Reminiscence Care Homes Limited

Somerset Villa

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 17 May 2017 and was unannounced.

The service provides care for up to 16 people, some of whom are living with dementia. At the time of our inspection 14 people were using the service.

We carried out this inspection after concerns were shared with us about the staffing and management of the service. This comprehensive inspection followed up our previous inspection on 10 May 2016. At that inspection we identified two breaches of regulation related to the staffing and management of the service. We rated the service Requires Improvement and the provider submitted an action plan setting out how they would address the shortfalls we identified..

At this inspection we checked to see if the actions had all been completed and found that they had not. We continue to have concerns about the operation of this service.

Since our last inspection a new provider had been identified to buy the business and at the time of our inspection this sale was going through and has since completed. This report relates to Reminiscence Care Limited, which remains the current registered provider.

A registered manager was in post and was also the owner of the business. This provider was intending to remain in post for a period of months following the purchase of the business. 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.

At this inspection we continued to have serious concerns regarding the safety of the service and the management of risk. We found poor practice with regard to the risks fire posed in particular. Fire exits could not be easily accessed and staff were not clear about fire procedures. Safety checks were routinely carried out as required, but risks were not assessed in detail and actions put in place to reduce them.

Medicines were not managed safely as stocktaking procedures were not accurate. This resulted in confusion and an inability to be certain that people had always received their medicines as prescribed. Some medicines were being routinely used to manage people's behaviour rather than employing techniques to distract and calm them.

Staffing levels had improved since our last inspection and were found to be generally satisfactory. Staff were very busy and this made their approach task focussed at times. Agency staff were frequently used which concerned relatives due to the lack of continuity. Recruitment procedures were not always sufficiently robust.

Most staff received training in safeguarding people from abuse and staff demonstrated a good understanding of action to take if they suspected abuse had taken place.

Staff received training but it was not up to date for all staff. Some key training which would have increased their skills and knowledge had not been provided. Staff did not receive appropriate induction, supervision and support.

The provider was not always operating in accordance with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA ensures that people's capacity to consent to their care and treatment is assessed. If people do not have capacity to consent for themselves the appropriate professionals, relatives or legal representatives should be involved to ensure that any decisions are taken in people's best interests according to a structured process. DoLS ensure that people are not unlawfully deprived of their liberty and where restrictions are required to protect people and keep them safe, this is done in line with legislation.

The provider had failed to ensure the required process was followed with regard to some important decisions about people's care and treatment. All people who used the service were effectively being deprived of their liberty due to a system of locked doors.

People were provided with enough to eat and drink and people's dietary preferences were taken into consideration. Ongoing monitoring of people's dietary needs could be more robust and people were not always referred to appropriate healthcare professionals for further advice.

People who used the service had their health needs met promptly in most cases but were not always being monitored effectively to ensure their health did not deteriorate.

Although staff were patient, kind and caring and people were treated with respect, the layout of the building, and some accepted practice, did not ensure everyone's dignity was maintained.

People were not enabled to be involved in decisions about their care and there was little commitment to providing information in accessible formats.

The service did not have a robust complaints procedure in operation and records of any formal or informal complaints were not present.

People's basic needs were met but they did not receive individualised care based on their particular needs and preferences. People were often lacking in stimulation and occupation. Although staff knew people well they did not demonstrate skills and expertise in managing people's distress and anxiety.

The provider had failed to bring about the required improvements identified at the last inspection. Many similar issues were identified at this inspection. The prospective sale of the business had had an impact on the quality of care as the provider did not delegate any responsibilities to others and failed to develop the staff to support her. This resulted in the provider being unable to ensure the quality and safety of the service despite their willingness to do so.

There were six breaches of regulation identified during this inspection. You can see what action we have told the provider to take at the back of the full version of this report.

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.

Risks were not well managed. Risk assessments were not detailed or always reviewed in the light of people's changing needs. Risks from fire were very poorly managed.

Medicines were not managed safely and people were at risk of not receiving their medicines as prescribed.

Staffing had recently been increased but staff struggled to spend time with people. Recruitment procedures were not robust.

Staff understood their responsibilities with regard to safeguarding people from abuse and most had received appropriate training.

Is the service effective?

Inadequate

The service was not effective.

Most staff had received training in MCA and DoLS but some practice was not in line with the legal requirements. All people who used the service were effectively deprived of their liberty due to a locked door policy.

Staff received a basic induction and training, although some relevant training had not been provided or refreshed. Staff did not have all the skills they needed to support people who were distressed.

People were positive about the food and they were offered choice.
On-going monitoring of people's dietary needs was not robust.

People were promptly supported to access healthcare professionals when they needed to. Some basic monitoring of people's health was not in place.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were caring, patient and kind. Although busy, staff tried to spend time with people where they could.

People's privacy and dignity was not always maintained due to the layout of the service and some accepted staff practice.

People, or their relatives, were always involved in making decisions about their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did not contain sufficient detail to help staff meet people's individual needs.

People were largely lacking stimulation and occupation. Sensory input and specialist care for those living with dementia was not demonstrated.

A robust complaints procedure was in not place and formal and informal concerns had not been recorded.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had not made the required improvements which had been identified at the previous inspection. Many concerns identified there remained an issue over a year later.

The prospective sale of the business had negatively impacted on the safety and quality of the business.

The provider had failed to maintain clear oversight of numerous issues which affected the safe delivery of care.

Somerset Villa

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 17 May 2017. The inspection was unannounced.

The inspection team consisted of two inspectors.

Before we inspected we reviewed the information we held about the service. This included any statutory notifications that had been sent to us. A notification is information about important events which the service is required to send us by law.

We spoke with two people who used the service, three relatives, one member of the domestic staff, one care staff, one senior care staff and an agency staff member. We also spoke with the registered manager who was also the owner of the business. We observed staff providing care and support and we used the Short Observational framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not communicate with us easily. All the people who used the service were living with dementia.

We reviewed five care plans, five medication records, three staff files, staffing rotas for the weeks leading up to the inspection and records relating to the quality and safety of the service and its equipment.

Inadequate

Is the service safe?

Our findings

People were not kept safe at all times at the service. We were particularly concerned about the management of the risk of fire. We saw that the front door, a fire exit, was locked with a key which a staff member kept with them. We found that the rear exit, through the conservatory, was similarly locked with no key present. This meant that neither door could be quickly opened in the event of an emergency. We questioned this and a staff member told us that all staff had keys. We asked the three staff who were in the hallway at the time if they had a key, all three told us that they did not. This meant that there could be a significant delay in evacuating the building in the event of a fire.

In addition to this concern we noted a stairgate across the bottom of the stairs which would mean people had to negotiate this when leaving the building. We asked why the stairgate was in place and a staff member told us that it had originally been put in place to stop the service's dog running up and down the stairs. However the provider told us that the stairgate was primarily to encourage people, whose mobility was poor, to use the lift instead of the stairs. We also saw that in the hallway, an occasional table and chairs presented a further obstacle for people to negotiate in an emergency.

Less than half the staff team had received fire training in the last year and those we spoke with were not able to tell us how they would act in the event of a fire. Staff told us they did not know how to use the evacuation chair on the upper floor and staff had received no training related to this. Some staff said they had not taken part in a fire drill and were not aware of the fire policy and procedure. Individual risk assessments were not in place to document what kind of help people would need to evacuate the building in the event of a fire. Agency staff told us that they had not received an induction and were not clear about their responsibilities in the event of an emergency such as a fire.

This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Although the local fire safety officer had visited the service in recent months and raised no concerns, we found significant failings at the time of our inspection. We asked the manager to ensure that sets of keys were immediately cut for all staff, including agency staff. We also asked for a key to be placed in the break glass which was already located by the back door. The provider confirmed that these actions had been put in place the following day.

In addition to this concern we found a mixed picture regarding the management of other risks to people's health and safety. We noted that some people who were at risk of developing pressure sores had pressure cushions and airflow mattresses provided. Repositioning charts were in place for people who were nursed in bed. However one person's two hourly repositioning checks were not always taking place and the risks of irregular recording had not been identified. Staff were unable to tell us about the correct setting for the mattresses which meant we could not be assured that people's risk of developing pressure sores was effectively reduced. One staff member told us that information about one person's correct pressure mattress setting was in their care plan but it was not.

People's risk of choking had not been proactively assessed. However, we saw that following one person's recent choking incident their care plan had been immediately reviewed, and now stated that they should be more closely monitored at meal times. Risks related to people's mobility and moving and handling needs had not been comprehensively assessed. People did not have their own slings and staff were unclear as to the size of the communal slings. Where people had lost weight we saw that this had not been considered in relation to their moving and handling needs.

People's risk of falling had been assessed but records did not give enough details about people's individual needs. For example, one person had had a number of falls, the latest resulting in an injury. They had also suffered a minor entrapment issue and had slipped from their chair. A referral had been made to the falls team but records did not show how staff had reviewed and managed their increased risk of falls in the interim.

This is a further breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks from the environment had been considered. Window restrictors were in place on upper floors to reduce the risk of people falling from height. Fire alarms, firefighting equipment and emergency lighting was regularly checked and maintained. Gas and electricity supplied were appropriately checked and the lift was regularly serviced and maintained. The service had systems in place designed to reduce the risk of legionella bacteria. Although these environmental risks were well managed we saw that others had not been given the same priority. For example, one member of staff had recently had an emergency at night and had needed to use the phone to call the manager down from their flat but the phone had not worked. They told us, "It sometimes runs out of battery". In this instance, this caused a delay in the injured person being able to leave for hospital as the ambulance crew needed some information from the manager.

The main communal areas of the service were carpeted and mostly appeared clean. However we noted a leak from the roof in the dining area and carpets were heavily stained. Two relatives commented, "The home needs revamping". Bathrooms were clean and a member of the domestic staff told us they had received infection control training, although records did not confirm this. They were clear about cleaning procedures at the service and were able to tell us about how to control the risk and spread of infection. However a number of bedrooms smelled strongly of urine and there was no structured programme of deep cleaning in place.

We noted a mixed picture with regard to medicines with some good and some poor practice. Medicines records were fully completed by staff and we found no gaps. Although each person's record had a photograph attached to it there was no other information about how they liked to take their medicines or what they were for. Protocols were in place for when people needed to take medicines on an occasional basis (PRN). We found that these were not always sufficiently detailed and did not give staff enough guidance. For example one person's protocol for when they required Lorazepam (which is often used to reduce anxiety) was mostly blank and only contained a maximum dosage in 24 hours.

We saw that one person who had been prescribed Lorazepam for occasional anxiety was being routinely given this three or four times a day. This did not follow the prescriber's instructions. The registered manager told us that some of these occasions had been because particular staff were not skilled at managing the person's behaviour. They said that they had spoken with the staff member but there were no records of this conversation and the amounts administered had not reduced significantly.

Stocktaking procedures were not effective which meant we could not be sure that people were receiving

their medicines as prescribed. Stocks were recorded in two different places which may had confused staff. A handwritten record of some medicines was kept, but stocks were not accurately carried over and the manager was not able to explain the many discrepancies. They told us, "We've over ordered or not sent back last month's unused [medicines]". We found multiple blister packs of several medicines in the medication cupboard including 151 Lorazepam tablets when, according to medication administration charts (MAR) there should have been a total of 134. This suggests that several tablets had been signed out as having been given when, in fact, they had not been. Most stocks of medication were not carried over at all on the MAR chart from one four week cycle to the next which made it impossible to establish if people received their medicines correctly. Staff told us they did not know about stocktaking measures.

We observed staff administering medicines and saw that they took time to ensure each person took their medicines and were very patient. We also noted however, that one person was prescribed a particular medicine which had to be given on an empty stomach. We saw that they were given this medicine after their breakfast which may have reduced its effectiveness.

Staff had received training in how to administer medicines safely and told us that the provider observed their practice occasionally, but no records of this were kept.

This is an additional breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People who used the service and relatives shared some concerns about the numbers of staff on duty and the continuity of staff in general, as there was a high use of external agency staff. This reliance on agency staff had arisen partly due to the forthcoming sale of the business. The provider explained that they had not been free to recruit permanent staff during the sale process. Although we saw that, as much as possible, the same agency staff were used, this was not always possible. One relative told us, "[There's] lots of coming and going".

Before the inspection we had received information that staffing at night was not appropriate to the needs of the people using the service. However we noted that staffing levels had recently been increased to two at night and three during the day. Previously there had been only one staff member on duty at night with the provider available if needed as they lived onsite. Although people who used the service and their relatives had some concerns about the high agency usage, both they and staff told us they felt there were now enough staff and had noted an improvement.

Throughout our inspection we observed that staff were very busy and had limited time to spend with people. Staff responded to people's needs well but did not always do so quickly. For example, one person required assistance with eating their breakfast but by the time the staff member was able to help them the food and drink had gone cold.

Staff employed at the service had been through a recruitment process before they started work. Permanent and agency staff had checks in place from the Disclosure and Barring Service to establish if they had any criminal record which would exclude them from working in this setting. References were taken up from previous employers, although we did not see that all were checked to ensure they were authentic. This lack of checking could place people at risk.

Most staff had received training in keeping people safe from abuse, although three had no record of this on the training record given to us. Staff were able to tell us what actions they would take if they suspected someone was at risk of harm although some were unclear about how to raise an issue with external

agencies such as the local authority or CQC. Information about this was available at the service but not easy for staff to locate. We noted that the service had co-operated with local authority investigations into recent safeguarding matters.

Inadequate

Is the service effective?

Our findings

Staff told us that they felt they received the training and support they required for them to carry out their roles. We saw that when staff began to work at the service they received a basic induction but we found that these had not been signed by the staff concerned. There was no evidence to confirm that staff undertook shadow shifts to learn from established staff but staff told us this was the usual practice. There was no record of any induction for agency staff.

At our previous inspection on 10 May 2016 we found that the provider had not ensured that staff received appropriate training, supervision and appraisal. This constituted a breach of regulation and we asked the service to provide us with an action plan documenting how they would make the required improvements. At this inspection we found that sufficient improvements had not been made, although some training had been arranged.

We saw from the service's training matrix that a variety of training was provided for staff which included safeguarding, food hygiene, Mental Capacity Act and Deprivation of Liberty Safeguards (MCA/DoLS) and caring for people with dementia. Some staff had gained nationally recognised qualifications in care and others were working towards this. However, some staff had not had recent training in key areas such as safeguarding, eating and drinking, fire safety and first aid. Seven people had no record of ever having had first aid training and four others received this training in 2011 which meant their practice was no longer current. Records for one staff member, who completed all their training as e learning as they were night staff, had been wiped from the system and we were unable to verify any of their training.

There was no routine system of supervision for staff. One staff member told us that they had been in post just less than a year but they had not had any formal supervision or a probationary review of their performance. Other staff told us that the provider was very supportive and confirmed that they had had some supervision but records did not confirm this. Staff told us that there was an annual appraisal in place but the process was not in depth. Staff meetings did not always take place. The most recently held meeting had not been well attended and there were no minutes.

This is a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Throughout the day we observed staff asking for people's consent before providing them with care and treatment. However, we found that the service was not always working in accordance with the requirements of the MCA and some information in care plans was confusing. People's capacity to consent to aspects of their care and treatment had been assessed but only by the provider and did not always include the person, their representative or advocate. The assessments were general and not specific to any decision about care and treatment.

One person's care plan contained information stating they wished to be resuscitated should their heart stop and to receive active treatment. The provider told us that there was, "Some doubt as to her mental capacity

to make decisions". This information was not recorded in their care plan. The provider had been unsuccessful in securing an MCA assessment by an independent advocate.

Another person had been found by the provider to lack capacity on admission to the service. The record was not dated and there were no further details about the person's capacity but they had signed other parts of their own care plan. The provider told us that the person's relative had Lasting Power of Attorney (LPA) but documentation was not present to confirm this. This was the case for other people where someone with LPA had been appointed. We only saw confirmation of this in records for one person.

This person also shared one of the four shared rooms at the service. No MCA process had taken place to establish the person's consent to this or any meeting to ensure sharing a room was in their best interests. Following a previous requirement from CQC in 2013 the provider had written to the person's next of kin to request retrospective permission for the person to share. As the provider was unable to show us documentation to prove that the next of kin had LPA, we were not clear that this permission was valid. Other people's relatives had been asked for their permission in a similar way which presented the same concerns. The registered manager told us that one person, who had no next of kin, preferred a shared room but this was not documented. The provider had not considered if people might have fluctuating capacity due to the nature of their illness. Given the compromises to a person's privacy and dignity sharing a room presents, we were concerned that proper processes had not been followed to establish their consent.

Applications for a DoLS had been appropriately made to the local authority for 11 of the 14 people living at the service. However, all people were deprived of their liberty due to the locked doors, for which only certain staff had the key. We observed that, partly due to the nature of the building, people were not free to walk around easily. Staff were heard to say to one person living with dementia and who liked to walk around almost constantly, "It's not really where you should be going" as they guided them back to the lounge.

This is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People who used the service appeared happy with the food and the choice available. One person commented negatively on the food but most seemed to enjoy it with one person saying, "It's nice, yes". The cook had only been in post a few days and was able to tell us who had diabetes and what their dietary requirements were. They also told us some people had a pureed diet although they were unaware of one person's specific dietary needs.

The rationale for giving one person a pureed diet was that they had previously choked on solid food. However there was no evidence in records that people's risk of aspiration (taking food into the lungs) had been fully assessed. The provider reacted quickly to incidents of choking by reviewing the person's care plan and putting them on a soft or pureed diet. However, appropriate referrals had not been made to a dietician or Speech and Language Therapist (SALT), who specialise in advice on swallowing difficulties.

Lunch was provided in a timely way and staff supported people to eat. Some people had aids such as special mats and plate guards to help them retain their independence at meal times. People were offered a choice of meals and alternatives if they did not want either of these.

Where people were identified as being at risk of not eating or drinking enough we saw that their weights were regularly monitored. High calorie milk shakes and snacks were promptly introduced to people's diets in response to unplanned weight loss. We saw that one person who was constantly walking about the

service had been supported to maintain their weight in spite of this increased level of activity.

We also saw less effective practice with regard to people's diets. One person's most recent care plan review indicated that they had continued to lose weight despite eating well. We observed this person and saw that they only ate when staff were present. We saw no attempt by staff to remain with the person and try and encourage them with different food options or finger foods.

We found the promotion of fluids overall to be satisfactory. Staff ensured people had access to hot and cold drinks and people who were nursed in bed also had adequate drinks. One person was allergic to one kind of squash and we noted that they had a different kind in their room. Care plans identified that some people were at risk of not eating or drinking enough, however their intake was not recorded on a food or fluid chart. This meant that we could not be assured that staff had an accurate picture of people's food and fluid intake.

One person, whose care plan stated that they needed staff supervision due to a risk of choking, was seen to eat their meal without this supervision. Staff were nearby and may have been alerted to any choking incident but we could not be assured of this. We also noted this person being given a large mug of tea. They could not manage to hold this as it was too heavy and tipped the majority of it down themselves. Staff did not respond to this but clearly this was the person's usual habit as they had put a plastic apron and two towels over them. Later in the day we saw the person being given a drink of squash which they drank quickly, appearing to be quite thirsty. This led us to question whether this person had been given enough to drink.

Staff were knowledgeable about people's care needs and current health conditions. Records showed that people had access to different healthcare services including GPs, district nurses, falls team, continence service and chiropodists. However, there was very limited referral to dieticians and SALTs. The provider told us they had made a referral to these services but they were very difficult to access. They did not provide us with records to confirm this.

This is a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff kept a record of when people had their bowels open. The bowel charts we viewed contained significant gaps. One person's chart had no record for periods of eight, nine and 13 days during the first part of the year. Another person had no record for 15 days. No specific action had been taken in response to this issue and we could not establish if this was a failure to make an accurate record or if staff were failing to monitor people effectively.

Requires Improvement

Is the service caring?

Our findings

People who use the service, and their relatives, were mostly very happy with the way staff provided care and support. One relative said, "Staff are kind and support people in a positive way. Some [people who used the service] can be quite difficult buy they [staff] cope really well". Another relative said, "[My relative] has settled well and I have confidence in the staff. They aren't judgemental". Relatives told us they were welcome to visit anytime and staff always had time to chat with them about their relative.

We observed kind and caring interactions throughout the day and staff demonstrated patience and treated people with respect. We saw staff, including some of the regular agency staff, treating people with kindness and sharing a joke with them which we saw was greatly welcomed.

We saw some examples of where people's independence was not promoted. One person was observed trying to help out by tidying up people's used cups and moving chairs back to the table. Staff told them to leave this to them which denied the person a chance to fulfil a useful role. There were very limited other activities at the time.

We also observed both good and poor practice with regard to people eating independently. Some people, who were eating well independently, were actively supported by staff which then denied them their independence. Others we saw had their independence promoted by the provision of suitable equipment and staff were aware this was important for their self-esteem.

Information in care plans was not always detailed and contained limited information about how the person had been involved in decisions about their care and treatment. Meetings for the people who used the service and their relatives did not take place. However the relatives we spoke with told us they were consulted about their relative's care and any changes in their needs but this was not formally recorded. We found an over reliance on consulting people's next of kin, even when they did not have an authorised LPA, rather than consulting the people themselves. Advocates for those without family were not used as the provider had had trouble accessing them.

The current plans to sell the business had not been shared with either the people who used the service or relatives in any structured way. The provider told us they had spoken with relatives as and when they saw them but there were no meetings and no records of any conversations. People who used the service did not appear to be aware of any prospective changes and the provider said, "I've spoken to them all but there's only one who remembers". There was no commitment to providing people with relevant information in a way they could understand.

Staff spoke respectfully to people throughout our inspection and care plans were written in a respectful way. We did note, however, that sometimes people were described as 'aggressive'. This is not a respectful or professional description of a person's distressed behaviour.

We observed staff upholding people's dignity. For example one person was assisted to their room so cream

could be applied to their legs. Whilst staff at the service maintained people's dignity in their day to day interactions with them we were concerned about the layout of the shared rooms we saw. One was partitioned by a curtain and the other by a small partition panel. In both cases people were not able to have a private space. In the curtained room the door was on one person's side of the curtain which meant that the other person always had to walk through the other persons space. We saw that in one shared room a full commode was by the bed. We asked staff how they would safeguard the dignity of the first person if they were on the commode and the second person, who could access the room independently, came into the bedroom. They told us that the person did not really use the commode in the daytime. This was not a satisfactory answer and the provider had not fully assessed the important issues which need to be considered when people share rooms.

We also found the way that one person had been provided with a plastic apron and two towels for when they ate and drank did not promote their dignity. These were left in situ after they had finished eating and their hands became stuck to the plastic and caused them some distress as we observed them trying to take the apron off for over 15 minutes. The apron and towels were not removed after they had finished their breakfast and were still in place at lunchtime.

Requires Improvement

Is the service responsive?

Our findings

The provider told us that people were given a copy of the complaints procedure with their contract when they first started using the service. Information about complaints was not routinely reissued. There was no record of any formal or informal complaints. We asked the provider how they managed informal issues and they told us this depended on people's capacity. The impact of this was not clear as there were no records. There was a risk that those people thought not to have capacity would not be effectively supported to have complaints investigated. Meetings for people who used the service were not held and therefore did not provide people with a forum in which to raise a complaint.

This is a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We saw that people's care and support needs were assessed before they moved into the service to ensure the service could meet their needs. A care plan was drawn up by the manager once they moved in. Care plans were handwritten, occasionally hard to read and staff had limited input into them. Information about people's past lives and preferences varied. Some plans had good information about people's histories and in others information was brief and basic. In spite of this staff demonstrated an awareness of people's individual needs and their preferences related to their care.

Care plans were reviewed each month and reflected people's basic care needs well. Recent changes in people's needs were documented for most people, but not all. For example, one person had sustained a fractured risk as a result of a fall. No account of this had been taken when reviewing this person's care plan. An injury such as this could undermine a person's confidence and reduce their independence but this had not been considered. Care was not always delivered in accordance with people's preferences. For example, staff told us that most people liked to have a shower and this was offered weekly rather than according to people's needs or preference.

Care was often task focussed with little consultation about how people wished to receive their care. People were not asked if they were happy to receive their care, especially personal care, from a staff member of the opposite gender. We noted from rotas that there were occasions when three male staff were on duty together even though most people who used the service were female.

We saw poor practice with regard to managing people's anxiety and distress. Care plans were not specific and did not give staff sufficient guidance. Plans advocated 'offering choice' and 'trying a gentle approach' but gave very little insight into potential triggers for a person's behaviour and suggested no strategies to distract and calm them. We observed a person walking about the service and being constantly redirected to sit down in the lounge. There was no sensory stimulation and no one to one interaction for anybody. Staff told us that they tried to spend time with people doing some kind of activities but this didn't always happen. They said there were very few structured activities.

People were observed throughout the morning to be largely unengaged with little to occupy or stimulate

them except the television. We did not see much evidence of activities from people's daily notes. We observed many people sitting in the same chair all morning from breakfast to lunch with nothing to do and, for some, minimal engagement.

One person, whose preference was to be left alone, had their wished respected and sat in another part of the service. One staff member explained how staff try to provide activities for people saying, "We take them out occasionally, one person went to church on Sunday and we have music a couple of times a week". In the afternoon of our inspection two singers visited and people who used the service, relatives and staff had a really enjoyable time. Everyone joined in the singing and staff danced with some people which they responded to very positively.

Inadequate

Is the service well-led?

Our findings

At our last inspection on 10 May 2016 we found that effective audit systems were not in place to assess and monitor the quality and safety of the service. We also found records to be incomplete. We judged that this was a breach of the regulation concerning good governance. We issued a requirement notice and the provider submitted an action plan setting out how they would make the necessary improvements. Although we found some minor improvements at this inspection concerns remained broadly the same.

At the start of our inspection we noted that the provider had failed to display the rating from the previous inspection. This is a legal requirement. We asked the provider about this and they were not aware of this requirement.

This is a breach of regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People who used the service and staff were not involved in developing the service and their views not sought. Surveys had not been sent out to any stakeholder in recent years and the prospective sale of the business had not been discussed formally with any group. Staff told us they found the manager accessible but were aware, partly due to the sale of the business, that they were under a lot of pressure.

Staff were unsettled due to the uncertain future of the business and current confusion over who was going to be the manager over the next few months. The provider had failed to appreciate this and take action. Meetings for staff were not regular and staff were not supported with appropriate supervision sessions. One staff member said, "There have been some arguments between staff". We saw evidence of disagreements between staff which had the potential to cause an uneasy atmosphere and impact on the quality of the care provided.

We saw that the provider had managed one recent incident of poor staff performance through the service's disciplinary process. The matter concerned a serious incident which placed people who used the service at risk. The provider had issued a verbal warning and set out their expectations with regard to staff's future behaviour. However, records of the meeting were not signed by the staff member concerned. A follow up meeting had been arranged to monitor how things were going. We noted that the second meeting had not taken place and no further follow up was scheduled.

This lack of oversight was repeated in other areas of the service. The provider did not delegate responsibilities to other staff members and this ensured that they had too much to do. Staff told us that they would refer most things to the manager rather than work autonomously. We saw evidence of this numerous times during our inspection. The result of this was that some important monitoring and auditing tasks did not happen or were not effective.

We reviewed accident and incident records and found a number of reported falls, some resulting in injury. Although falls were recorded there was no evidence of each incident being reviewed to see if any lessons

could be learned and actions put in place, such as the provision of bedrails, to reduce any future risk of falls.

The provider's strategy of holding all the responsibility themselves was partly due to the fact that they had no supporting management team in place. They had recently advertised for a deputy manager and when unable to secure a suitable candidate they had promoted someone from within the service. This proved to be an unsuccessful appointment. In addition both senior staff were new to their roles, having never worked at this level before. The provider had failed to provide them with the leadership and mentorship they needed to work effectively.

The provider did not demonstrate an awareness of current guidance and best practice. In many areas of the service we found them failing to effectively address the issues, in spite of their best efforts and willingness to do so. Supervision of staff, training, record keeping, maintenance of the environment, management of medication, monitoring of people's health conditions, communication and monitoring of the safety and quality of the care provided were all in need of significant improvement. Many of these areas had been similarly in need of improvement at the last inspection over a year ago. People who used the service were not receiving a high quality service as a result of this, and may not have been receiving one in the intervening period. This is not acceptable.

This is a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure care and treatment was provided with the consent of the relevant person and in accordance with the provisions of the Mental Capacity Act 2005. Regulation 11 (1) (3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to provide safe care and treatment as they had not assessed and mitigated risks to people's health and safety. The provider had also failed to ensure the proper and safe management of medicines. Regulation 12 (1) (2) (a), (b) and (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider failed to ensure the nutritional and hydration needs of the people who used the service were met. Regulation 14 (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 16 HSCA RA Regulations 2014

personal care	Receiving and acting on complaints The provider failed to operate an effective and accessible complaints procedure. Regulation 16 (2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to maintain effective systems to assess, monitor and improve the quality and safety of the service or to assess, monitor and mitigate risks to the health, safety and welfare of the people who used the service. Regulation 17 (2) (a) and (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider failed to display the most recent rating of the service provider's overall performance. Regulation 20 A (5) (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure staff received appropriate support, training and supervision to enable them to carry out their role. Regulation 18 (2) (a).