people's safety and well-being. The overall rating for this is inadequate.

Orchard Court is registered to provide residential and personal care for up to 20 people. There are three separate units within the service with six to seven people living on each unit. At the time of this inspection there were 20 people living in the service. One of these people was in hospital during our inspection. 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 had complex needs which, at times, needed one to one or two to one support from staff who were trained in specific and specialised areas of care delivery. During our inspection we found that this was not being provided at the service to the level people needed to ensure their safety.

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.

We found there to be insufficient numbers of staff working at the service to keep people safe. People were not receiving the levels of supervision they needed and staff lacked the specialist knowledge and skills to care for and support people safely. People had experienced and were at risk of experiencing unsafe care and support as a result. Staff training was not adequate and not designed to meet the needs of people who used the service.

People were not safe due to safeguarding incidents not being appropriately acted on or reported and risks to people were not adequately planned for. Care plans and risk assessments did not always reflect people's current needs.

Medicines were being managed safely when we inspected the service, however, there was a lack of information for people with diabetes. We raised this with the provider who took steps to address this during the course of our inspection.

People had a choice of food and drink each day and were given these in sufficient quantities, however, people's nutritional risk was not always safely monitored and addressed.

People were not able to spend their time engaged in activities they may have enjoyed and people were not often given the opportunity to access the community. This was due to staffing levels at the service. People were not living fulfilling lives and there was a lack of emphasis on people's goals and aspirations. People spent long periods of time with little or nothing to do.

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.

Staff training and performance was not being effectively monitored and staff told us they felt unsupported and under-valued at the service. There was an unhealthy culture of mistrust between management and staff and this impacted on the quality of care being delivered.

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

The 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.

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.

There were insufficient staff to ensure people's safety and they spent long periods of time with little or nothing to do.at the service.

People who required one to one and two to one care were not always getting this which put them and other people using the service at risk.

People were not being protected from the risk of abuse as incidents were not being acted on as required. Staff lacked the training to safely manage the people using the service.

Risk assessments and care plans did not always provide adequate or accurate information to ensure people's safety and risks to people had not always been acted on.

Medicines were being managed safely at the service.

Safe recruitment systems were in place; however, references for staff had not always been obtained or adequately checked.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not adequately trained and supported in their roles to provide the care required to people.

The principles of the mental capacity act had not always been followed.

Health professionals had been involved in people's care but people's health needs were not always effectively monitored.

People were given a choice of food and drink and were given sufficient quantities.

Is the service caring?

Requires Improvement

The service was not caring.

People were not engaged in activities they enjoyed and their goals and aspirations were not being fulfilled.

People's views about the service were not regularly being sought.

People were not involved in the planning and delivery of their care and support.

Is the service responsive?

Requires Improvement

The service was not responsive.

Care and support was not planned and assessed to meet people's individual needs.

There was a lack of emphasis on people reaching their potentials and leading fulfilling lives which encouraged and supported their independence.

People's care records were not regularly reviewed with them or their representatives.

People's cultural and religious needs and preferences had been considered.

People, their relatives and representatives knew how to complain and told us they felt comfortable doing so.

Is the service well-led?

Inadequate

The service was not well-led.

Staff did not feel supported and were not encouraged to express their views about how the service was being run. There was an unhealthy culture within the service and a lack of trust from staff and management.

There was a lack of management oversight in relation to incidents and accidents and no oversight of people's risks. There was no assessment of risk across the service.

Quality monitoring systems did not exist or were ineffective as they failed to pick up on incidents which had taken place.

People and their representatives were not involved in quality monitoring at the service and there were no effective systems in place to obtain these views.

Incidents had not been recognised as such and therefore had not been notified as required.	

Orchard Court

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 23 November 2017 and was unannounced. The inspection team consisted of two inspectors 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.

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. Prior to our inspection we had received concerns from the Local Authority in relation to how the service was being run.

Over the course of the inspection we spoke with three people who used the service. We were unable to speak with more people due to their complex communication needs. We also spoke with six relatives of people who used the service, the provider, the deputy manager, a team leader and four support workers.

We viewed four records about people's care and treatment which included their daily care records, risk assessments and medicines records. We did this to ensure 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

People were at risk due to an insufficient number of support staff working at the service. We found that people had complex needs and many of the people we reviewed needed one to one and sometimes two to one care. This level of support had been assessed and agreed with the funding authority, however, there was no record of who required what level of support and when. We asked the provider how they determined staffing levels at the service. They told us that no system for assessing staff numbers was used and that they were unclear about how many people should have one to one and two to one care. The provider told us they believed this information should have been given to them when they took the service over, however, this had happened in February 2017, we found that no steps had been taken to establish this since then. The care that people needed to keep them safe was not being provided by the service and we found instances during our inspection when there was no staff on a unit due to them having to carry out cooking, cleaning, laundry and shopping tasks within the service.

One person using the service was at risk due to them having a condition which made them prone to picking up inedible items and putting them in their mouth. We looked at this person's staffing needs and found that they required a minimum of seven hours of one to one care during the day to keep them safe. This person's care plan stated: "It is really important that supervision is given throughout the day as I will consume inedible objects." However, this person was not receiving this one to one support from staff. We observed several occasions where this person was not with a staff member and on one occasion we found this person in a toilet on their own. This toilet had items which the person may have attempted to eat. We checked their care records and found several incidents which involved this person being found with inedible items in their mouth which put the person at risk. Daily notes provided evidence that on several days leading up to our inspection the person had received as little as two hours one to one support over one day. We raised this with the provider during our inspection due to the risk posed to the person. They were unable to explain why the person hadn't had the level of support they required. Steps had not been taken to protect this person by providing the staff supervision they needed to keep them safe. This put the person at risk.

Support staff at the service were required to cook the meals, clean the service and carry out laundry tasks as well as provide care and meaningful activities for people to engage in. During our inspection we found that staff were unable to spend any meaningful time with people during the course of the day, unless staff members took people out into the community. On the day of our inspection, two staff members had taken a person shopping. This left this unit short of staff and during the afternoon we found the unit with five people on it and only one member of staff. The staff member was peeling potatoes which meant that five people were in the day room without any staff. We observed people sitting for long periods of time who were not engaged in any kind of activity due to staffing levels within the service.

Another person using the service was at risk of falls and suffered from epilepsy which meant they had frequent seizures. This person required one to one care for seven hours each day. During our inspection we observed that the person was not receiving this care. We found instances when this person was left on their own.

A large number of staff had left the service, many of whom had worked at the service for some time and who had known the people using the service well. When we spoke with staff they confirmed this to be the case and described how the service now had to rely on agency staff whilst more staff were recruited. The people using the service had complex conditions; some could display behaviours which may have been challenging. Some staff were not familiar with people's risks and could not therefore ensure their safety. For example, we found one staff member who had taken their handbag onto one of the units and left it on the floor within easy reach of the people who used the service in a communal area. As the person who had a conditions called PICA which meant that they would attempt to ingest inedible objects was on this unit, this put them at risk and as they were not receiving the kind of supervision they needed. Staff were unable to mitigate the risk by supervising them appropriately.

One person using the service was not incontinent during the day and yet was using an incontinence pad as staff did not always have time to take the person to the toilet and agency staff being used at the service did not know the routine in relation to the person and their personal care needs. This was not dignified for this person and was due to a lack of knowledgeable, adequately trained staff working at the service.

When we spoke with staff who worked at the service they told us that staffing levels had been reduced and this had impacted on people's quality of life. One staff member told us, "We used to have more staff on which enabled us to look after people better than we do at the moment." Another staff member said, "We've lost a lot of staff recently. Staff have left because of staffing levels." Our observations found that people were not getting the one to one care they needed and that, at times, units were left with little or no staff, which put people at risk. We found that people were not able to spend their time in the way they would have liked and there were long periods of time when people were left sitting on their own doing very little. This was due to staffing levels at the service.

We spoke with people who used the service who expressed to us that there were not always staff available to assist them as they required. One person told us they "tried not to rely on them [staff]." When we asked if staff responded to them, another person said, "Only sometimes, sometimes they don't answer me." We found staff unable to support people in the way they needed and that this impacted on how safe people felt at the service. Two relatives expressed concerns about staffing levels at the service, one commented: "They haven't got the staff to keep [person using the service] entertained." We observed during our inspection that there was a lack of activity within the service and people sat for long periods with little or nothing to do.

The above evidence indicates a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

People were not being adequately protected from the risk of abuse due to a lack of systems being in place to ensure incidents of possible abuse were recorded and acted on. We reviewed care plans and daily records as part of our inspection and found several instances of unexplained bruising and incidents where one person who used the service had been verbally or physically abusive towards another. Although these incidents had been recorded on daily records, no safeguarding referrals had been made to protect people who used the service from the risk of abuse. We asked the registered manager to provide us with a record of incidents and accidents that had taken place at the service. Many of the incidents we found recorded in daily records had not been recognised as safeguarding incidents. There was no monitoring of people's risk in relation to abuse and action had not been taken to ensure the appropriate agencies were notified as needed.

Some people who used the service could display behaviour which, at times, may have been challenging for staff to manage. When we spoke with staff they described instances where people had been verbally or

physically challenging and described needing to monitor people to try and manage this behaviour. However, as there was a lack of staff to do this as required, this put people who used the service at risk of abuse. We asked staff if people could become physically challenging and they told us that, at times, some people could. We found daily records which showed several instances where people had "tried to hit out at staff" and at people who used the service. However, none of the staff working at the service had received training in managing challenging behaviour or in the use of any form of restraint. The Statement of Purpose for the service detailed that restraint would be used only in an emergency and to protect people who used the service, however, training records we reviewed did not contain any evidence of training being delivered to staff in this area. This put both people using the service and staff at risk of abuse.

Staff we spoke with had been trained in safeguarding people and knew how to raise safeguarding concerns should they need to. However, some of the staff lacked the specialist training and knowledge to safely support people who used the service and to protect them from the risk of abuse.

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

Risks to people's health and well-being were not being safely managed at the service as people were not receiving the kind of support they needed. Staff were not adequately trained to provide some of the specialist care people needed and agency staff were being used who lacked any knowledge of people and their complex needs. Risk assessments did not always provide an accurate and up to date record of people's risks and did not provide enough information for staff to be able to safely manage people's risks. For example, one person who was at risk of falls and who had fallen in the weeks prior to our inspection had been deemed to be at low risk. This risk assessment had not taken into account recent incidents and was not accurate in the assessment of their risk. The person was at on-going risk of unsafe care and treatment due to this. They required one to one support throughout the day and yet this was not being provided by the service due to a lack of staff. Although this level of support had been agreed by the provider, steps had not been taken to put this into place to ensure this person's safety.

We found two people had lost a significant amount of weight since January 2017. We raised this with management during our inspection who told us that one person's weight loss had been intentional. When we raised that another person had lost a similar amount of weight, nearly nine kilograms since January 2017, the staff member told us this had not been picked up by staff and that no action had been taken to address the weight loss. This put the person at risk. When we looked at the person's risk assessment for nutrition they had been assessed as low risk, despite them losing weight over a long period of time. No referral had been made to a dietitian about their weight loss.

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.

People were receiving their medicines safely. We reviewed records in relation to the administration of people's medicines and found that staff were administering these safely and as required. Checks were carried out regularly to ensure that people were getting their medicines. Staff were trained in relation to administering medicines to people. Only trained staff were administering the medicines at the service. There was a lack of detail provided to staff in relation to one person who was diabetic. There was no clear guidance provided for staff on how to safely manage this person's condition. We raised this with the provider and this was address during the course of our inspection.

People were protected from the risk of infection as there were adequate cleaning arrangements in place at

the service. The support staff were required to carry out the cleaning tasks and although this took them away from supporting people in the way they needed, we found the home to be in a clean and hygienic state at the time of our inspection. We were provided with audits which had taken place in June and July 2017 and saw that cleaning schedules were in place for staff. There was an infection policy in place which provided guidance for staff.

Incidents and accidents were not always recorded and there was no oversight in relation to these. We asked to see the accidents and incidents records over the last three months and found the incidents we had identified through daily notes and care records had not been identified as incidents. Therefore they had not been recorded and monitored and that no action had been taken as a result.

Most staff had been safely recruited into the service and they had the required recruitment checks in place. However, we did identify a staff member who did not have any references in place and one staff member whose references may have caused concern about their suitability to work at the service. We raised this with the provider during our inspection who confirmed that no action had been taken to address this.

Requires Improvement

Is the service effective?

Our findings

Staff did not have the required knowledge, skills and experience to deliver effective care and support to people and this was due to a lack of training being delivered by the provider. Many of the people who used the service had complex needs and conditions which required staff to be trained in managing their behaviours and adopting techniques should people become physically or verbally challenging. This type of training was not being delivered at the service and although staff were receiving training in some key areas of safe care delivery, such as moving and handling training, we were told most of the training had moved to on-line courses since the provider had taken over at the service. We found evidence of incidents which had taken place at the service which staff required specialised training to deal with effectively, such as people displaying physically challenging behaviour. This training had not been provided to staff so they were not managing the person's behaviour effectively.

Staff we spoke with described needing to monitor people to keep them safe and described instances when people had become verbally and physically challenging. We asked staff whether they were trained in managing these behaviours and whether they had been trained in any form of restraint. Staff told us they had not been trained in this and staff training records we reviewed confirmed this. We found records relating to several instances of challenging behaviours and staff described dealing with these through the course of their work, however, staff were not being supported to do this safely and in line with best practice guidelines. No direction or guidance was provided to staff in relation to people's behaviours and how to manage them. This put staff and people using the service at risk of harm as staff were not adequately trained and skilled to support the people using the service.

The majority of staff members we spoke with described feeling unsupported. One commented, "Our management doesn't make it easy on us." Another staff member said, "My voice doesn't make a difference at Orchard Court anymore." There was little evidence in supervision records and staff meeting minutes of staff being able to express their views about how the service was being run. The staff meeting minutes lacked a supportive approach to staff and we were told that 16 staff members had left the service in recent months. Some of these staff members had worked at the service for many years.

The above evidence indicates a breach of Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

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 less restrictive as possible. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The provider had made suitable DoLS applications to the relevant authorities and people had been subject

to these safeguards where appropriate. Some of the safeguards in place required levels of monitoring which were not being delivered. For example, one person had a DoLS in place which stated that if they displayed certain behaviours these needed to be recorded. As this person was not receiving the one to one care they needed, it would not have been possible for the service to do this accurately.

The principles of the Mental Capacity Act had not always been followed and care records lacked detail in relation to decisions made in people's best interest. We raised this with the deputy manager who acknowledged further work was needed in this area. We did observe staff seeking consent from people before delivering care to them during the course of our inspection.

Although people's care needs had been assessed, there was little evidence of reviews of these which took into account current legislation, standards and best practice in the delivery of care and support to people with the complex needs of those who used the service. Care plans and risk assessments were not always reflective of people's current needs, choices and risks and the service was not fully considering how people may have chosen to live their lives at the service.

The service was split over three units and support was provided to people within each unit. The corridors were wide and doorways wide enough to accommodate wheelchair access should this be needed. During our inspection the service was very cold due to work being done to the heating system. From speaking with staff, relatives and the local authority who had recently visited the service, we were told the home was frequently cold due to on-going issues with the heating and hot water. The maintenance records we were shown were blank and there was no record of how the premises were regularly checked. We were told the provider had oversight of this, however, none of the records we looked at showed the premises were being maintained on an on-going basis. We found corridors to be very dark. We were told that this was because people using the service preferred them to be lit by fairy lights. People or their relatives had not been recorded as stating this preference. Nails were protruding from walls as pictures had been removed due to people pulling them down. This posed a risk to people of catching themselves on these. There had been little thought at the service about adapting the surroundings to meet the needs of the people who used it.

People's health needs were monitored and health professionals had been referred to when needed for some of the people who used the service. One person had lost a significant amount of weight at the service and this had not been referred due to it not being identified. We raised this during our inspection. People were referred to GPs, district nurses and mental health teams when this was required.

People had a choice of meals and drinks and were provided with sufficient quantities of food and drink. People and their relatives were positive about the food. One relative told us, "They give him a good varied diet. His food is pureed and he likes anything with chicken in. If there is something he doesn't like they give him something else." Support staff prepared the food and drinks during their shifts which limited their time with people, however, there were kitchens on each unit designed so that people could get involved in meal preparation should they choose to.

Requires Improvement

Is the service caring?

Our findings

People were not treated with respect and compassion by the provider. We found people lacked time to do the things they enjoyed as staffing levels meant staff were having to focus on tasks within the service, such as cooking and cleaning. Although people were being funded by the local authority for one to one and two to one care, this was not happening in practice. Staff we spoke with told us that people often spent long periods of time doing very little and day trips and holidays very rarely now took place. One staff member told us, "People are just sitting there all day. The choices have all just gone away." Another staff member said, "People used to go out all the time. They're lucky if they go out once a week now." We asked to see plans for people to go out into the community and on day trips. We were told this happened as and when staffing numbers allowed. One person had been taken out during our inspection, however, we observed some people sat for long periods doing very little. People were not being engaged in activities they enjoyed, nor were they getting the staff interaction and support that was being funded for them.

We raised our concerns about people's inactivity and the fact that they seemed to have little to occupy them with the provider. We queried whether people went on any holidays. The provider told us that they were not willing to take the risk on taking people away due to their conditions. We raised concerns about people not getting the one to one support to allow them to engage in activities they enjoyed. The provider told us they would look to getting these people's needs re-assessed. The provider lacked an understanding of the complexities of people's needs and the importance of people being able to lead fulfilling lives which enabled them to reach their full potential. The provider did not display a compassionate and caring approach to people using the service and this was evident in the way in which the service was operating.

Although people's needs and preferences were detailed in their care plans, there was little evidence this was being respected and acted on. Staff we observed were busy in their work which meant they were unable to engage with people fully or as they may have liked. As a large number of staff who had worked at the service for many years had left, the service was reliant on some agency staff and these staff lacked knowledge about people's likes and dislikes and how they wanted to spend their time.

One person using the service raised their anxieties with us about people entering their room and taking their personal items. This was causing the person some distress. This issue was not being effectively managed due to staff being unable to spend time with the person providing them with reassurance. The person's privacy was not being respected and how they felt had not been recognised or acknowledged. The person was also anxious due to another person who used the service exposing themselves. This behaviour was not adequately managed as staff were unable to spend the one to one time with the person to minimise them doing this.

Some of the staff we spoke with who had worked at the service for many years and knew people well and understood how to best communicate with them. They were able to describe people's likes and dislikes and tried to engage people in activities they enjoyed when they had the time. However, several staff members described a deterioration in the quality of care and support they were able to provide and attributed this to staffing levels. One staff member said, "We used to have more staff which enabled us to look after people

better than we do at the moment." Another staff member told us, "Our residents sit there most of the day staring at the TV or the wall."

People's views about the service were not sought and there were no arrangements in place to enable people to express their views about their care and support. There were no records from meetings held with people who used the service and we were told that no meetings with people had taken place. People were asked what they would like to eat each day but no views had been obtained about how they'd like to spend to their time and any improvements the service could make in relation to their care and support. People and their representatives had not been involved in on-going reviews of their care and support to enable this to be planned to meet their individual needs.

The above evidence indicates a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care.

Visitors were welcome at the service and could visit when they chose to. One person's relatives visited them every day and were made to feel welcome and comfortable by the staff. People could spend time with their relatives in their rooms or within the communal areas of the home.

Requires Improvement

Is the service responsive?

Our findings

People did not receive care and support that was personalised to meet their individual needs. Although care plans provided some detail in relation to people's individual care and support needs, these were not being realised in practice. There was little emphasis on people's individual goals and aspirations and a lack of focus on people achieving their potential. Care and support was provided as and when staff were available to do so and due to low staffing levels, often people were left for long periods with little or nothing to occupy them. Staff who had worked at the service for some time understood people's needs; however, they told us they lacked the time to spend with people. Due to the complex nature of some people's conditions, they would have benefitted from and had been funded for one to one support. This was agreed so people could live fulfilling lives. However, there was no structure in place for this to happen.

People's needs were assessed prior to them starting to use the service although most of the people had been there for many years and so any care plans and records had been carried forward from their original assessment. There was a lack of involvement from people and their representatives in on-going reviews and assessments of their care needs and care records did not always reflect people's current risks. For example, people whose behaviours may have been challenging for staff to manage did not have adequate plans in place for staff to safely manage this. The care records and assessments did not always reflect how people lived their lives at the time of our inspection.

People's independence was not being promoted. Although some people were able to go out into the community as they would have liked, this did not happen for everybody due to staffing constraints. When we spoke with staff they told us people used to go out far more than they did at the time of our inspection and now people were often left in the home without the opportunity to get out and about. We observed this to be the case and found people whose care records stated they enjoyed going out, were not able to do so.

We asked people who used the service how they spent their time. One person said, "I like watching telly, Bob Marley CDs, (model) buses to play with." When we asked this person if they had enough to do, they replied, "Never." Another person told us they, "Watched telly." One relative when asked about how their relative spent their time told us, "He does spend a lot of time in his room. He doesn't seem to go into the lounge. It has bothered us a little bit." Care and support was not being designed to meet individual needs and preferences and this was impacting on how people were able to spend their time and live their lives.

The above evidence indicates a breach of Regulation 9 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care.

People's needs had been considered in relation to the Equalities Act and there had been some consideration of this in people's care planning. Their communication methods had been detailed as had their needs in relation to cultural or religious preferences. One person who used the service told us they were able to attend church regularly.

The provider told us they had not received any verbal or written complaints since they took over the service

in February 2017. We spoke with people and their relatives who told us they would be able to complain if they needed to. There was a copy of the complaints policy displayed in a communal corridor.

Inadequate

Is the service well-led?

Our findings

Staff were not being adequately supported and there was an unhealthy culture of mistrust within the service which resulted in care and support not being delivered safely and effectively. We spoke with staff members during and following our inspection to find out whether they felt they could approach management should they need to. Most of the staff we spoke with did not feel supported in their roles and they described being unable to have confidential conversations with management. One staff member told us, "Communication is appalling." They went on to say, "Nobody has given staff any direction. It seems uncoordinated." Another staff member told us, "There is absolutely nobody in that building that will support you. You can't trust anybody." Another staff member told us, "Nothing you say is confidential."

Two staff members expressed concerns about how people were treated and expressed concerns about the provider's understanding of people with complex conditions. Staff lacked confidence in the provider and in the management at the service and felt they were unable to express their concerns. During our inspection we found an unsupportive environment where staff were doing their best to care for people in a service which lacked any management support to do this effectively.

We looked at staff meeting records. There was little evidence that staff were able to express their views and no evidence that concerns had been taken on board and addressed by the registered manager or the provider. The meeting records we looked at were a record of the provider and registered manager telling staff about changes and adjustments at the service. There was no evidence that staff were able to contribute to these meetings and no record of staff views being listened to.

We asked the provider about the one to one and two to one hours of support people should receive at the service. The provider was unable to tell us what these were and explained the local authority who were funding the care had been unable to tell them this. No assessment of the support needed by people had been done by the provider in relation to people's care and support needs nor in relation to what had been agreed to be provided to them by the funding authority. There was no staff dependency tool in place to determine staffing levels based on need and one to one and two to one hours of care. People were not being supported by enough staff to keep them safe and no assessment or quality check had been carried out in relation to this.

People were unsafe due to inadequate quality monitoring systems being in place at the service. We looked at daily records made by staff and found numerous incidents involving people. Many of these incidents put people at risk. For example, we found numerous records in relation to one person who was frequently found with inedible objects in their mouth. When we asked for a record of incidents and accidents which had taken place, we found that none of the incidents were recorded and we were shown records which indicated that no incidents and accidents had taken place. There was no oversight in relation to incidents and accidents and therefore no assessment of risk and action which may needed to have been taken as a result. This put people using the service at risk of harm.

We asked the see how the premises were maintained and who was responsible for this. We were told the

provider had taken on this task when they had taken the service over. We asked to see the maintenance logs and premises checks and were told that none were available to us. There were on-going heating and hot water issues during the course of our inspection which was concerning due to the very cold weather being experienced. We found the service cold during our inspection and were told by staff that the heating was often turned off in a cost cutting exercise by the provider. The premises were not being safely and adequately maintained due to the lack of regular checks and maintenance work.

There was no way of staff communicating with each other between the three different units. People did not have buzzers in their rooms to alert staff if they needed them and staff would have to call each other from one unit to another. When we raised this with the provider they did not see this as being a safety issue. When we spoke with staff who worked at night they told us that this arrangement put people at risk as they were unable to alert their colleagues should they need to. There had been no risk assessment carried out in relation to this and no quality monitoring in relation to staff and how they were able to respond to people. Several people using the service needed two to one staff ratios for personal care and this put them and staff at risk when staff were on their own within each individual unit at night.

We found care plan audits, although done regularly, were ineffective as the risk assessments and care plans did not always reflect people's current risks. For example, we found nutritional risk was not always correctly calculated and people's weight loss had not been monitored to keep them safe. Two people who needed one to one supervision for seven hours each day to keep them safe were not getting this and no steps had been taken to mitigate their risk. None of these risks had been recognised or planned for.

There was no service wide strategy in place and staff were unclear as to the aims and objectives of the provider. Three staff members expressed to us the quality of care delivery had declined in recent months and people were not receiving the kind of care to keep them safe and enable them to do the things they would have liked to. People were not engaged in activities during our inspection and staffing levels determined what people were and weren't able to do.

Staff and people who used the service were not involved in how the service operated. There were no systems in place to obtain feedback from people and their representatives. Following our inspection visit the registered manager sent out a survey to people' relatives. However, this was sent including details for a provider which was no longer registered to provide the service and one of the relatives we spoke with had to visit the post office to collect their survey as insufficient postage had been used. They had been asked to pay the extra money to receive their survey.

We asked to see a number of policies and procedures in place to assess whether the management and provider were working in line with these. On two of these policies, the first pages stated that they had been approved by the existing provider and were dated since they took over the service; however, subsequent pages showed them to be the policies and procedures of the provider who had been running the service prior to the existing provider taking over. These pages were dated 2012. We raised this with the registered manager who told us no new policies and procedures had been put into place by the existing provider in relation to managing medicines and equality and diversity.

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

Incidents had not always been notified as required due to a lack of oversight of incidents. As these had not been recognised as incidents, CQC had not been notified as required. We found numerous safeguarding incidents in relation to unexplained bruising and behaviour which may have challenged to have gone

unreported.

The above evidence indicates a breach of Regulation 18 of the Registrations Regulations 2009. Notification of other incidents.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Notifications to CQC had not been made as required by law.

The enforcement action we took:

We imposed urgent conditions on the registration which prevents new admissions to the service and requires the provider to submit regular reports to prove the safety of service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not receiving care to meet their individual needs and preferences. People were not getting the care and support they required and were not able to spend their time in the way they would have liked. People were not involved in on-going assessments of their care and support needs and were not supported to live their lives on the way they would choose at the service.

The enforcement action we took:

We imposed urgent conditions on the registration which prevents new admissions to the service and requires the provider to submit regular reports to prove the safety of service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and support was not being delivered safely due to people's risks not being accurately assessed and people not being monitored in the way that was required to ensure their safety.

The enforcement action we took:

We imposed urgent conditions on the registration which prevents new admissions to the service and requires the provider to submit regular reports to prove the safety of service users.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding incidents were not being adequately monitored at the service and had not been responded to appropriately as a result. People were not being adequately protected from the risk of abuse.

The enforcement action we took:

We imposed urgent conditions on the registration which prevents new admissions to the service and requires the provider to submit regular reports to prove the safety of service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was not adequate management oversight to ensure the safe running of the service and to ensure that people were adequately protected from the risk of harm.

The enforcement action we took:

We imposed urgent conditions on the registration which prevents new admissions to the service and requires the provider to submit regular reports to prove the safety of service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People were not getting the one to one and two to one care and support they required and which had been agreed for them. Staffing levels were not being adequately assessed and the service was understaffed.

The enforcement action we took:

We imposed urgent conditions on the registration which prevents new admissions to the service and requires the provider to submit regular reports to prove the safety of service users.