Buckland Care Limited

Willow Bank House Residential Home

Inspection report

Willow Bank House
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

At the last comprehensive inspection on 14 July 2016 the service was rated as 'Good' overall. We returned on 9 June 2017 and completed a focussed inspection because we had received some concerns that risks to people were not always managed to keep them safe, and staffing levels may not be sufficient to meet people's needs. We only looked at Safe and Well led and found they continued to be rated Good in these areas.

This inspection visit was a responsive fully comprehensive inspection because we had received information of concern, specifically related to allegations of poor care and mistreatment. We looked at these concerns as part of this inspection and found evidence that supported what we had been told.

This inspection started on 8 March 2018 and was an unannounced visit. We returned announced on 15 March 2018 so we could speak with more staff, more people, to speak with the provider and to look at the provider's quality assurance systems.

Because of our concerns, following this inspection, we formally wrote to the provider asking them to tell us how they would address our immediate concerns. The provider sent us their response and action plan and we agreed to complete a third inspection visit to assure ourselves, improvements to the service had taken place. We returned unannounced on 4 April 2018. Some improvements had been made however they required more robust monitoring to ensure the improvements were embedded in staff practice. We continued to find evidence of poor practice despite the provider's action plan and improved control measures.

Willow Bank House is a residential care home registered to provide care to 63 people, including older people and people living with dementia. People in care homes receive accommodation and nursing and/or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. At the time of our inspection visit, 56 people lived at the home. Care was provided across two floors with a small unit on each floor. One unit supported five people living with advanced dementia and was called Angel Beck. The other unit was a female only unit for five people called Raybold.

A requirement of the service's registration is that they have a registered manager. 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 and the associated Regulations about how the service is run. At the time of our inspection visit there was a registered manager in post, but they were on a temporary leave of absence. At the time of our inspection visits, an interim deputy manager was managing the service.

People were not safe. Although some people and relatives said they felt the service was safe, we found risks to people were not managed well and were not always known or clearly understood by staff. Risks to people were not consistently assessed and therefore people were not kept safe from the risk of harm. Recording of risks was not always evident, and in some cases the records had not been reviewed when needed to reflect changes in people's care and support needs. People were not kept safe from risks associated with some aspects of the environment and staff's lack of attention placed people at unnecessary risk.

The provider had not always ensured staff had the training or knowledge they needed to undertake their roles safely and appropriately. Staff attended training, but there were significant gaps in staffs knowledge about current good practice. Some staff did not feel supported, especially when reporting poor practice. The staff team consistently included agency staff. The mix of agency staff and staff who lacked experience and knowledge of people's needs meant staffing was not effective in responding to people's needs. Staff deployment did not support people's identified needs so put people at risk.

People were not supported in a consistently caring way. Staff did not always support people in a dignified way and people's rights to privacy were not always respected by the staff.

Staff told us people made their own decisions, but this did not match what we saw or what people and relatives told us. People spent time in different communal rooms according to staff decisions, not according to people's choice which had a detrimental impact on their wellbeing. Records did not explain how best interests decisions were made, or who made them, on behalf of people who lacked capacity.

People who were at risk of poor nutrition did not receive the support and encouragement they needed to eat and drink enough. Staff did not record people's food and fluid intake accurately, which meant they were unable to identify increasing risks to people's nutrition. The provider had failed to adequately explore ways of making the home more dementia friendly. People had access to health professionals when their health needs changed, but the provider's systems and records did not demonstrate that people's healthcare needs were being met and professional's advice was followed.

People had limited opportunities to follow their interests and hobbies. Some people enjoyed their own company or some group activities, but for others who wanted to be involved in activities that interested them, there were minimal opportunities. People wanted staff to spend time with them, but this was not achievable because staff were too busy supporting people with task based care. People did not always receive care that was responsive to their individual needs and their care was not person centred because choices were not always supported.

Systems used to monitor the quality of the home were not effective at identifying concerns and protecting people from risks to their health, safety and well-being. The governance system at the time of our inspection was not robust and in most areas it was ineffective. Between the first and last day of our inspection visit, there had been very little improvement in the quality of the service in response to our concerns. The provider had not taken the actions to mitigate risks, as described in their own action plan.

The registered manager had not submitted statutory notifications to us in accordance with their legal

responsibility to do so.

There were seven breaches of the regulations and the overall rating for this service is 'Inadequate' and the service is therefore in 'Special Measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care, should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People's individual risks had not been adequately assessed and managed to reduce the risk of avoidable harm. There were insufficient experienced and trained staff to keep people safe, which meant people did not always receive the care and support they needed. People were not always protected from the risk of harm or abuse, because staff told us they had seen people mistreated, but had failed to report it to the provider, us or other agencies. Medicines were not managed safely. The system to monitor how medicines were managed did not provide assurance that people received their medicines as prescribed.

Is the service effective?

Inadequate

The service was not effective.

Systems were not effective to monitor and ensure staff completed and understood the required training to meet people's needs. Where there was conflicting information about people's capacity to make specific decisions, mental capacity assessments had not always been considered or completed and best interest decision meetings were not recorded. There were no checks in place to ensure people who made decisions on another person's behalf, had legal authority to do so. People were supported to maintain their health and referred to external healthcare professionals when a need was identified, but some people identified as at risk, had not always received support in line with specialist advice. Food and fluid monitoring for people identified at risk of not eating or drinking enough was not effective.

Is the service caring?

Inadequate

The service was not caring.

People's wishes were not always followed. Staff practice meant people were not cared for with kindness. People were not supported to live their lives in a way that respected their wishes. People's privacy was not always considered, reviewed and

maintained and people did not always receive dignified care.

Is the service responsive?

Requires Improvement 

The service was not consistently responsive.

Staff understood people's personal preferences and how they wanted to spend their time, but there was minimal physical and mental stimulation for people, which did not always meet their needs. Care plans and associated risks did not adequately describe actions for staff to respond appropriately to people's needs. People's care needs and preferences were not always considered, known by staff or responded to, to ensure good outcomes for people's health or wellbeing.

Is the service well-led?

Inadequate 

The service was not well-led.

People were not protected by effective quality assurance systems. The systems in place and the culture at the home did not provide staff with the tools or leadership to do their job effectively and to protect people from risk of harm. There was no culture of learning or developing within the leadership and management of the service. People and relatives who raised concerns to the management had no confidence actions led to improvements. People's views were not sought effectively and feedback had not been used to make improvements in the quality of service provided.

Willow Bank House Residential Home

Detailed findings

Background to this inspection

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

The inspection was prompted because we received concerning information. The information shared with CQC suggested people had been subjected to physical and emotional harm, people were not given sufficient fluids and food and staff were not always trained and did not know how to safely support people. We also received information suggesting the management was ineffective in protecting people from risk and that the overall management and governance within the home was not transparent and effective in responding to address people's or staff's concerns. We looked at some of these concerns during this inspection.

We knew that the police were investigating some of these allegations at the time of our inspection. Following this inspection, we continued to work with other agencies such as the local authority, safeguarding and the police. This was to assure ourselves the provider was aware of the known risks and that action was taken to mitigate risk to people and staff at the home.

We found the provider was in breach of the Health and Social Care Act 2008 (Regulated activities) and Health and Social Care Act 2009 (Registration).

This inspection visit took place on 8 March 2018 and was unannounced. The inspection team consisted of two inspectors, a CQC pharmacist, a specialist nurse and an expert by experience. An expert by experience is someone who has experience of this type of service. Two inspectors, a CQC pharmacist and a specialist

nurse returned on 15 March 2018, to speak with the general manager, the directors of the provider's company review their quality assurance systems and continue speaking with more staff, people and relatives.

In view of our findings from the first 2 days of our inspection, we asked the provider to tell us what they would do immediaitely to ensure people were safe and cared for. In response, the provider sent an action plan and we returned unannounced on 4 April 2018 to check what they had done. Not all risks and actions had been implemented to keep people safe and some people were not supported in line with their expressed wishes.

To help us understand people's experiences of the service, we spent time during the inspection visits observing and talking with people in the communal areas of the home, or their bedrooms with their permission. This was to see how people spent their time, how staff involved them in how they spent their time, how staff provided their care and what they personally thought about the service they received.

We spoke with five people who lived at Willow Bank and six visiting relatives. We spoke with two directors, a general manager, an area manager, a support manager, an interim deputy manager, an administrator, eight care staff and four ancillary staff who worked as housekeepers, and a cook. We also spoke with four visiting healthcare professionals and a representative from the local authority.

We looked at eight people's care records and other records relevant to their support, such as medicines records and daily records. We looked at quality assurance checks, audits, people and relative meeting minutes, compliments, complaint records, training records, medicines, nutritional charts and incident and accident records. This was to see whether the care people received was recorded and delivered according to people's identified needs and care plans.

Inadequate

Our findings

At our last inspection in June 2016 we rated the provider as 'Good' under the key question 'Is the service safe?" At this inspection we found the provider's systems and processes failed to ensure people received a safe service. Therefore the rating has changed to Inadequate.

Before this inspection visit, we received a number of concerns that suggested people were at risk of harm. The information shared with us included details of people being exposed to physical harm, neglectful care, insufficient staff to meet people's physical and emotional needs, and staff not knowing how to move and transfer people safely.

Our observations and conversations with people, relatives and staff demonstrated people had not been kept safe and protected at Willow Bank House. From speaking with staff, they all knew what constituted abuse and what their responsibilities were to report any concerns. One staff member told us, "You have to record everything…even the slightest thing has to be recorded." An agency staff member was not aware of the provider's whistleblowing policy, but said if they witnessed anything of concern they would, "Talk to the care home manager and if the problem was not sorted out, I would go to a higher organisation." We were confident staff knew what to do and what to report, but some staff had failed to take responsibility when they saw or believed people were being mistreated.

A number of staff told us they had witnessed or were aware of abusive behaviour that placed people at risk of harm. The provider's whistleblowing policy recognised staff may not feel confident reporting concerns to a manager so advised staff to raise concerns to a senior manager or registered person. Staff had failed to do this. The policy also said staff could raise their concerns with outside organisations such as CQC and the local safeguarding authority, but staff had not had the confidence to do this. This meant people had not been referred to the local safeguarding authority and these incidents had not been investigated.

We asked staff why they had not raised their concerns. They told us they had no faith in the provider's whistleblowing procedures or confidence that the management team would take action to safeguard people. Staff comments included: "People knew but nobody wants to lose their job…I can't afford to lose my job. Staff knew about the abuse but they were scared stiff and they knew nothing would be done." When staff voluntarily shared their concerns with us, we asked how long this had gone on for. One staff member said, "A long time...over a year." All staff we spoke with said they had been afraid to report their concerns, but told us now the provider had taken action, they felt people were not at risk of further physical abuse. Following our first inspection visit, we shared information with the relevant agencies involved in

safeguarding vulnerable people. The local authority had written to families asking for them to contact them if they had any concerns about the care their family member received. When we returned on 4 April 2018, we found the provider was still failing to meet their safeguarding responsibilities. Two further safeguarding incidents on or around 26 March 2018 that involved people being abusive to each other had not been referred to us or other agencies by the interim management. Records of who was involved were incomplete so it made it difficult to see if people had been harmed and it meant the authorities did not have sufficient information to keep those involved, protected. Therefore we had no confidence in the management's understanding of how to keep people safe.

Some staff's knowledge of the impact of dementia, how it affected people's behaviours and how they should support them, was extremely poor. One team leader described people who lived with dementia as being like 'kids', which they found to be funny. Records viewed by us and the local authority described service users as being chastised for their 'poor behaviour' and 'sent to their rooms'. One record completed by the registered manager on 2 February 2018 said, '[Person] spoken to firmly by home manager in authoritarian manner and told she would have to spend the rest of the evening in her room if she persists.' Another record completed 30 November 2017 by a staff member read, 'I explained to him if he was not going to allow the other residents to watch TV in peace, he would not have that privilege either and I turned the TV off.' These records clearly recorded a practice and culture that showed care and treatment was not provided in a way that protected people from being degraded, and that their support became controlled and failed to meet their needs.

The provider had not taken effective action to prevent people from being exposed to physical and emotional abuse. This was a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding people from abuse and improper treatment.

People and relatives gave us mixed feedback about whether there was enough staff to meet their physical, emotional and social needs. One relative said their relation had the support they needed, but one person said, "I have been upset as I am lonely and no-one has time to come and sit and chat." Other people and relatives said staff were busy and did not always have time to sit, chat and pass the time of day.

Some people we spoke with told us they did not always feel safe at Willow Bank House. During our first inspection visit we were talking with one person in their bedroom. A staff member came in, and asked the person how they were and brought them a cup of tea. When the staff member left, the person began to cry and told us, "There is 'nothing nice about this place' and 'they just come in and put the drink down." This person also told us, "That was the first time this staff member had knocked on my door and spoken to me and asked how I was."

Another person shared a recent experience they had which gave them cause to be unsettled. They said, "I have been slightly upset, the other night I was just nodding off to sleep and I had an intruder in my bedroom, another resident. I pressed my alarm and carers came in a matter of seconds, they removed the intruder but it did upset my night's sleep." A relative shared an example with us that their relative had experience of people coming into their room uninvited on a number of occasions. This had caused them increased anxiety and distress.

We found there were not enough experienced and trained staff on shift who knew people well, and who supported people in line with their preferred wishes and needs. We found shifts were not effectively managed, so staff working across certain floors and units, were not always where they needed to be. We saw periods when there were no staff available in the lounge on the first floor even though there were women living there who could demonstrate anxiety around men. During the afternoon of the first day of our

inspection, there were four men in the lounge, and no visible staff presence to make sure people remained safe.

'Angel Beck' was a secure unit on the ground floor for five people with advanced dementia care needs. However, other people were taken to the unit during the day, which staff told us could result in 12 or 13 people being in a small confined area. On the first day of our visit we saw some people on the unit placed furniture on top of the medicines trolley, putting people at risk of injury. Staff were not visible in the room to prevent this from happening.

Staff particularly spoke of the demands of caring for people on Angel Beck, "It can be mind tiring and draining because you have to be watching them all the time. It is in the afternoon they get more agitated, but when there are two of you it is fine in there." One staff member told us it was very hard to support people on Angel Beck because it was a 'tiny room' with sometimes 13 people in it. This staff member said they 'took' people down there when they demonstrated behaviours that could cause concern to the person or others. They told us how these behaviours could have a detrimental effect on the others on the unit. "They are banging on the door, shouting and screaming. It is too hard to handle with two carers, 12 people would be your limit because you do need to have eyes everywhere, because you can't switch off for a second." Staffing levels on Angel Beck were two care staff. However, staff said at times, this was not sufficient or maintained. One staff member told us several people always needed two staff to support them to use the bathroom, which meant there was frequently no staff in the room. We saw occasions on our first day where there was only one staff member. After our first two visits in March 2018, the provider told us they had increased staffing levels to two staff on this unit and limited the amount of people sent to this unit. When we visited on 4 April 2018, there were two staff on the unit at all times and staff said it worked better and the atmosphere was more relaxed. However, a care staff member at night continued to take a person to this unit.

There were not enough staff to support people who displayed behaviours that challenged others, but staffing levels did not enable them to support people effectively. On the ground floor we saw people asleep in other people's rooms. Staff said this happened a lot and were unable to stop this. We saw one person asleep in another person's bed and asked a staff member if the person whose room it was would become anxious if they saw this. They agreed it could cause the person to become agitated and upset and said, "But what can you do…this person likes going in that room because it is sunny." Staff told us they did not always work with the identified staffing numbers which meant they could not always provide the care people required. When we asked staff how this impacted on people, one staff member responded, "That is mostly why they are agitated. If you are wet and cold (because staff don't have time to provide personal care), well I wouldn't want to sleep like that."

People and staff told us that emergency call bells were not always responded to in a timely way. One relative told us they had found a person bleeding, with a cut to their arm, but when they rang the emergency call bell, it took 10 minutes for staff to respond. Domestic staff told us they regularly responded to emergency bells, to check people were not at immediate risk because care staff were busy with other people and unable to respond. One staff member told us, "I can't do anything, but I can be with them. The emergency bell can go on for five minutes. Me and [name of other staff member] have to go in quite a lot and wait for staff to come up."

The provider did not use the equipment available to minimise risks to people's safety or to learn from incidents. The layout of the home meant people were often out of view of staff so they could not always monitor where people were. Corridors and bedrooms were not visible from the main communal areas. CCTV was installed in the communal areas, but the provider told us this was to establish if any incidents

happened, the reasons why. This was used retrospectively rather than for continual monitoring. Some staff told us they knew when incidents had occurred, CCTV footage was not always available. One staff member told us about one person who had a bad fall and sustained bruising. They said the person's relative asked to see the camera footage, but was told it was not available.

The directors and the deputy manager said they used a dependency tool to assess 'safe' staffing levels, but this was last dated October 2017. People had moved into the home after October 2017 but there was no documentary evidence those people's needs had been evaluated to inform current staff rotas. The deputy manager said they looked at 'staff experience' to determine staffing levels. However during our second visit, only 50% of the staff on duty were permanent staff and the rest were agency staff. Our conversations with all staff about people's needs and health conditions, confirmed that staff did not always have the knowledge and experience to provide safe care. One healthcare professional told us, "There are times they manage it well (staff numbers) but given the geography of the home, I think that does sometimes make it difficult."

Following our inspection visit the provider sent us an updated dependency tool based on people's current dependencies, within each area of the home. We returned on the 4 April 2018 and whilst there were enough staff on duty to provide safe care during the day, there were only five staff in the home on duty at night to support 56 people. Some staff told us there had been occasions this reduced to three staff, mainly through unplanned absences. Records showed when one person woke up and was unsettled, staff 'put them in Angel Beck' to prevent them walking around the main areas of the home. A senior staff member told us this should not have been done, but agreed that it was more to help staff, rather than meet that person's needs at that time. The provider's own records of falls within the home also indicated that staffing levels or their deployment at night were not effective to help keep people safe. For example, three falls occurred on 16 January 2018 between 23.30 and 06.06am and four occurred on 20 January 2018 between 02.55am and 06.40am. Overall in January 2018, 24 out of the 33 falls in the home occurred between 10.00pm and 7.00am. There was no evidence of any analysis or investigation to identify any potential causes such as inadequate staffing levels at these times.

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

Risk management was ineffective. Information was put into the electronic care system about people's needs and abilities, which produced a risk scoring for areas such as leaving the building and pressure breakdown of skin. Staff told us they knew about risks to people's health and wellbeing by looking at their care plans. For people at risk of skin damage, staff knew they needed regular turning and for people at risk of falling from bed, staff knew how to reduce risk, such as using a crash mat. However, we found staff did not use sensor equipment properly which could increase potential injuries. Repositioning charts were not always completed, which meant there was a risk that people were not being supported to change position to promote skin integrity. Staff did not always demonstrate sound risk management in their everyday practice. For example people were wearing shoes that were worn or damaged and were wearing other people's footwear that was too big. Staff had not supported them to change into their own or well-fitting shoes. A senior member of staff confirmed this placed people at a higher risk of falling. Relatives raised concerns that clothing and laundry continually went missing. One relative said they worried because, "[Person] was wearing someone else's shoes the other day and we informed a carer who agreed that the shoes were not theirs and they need to come off immediately as they were also too big and [person] might fall." They said, "They were replaced with her own shoes although the other shoes are still in her room on the wardrobe". Staff failed to recognise and take action to mitigate risks.

One staff member said they were told to transfer a person even though they had not been trained. Another

staff member told us how they used equipment to reduce a persons' risk of injury through falls from bed, however they used this equipment incorrectly which had potential to cause the person further injury. In fact, throughout our visits, we were shown photographs of unexplained bruising for this person. The potential falling onto this equipment may have been the cause, however the provider had not completed any analysis or knew that staff maybe using equipment in a way it was not designed.

The provider's risk management for analysing falls was not sufficient. Records did not clearly demonstrate whether individual risks had been assessed following a fall and what further action had been taken to minimise the risks to people. There was no analysis of when or where falls had occurred to identify any trends or patterns. We had concerns that some falls were not being recorded. For example, one person's 'fall vs fluid intake analysis', showed falls occurred on 22 December 2017, 2 January 2018, 23 January 2018, 27 January 2018, 29 January 2018 and 14 March 2018. However, the record of falls stated their last fall was on 6 December 2017. Their falls support plan, which was reviewed on 27 February 2018 stated, 'There is no history of falls at this time and the risk is low'. Falls records, analysis and care reviews, demonstrated falls risks were not recognised, analysed or managed appropriately.

On 4 April 2018 we checked whether the incident and accident records involving falls had improved since our visits in March 2018. We knew of one person who had sustained falls in March and April 2018, resulting in a hospital admission. There were no incidents or accidents recorded for this person and no documentation was made available to show how the falls had been managed. The area manager told us improvements were being made to their care system that would identify potential patterns in accidents and incidents. However, on the last day of our inspection visit, we found there were still gaps in records of falls. The provider's analysis will only be effective, if all incidents, accidents and falls are reported to them for analysis.

Risks around specific behaviours due to people's dementia care needs were not managed effectively, because risk management plans did not contain information about the actions staff needed to take to promote and maintain people's mental wellbeing. We were told of one person who had previously displayed disinhibited behaviours, sometimes towards females. Their relative was confident this person was safe, because they believed there was a plan in place to manage the person's interaction with females who lived in the home. However, this person was able to freely go and sit in the Raybould Unit, which we were told was for vulnerable females. On the first day of our inspection visit, there were long periods of time when the person sat in the lounge on that unit with female residents and there were no staff present. One staff member confirmed, "[Name of person], walks round by themself." Records of the person's pre-assessment, before they moved into the home, were brief and did not contain any information about their disinhibited behaviour, which could put them and other vulnerable people at risk. Staff's knowledge of this person was inconsistent which meant risks to this person and others, were not effectively known and managed.

We looked at the behaviour support plan for one person who could become very agitated around personal care. Their care plan stated that two staff should provide personal care, one to assist and the other to distract the person. There was no information about the most effective way of distracting this person based on their individual needs and motivations. This person could also demonstrate 'tactile behaviour' that could put them in dangerous situations. The behaviour management plan was, "I live in the Angel Beck suite and have 24 hour supervision." There was no other information about how the person should be supported to keep the person, staff and other people safe.

Medicines were not managed safely, which meant there was a risk that people did not receive their medicines as prescribed. We looked the medicine administration records (MAR) for 10 people, spoke with staff and observed how medicines were given to people. The provider used an electronic system to record the receipt, administration and disposal of medicines. The system was not able to fully demonstrate that

people were getting their medicines as prescribed by their doctor, because staff frequently changed the quantities recorded in the electronic system so they matched the quantity actually available, without first investigating why the discrepancies had occurred.

Differences in the medicine quantities could indicate that medicines were not being administered correctly. We found out of the 10 people audited, four of them had not received some of their medicines, because the medicine was not available to be given. For example, one person who had been prescribed a long term antibiotic had not received their prescribed dose for 31 days because there was none in stock. Another person had been prescribed three medicines to treat Parkinson's disease. They had not received two of them for three days because they were not available. It is important that people prescribed medicines to treat Parkinson's have them at the time specified by the prescriber to control their symptoms, such as tremors. Staff did not always follow the prescriber's specific instructions. For example one of the medicines was to be administered at 9pm; however the record showed this medicine was administered between 30 minutes and two and a half hours later than the time specified. It was reported that this person had sustained a number of falls; the poor timing of the administration of these medicines could have contributed to those falls.

The guidelines for staff for 'as and when required' medicines were not detailed. The guidelines did not explain what the terms such as "agitated or aggressive" meant or how these behaviours were exhibited by the individuals concerned. We found a number of people had been prescribed a sedative medicine on an 'as and when required' basis, to treat their anxiety and aggression. When these medicines had been given, we found no written evidence that demonstrated the need for their administration. The provider was therefore unable to demonstrate that sedative medicines were being administered appropriately and consistently by all staff.

Staff recorded when people had medicine skin patches applied to their body. However, the records did not show where on the body the patches had been applied, or whether they were applied on alternating sites. Staff did not follow the manufacturer's guidelines on rotating these patches around the body. This meant the patches were not being applied safely and could result in people experiencing unnecessary side effects. By the time of our second visit, the provider had introduced a paper based record so that the manufacturer's guidance on using different sites around the body could be followed.

Refrigerator temperature records and the monitoring of those medicines that needed to be stored in a refrigerator, was not being maintained in accordance with best practice guidance to ensure medicines retained their efficacy. The maximum and minimum temperatures of the refrigerator were being monitored on a daily basis, but the minimum temperature of the refrigerator was below the recommended temperature of two degrees Celsius. The provider was advised to check what effects this may have on the medicines being stored in the refrigerator and take action accordingly. Medicines were not always being stored securely for the protection of people using the service. Keys were left in a lock of a medicines cabinet which meant people without authority, could remove medicines. Topical medicines, such as creams, were being kept in people's rooms. This had potential for people to use these medicines inappropriately with a detrimental effect to their health.

When we returned on 4 April 2018 we found guidelines were in place that told staff when to give people 'as and when required' medicines and the safe dosage limits. One person's protocol said staff should use a sedative medicine for personal care, but only when all other interventions had been attempted. A staff member told us on the day of our visit, they had offered the sedative medicine as a first option, instead of following the guidelines. Patch records were being completed, which showed which part of the body they were applied to, but records of the dates that patches were changed did not correspond with the prescribed

change dates on the MAR. Although some improvements had been made, staff culture, poor practice and limited management continued so there continued to be risks that staff did not understand the importance of safe medicines management.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

The home was clean and maintained. Members of the domestic staff told us they had the training required to ensure they understood their responsibilities to keep the home clean and infection free. One member of the domestic team told us how they used different coloured mops in different areas of the home to prevent the spread of infection. Domestic staff told us they had cleaning equipment available, but felt additional hoovers and a new carpet cleaning machine would make their job easier and enable them to clean more effectively. A member of staff who worked in the laundry explained the process to ensure dirty and soiled laundry was kept separate to reduce the risk of contamination.

The maintenance person described the checks they made to ensure the safety of the environment. This included water temperature checks, equipment checks and ensuring emergency equipment was working effectively. However, staff told us maintenance of the home was not supported and whenever items needed to be replaced through wear or safety reasons, management often refused because of the cost.

Inadequate

Our findings

At our last inspection in June 2016 we rated the provider as 'Good' under the key question 'Is the service effective?" At this inspection we found the provider's systems and processes failed to ensure people received an effective service, therefore the rating has changed to Inadequate.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). When people lack mental capacity to make certain decisions, any decision taken on their behalf must be in their best interests and the least restrictive as possible. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The providers website said, 'Willow Bank prides itself on focussing on giving residents freedom to maintain a good quality of life under watchful care, for those who otherwise would be forced to live within lifestyle constraints'. We found people were being unnecessarily restricted, against the principles of the MCA. There was a lack of records to explain why some aspects of care had been provided in people's best interests. For example, Angel Beck was a small unit for people with complex behaviours. Five people's bedrooms were located in this unit, with a communal lounge area. This unit had coded access, so people were unable to enter or leave the unit without the support of staff. Staff told us they 'took' other people to this unit who 'wandered' or who needed their food and fluid intake to be monitored. At times, there were 13 people in the unit, which caused people to become more agitated and had potential to escalate behaviours, because there were not enough staff to prevent situations escalating.

Some people 'taken' to this unit had not been assessed to confirm this environment was in their best interests. There were no 'best interest discussion' records to support the decisions made on their behalf. During our second visit, we saw occasions when people tried to leave the unit. The door was opened for some people, but some people were stopped from leaving the unit. This practice meant people's liberties were unnecessarily restricted. The practice supported staff to 'manage' people, but did not support individual people to live with the least restrictions to their liberty.

The provider's action plan dated 26 March 2018 told us they were only using Angel Beck for people who had been assessed as requiring constant observation. On 4 April 2018, records showed, '[person] got out of bed so I took him to Angel Beck'. The person was taken there at 00.28am and remained there until 02.14am. Staff then recorded the person slept until 07.14am. This person would have slept in a chair as their own bedroom was not within the unit and they were unable to leave voluntarily. There was no MCA assessment completed or best interest decision recorded to show other less restrictive options had been considered or whether this was the person's choice. Staff took the most restrictive option first.

We looked at other care records for people that lacked capacity. We spoke with a team leader responsible for completing best interest's decisions who told us, "I am waiting for my training", but they made decisions on behalf of people. We were told they had training in this area when they started work at the home, but there was no process to check the staff member understood and followed the principles of the MCA. For one person who lacked capacity, the team leader and another staff member made a best interest decision, but there was no record of what was discussed, who was present, why the decision was reached and whether the timing of that decision was best for that person. They told us they had not consulted family or an advocate, or other healthcare professional. They said a family member was due to the visit the home in a week, but felt it was not important to wait, or speak with them before they came to their decision.

On 4 April 2018 a DoLS assessor confirmed there was a continuing lack of mental capacity assessments and best interest documentation on file. For example, one service user who lived on Angel Beck had a DoLS dated 14 July 2017 that expired 13 October 2017. There was no documentary evidence that a new DoLS application had been submitted. There was a condition attached to the DoLS authorisation, that "Willow Bank staff to complete Mental Capacity assessment and Best Interests decision documentation regarding areas of care where [name] is not able to make her own decisions." Staff had completed a mental capacity assessment on 25 July 2017, but there was no best interest documentation. This meant the provider had not met the conditions imposed within the DoLS. Where there were conditions on DoLS, these had not been incorporated into people's care plans.

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

Agency staff said they had an induction when they first started working at the home, which enabled them to be effective during their shift. One agency member of staff told us, "The staff were very helpful. If I don't know anything I can ask. They are very helpful staff." A member of staff who had returned to work at the home told us they still had to have an induction when they started working there again. They told us the induction included shadowing the deputy manager for a week which gave them the confidence to carry out their role and responsibilities.

The staff training schedule showed some staff had not had refresher training in line with the provider's expectations. Some people needed support with catheter care, diabetes care with behaviours that challenged others. Staff had received training in caring for people living with dementia, but sometimes this was not demonstrated in their practice. For example, the lunch time experience on one of the units was loud and busy which could cause anxiety to some people living with dementia. Some staff called across the room and stacked plates noisily, without understanding that people living with dementia may find loud or sudden sounds and noises distressing. One staff member told us the atmosphere could become tense on Angel Beck and although they had received some training in dementia care said, "I would like more so I could be more aware of why they are getting agitated, especially in the evening." Following our visits, the provider confirmed training had been organised. They were seeking new training providers to ensure the training was informative and beneficial in increasing staff knowledge.

Kitchen staff had a good knowledge of people's dietary needs and which people required their meals specially prepared, because they were at risk of choking. The provider had appointed a 'head of nutrition'; however this staff member said they had not received any additional training for their role. Despite this, they felt confident in their role which they described as, "To make sure everybody is stabilising their weight and if somebody is dropping their weight, (ask) why?" They told us how they had encouraged one person who was reluctant to eat. "I sit with her and then eat something myself and she will mimic me." They explained how they had given another person who was reluctant to sit at the table to eat, finger foods so they could eat as they walked around. This person's relative confirmed this staff member had been able to persuade their family member to eat when others had been unable to.

Lunches were provided in communal dining rooms or in people's own rooms if they preferred. People were asked the day before, what they wanted to eat which was not always helpful for people with a cognitive impairment. We saw at lunchtime, staff asked people what they wanted, without showing any plated options to help people make an informed visual choice. One staff member raised concerns that people who stayed in their rooms and needed support to eat, did not always receive it. On day one of our visit, we saw one person in their room was asleep throughout the mealtime. Periodically we checked to see if they had anything to eat during or after lunchtime. The person remained asleep so did not eat at lunchtime although we could not be confident, they had their lunchtime meal later in the day. We saw another person walk away from the table with their meal and they placed it by an external door on the opposite side of the home to the dining room. No staff followed this person. The person did not eat their meal however when we read this persons' food records, staff had recorded they had eaten 100% of their meal. We raised our concern at the time of our feedback because this was not witnessed, staff could not have known. This meant we had concerns that food monitoring and recording was not effective or accurate.

Staff told us they recorded people's fluid intake on the hand held devices so they could see at a glance people's fluid intake. However, records showed that either people were not being supported to drink enough or staff were not accurately recording it and therefore required improvement. For example, one person's records showed they had only had 200mls on 11 March 2018, 550mls on 6 March 2018 and 350 mls on 16 February 2018. No fluids were recorded on 18 March 2018 and their was no evidence this was followed up. Also the amount taken was always a round amount such as 200ml or 400ml. This therefore indicated staff recorded the amount of fluids given rather than the actual amount taken. Senior staff told us they were responsible to check documentation but told us a lack of time during their shift prevented this from always happening. A relative felt staff were not always responsive to people's changing health conditions or if people had a recently diagnosed illness, advice was not always followed. One relative said, "There is a jug of water in her room but no glass to drink from, she is prone to urine infections and they are not encouraging her to have fluids. She is so thirsty now. It took eight days for her to be given some antibiotics after first being diagnosed with a urine infection (but they did not know why?). She was so dehydrated on the Monday the GP was unable to retrieve a urine sample so they had to return on the Wednesday to try again."

Food charts were completed but the information recorded was not fit to provide a complete picture of what people had eaten. Records showed, 'breakfast', 'lunch' and 'dinner', the portion size and how much had been eaten. However, it didn't say what the meal actually was and whether it had been fortified with extra calories. This information is very important for any healthcare professionals involved in the person's nutritional care and is also a rich source of information of what those people, who are not able to verbally communicate their choices, prefer and like to eat.

Improvements were required when staff monitored people for weight loss or weight gain. People were weighed, but some of the results, and information from the provider following our inspection visits, indicated the scales were not accurate. The provider arranged for the scales to be calibrated to confirm their

accuracy. Some healthcare professionals told us they had some concerns with people's weight monitoring. A healthcare professional told us, "I think they do understand fluids, but there have been concerns about their understanding of weights." They also said they felt staff's knowledge of certain medical conditions was not enough. For example, they said, "They are taking people with more medical issues such as diabetes, but they are not good at managing diabetes." The lack of training in this area and what staff told us showed this was an area for improvement.

Health professionals complimented the interim deputy manager because, "She knows the residents very well and she tends to call us appropriately and knows about the residents." However, they felt that the high staff turnover meant other staff were not so aware of people's conditions and did not always recognise when people's health had deteriorated. They told us, "We can get there and someone is quite sick and a carer (staff) hasn't realised how poorly they are…they do try and pick up chestiness quite quickly." Health professionals remarked, "There are a lot of really good carers, but there may be some who don't know them well." They gave us an example of care staff not knowing people's surnames. One healthcare professional told us they would not have such confidence if the interim deputy manager wasn't there – "Her knowledge of what medication people is on is usually right. If she wasn't there, I don't know what they would do."

The providers website said, 'We do everything we can to make our residents feel at ease, with tailored features for those living with dementia' and 'our homes have been adapted to aid those living with a dementia-related illness'. We found the adaptation, design, decoration of the premises did not meet people's individual needs because it did not support people living with dementia. Dementia studies recognise it is important for providers in understanding that an older person with or without dementia will probably perceive their surroundings differently is a good starting point for the design of living environments. Good design can help in making it easier to interpret and navigate a building in safety, and the use of colour and contrast can be used in different ways to assist in this. Without good contrasts of colour, some people living with dementia could face additional challenges in how they make sense of their environment. People's bedrooms all looked the same and people's doors were all painted the same colour so there was nothing to distinguish them from any of the others. We found on two days of our visits, people going into other people's bedrooms. There were no memory boxes or pictures or objects to remind people where their rooms were so they could find them independently. There was nothing in corridors to engage people or stimulate memories as they walked around the home. We saw one staff member showing a person where their room was because they had forgotten.

Other areas of the home and their use had not been considered and thought through. During day one of our visit, we saw people in Angel Beck standing on chairs and dragging chairs around. We also saw a person lift a chair onto a table. Staff told us they felt vulnerable. One staff member said, "This room (Angel Beck) is full of hazards and not suitable for these residents that have such advanced dementia." Angel Beck was a small unit and there was nowhere for people to walk who liked to explore their environment. This meant that at different times of the day, people were pacing backwards and forwards which had the potential to exacerbate behaviours as they bumped into each other. At 4.00pm on the third day of our visit, six people were walking up and down the communal lounge, two of whom were trying to get out of a door into the garden. Staff did not open the door because the garden did not offer a secure environment for people.

Inadequate

Our findings

At our last inspection in June 2016 we rated the provider as 'Good' under the key question 'Is the service caring?". At this inspection we found the provider's systems and processes did not ensure people received a caring service and staff did not always maintain a caring approach in how they supported people. The rating has therefore changed to Inadequate.

People had mixed views about whether they thought staff were caring. Positive comments from people and relatives included, "I like it here, I like to sit in this quieter lounge and I can watch TV. It's a very nice room" and, "The carers (staff) are all polite and respectful, they all seem to be very nice people." Some people and relatives said staff knew them well, especially one person living at the home who said, "I feel the carers (staff) know me as a person and it makes a big difference to me."

Whilst we acknowledged some people and relatives were happy and had positive experiences of being cared for at Willow Bank, the level of concerns shared by other relatives and staff meant, we could not say everyone received the same level of compassionate care. Some people received a service that did not support their needs or follow the principles of person centred care. One person said of some staff, "Sometimes there aren't enough staff, sometimes they are rude to me, some of them have no manners, they are rude, they don't knock on my door and ask if they can come in, they just walk straight in." They also said, "Some of the carers are very nice, but others just don't give a damn."

Some people told us they felt socially isolated and on occasions were left alone which was not always how they wanted to spend their time. One person told how staff were not caring towards them. This person said, "I have just been to the toilet and they won't let me leave my room now, I don't know why. Sometimes I go to the lounge if they will let me, I have to wait for them to come and help me. I spend time in my room as it's a case of having to wait for the carers (staff)." This person said, "I have been upset as I am lonely and no-one has time to come to sit and chat." Other people we spoke with shared the same concerns that this was common practice.

Some relatives openly and freely shared their concerns with us about how their family members were cared for. One relative said, "[Person] has only been here a short time and we have found them in quite a state, [Person] had been here a few days and we visited and found dried vomit in and around their mouth, staff didn't seem to notice or care." They told us they had to bring in a different duvet within a few days as the one their relative was sleeping on, "Was so soiled and so stained it was disgusting." This relative felt they could not leave their family member in the home without visiting every day to ensure they were being

looked after.

From comments staff shared with us, it was clear they were aware some people had not always received kind and compassionate care that kept them safe. However, staff had prioritised their own fears for not reporting concerns instead of making sure people received the right levels of care, treatment and support that they deserved. We found the provider and staff did not show concern for people's wellbeing in a caring and meaningful way, especially as some staff told us they had witnessed people being mistreated and they had not protected them.

Our own observations demonstrated that care was frequently task focussed and some staff did not always provide a caring and thoughtful approach to how they supported some people. Staff missed opportunities to interact with people in a meaningful and thoughtful way. We saw one member of staff supporting a person to eat. They were reading their electronic device (records of people's care details) and not engaging with the person at all. They did not speak to the person and the only time they looked at them, was when they were putting the fork into the person's mouth. The lack of management of the shift and observations meant this practice was not stopped and it became 'accepted' practice.

People's right to privacy and dignity was not always maintained. CCTV monitored communal areas of the homes such as communal corridors. The directors told us people and relatives had agreed to this monitoring because they signed their agreement to live at the home. However, people we spoke with had mixed feelings about this. One relative said, "We were aware of the CCTV cameras in the communal areas, I think they are a good thing." However, another person did not welcome this. They said, "I knew about the CCTV cameras when they were first installed, I wasn't asked about it, it's an invasion of my privacy, I find it disgusting."

Care records included details of people who, due to their confusions, sometimes walked around communal corridors undressed. No consideration had been given as to the impact on those people's privacy. The directors said the use of CCTV, "Protected people", however there was no system or policy to review the requirement for such observations or infringements on people's privacy. The directors agreed to review this and get people's feedback on the continued use of CCTV within the home.

People were not consistently supported to participate in planning or reviewing their care. People were not given information about their care plans or reviews of care in ways that were meaningful to them, such as in an easy read or pictorial format. For people who were less able to communicate, there was no evidence of how staff sought their feedback on the care they received, and how they would prefer that care to be delivered. It was not clear how relatives participated in reviewing people's care as this was not consistently documented. We found the provider had not actively involved people in making decisions about their care, for example, around the use of CCTV in communal areas or by telling relatives when people had fallen or if they had unexplained bruising. Staff took people into locked areas of the home that had a negative effect on their wellbeing, without any thought or consideration as to whether it was in the person's best interests. Staff comments to us were inappropriate in how they described some people, especially those people living with dementia.

People had a lack of dignified care with some aspects of personal care. Staff told us they used towels to wash people and each part of the towel was used for a different part of the body. We could not always be sure staff followed this and some towels we saw, were clearly stained and did encourage or promote dignity. Staff told us more towels had been purchased, but staff said this was not the answer.

Some people and relatives told us laundry was not managed well which impacted on people's dignity. One

relative said, "We were told clothes and shoes had gone missing and we have seen her in someone else's clothes. In the entrance hall, there was a box – 'missing spectacles' with at least 20 pairs that were unclaimed and a box that contained watches and other personal items unclaimed.

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

Requires Improvement

Our findings

At our last inspection in June 2016 we rated the provider as 'Good' under the key question 'Is the service responsive?" At this inspection, we found improvements were needed and therefore the rating has changed to Requires Improvement. This was because the provider's systems and processes meant staff were not responsive to people's care needs and a lack of consistent records had potential to put people at unnecessary risk.

Some relatives said they were pleased with the service their family member received and they felt staff knew their relation's needs. One relative said about staff's responsiveness, "The staff here are lovely. I do feel they know her quite well, what her needs are and how to look after her. They know that she likes to pick things up that don't belong to her and they know how to deal with that."

However, from our observations over three inspection visits we found staff were not responsive to meet people's needs. This was because the impact of staff deployment, staff knowledge of people and the lack of consistent records, meant people received an inconsistent service. People received care and support that was not always planned in a way that met their individual needs. For example, there was a lack of clarity about the purpose of some units so staff could effectively respond to people's mental and emotional wellbeing. We were told 'Angel Beck' was a unit for five people with advanced dementia care needs and the small number of people on the unit helped staff to best prevent people's behaviours from escalating. We were told it was a closed unit (coded) and that staff had access to emergency bells if they required additional support. However, we saw occasions when there were over 10 people in this unit, some whose bedrooms were in other areas of the home. The space in the communal living area was designed to accommodate five people but t we saw over 10 people frequently sharing this space which meant people were in very close proximity with each other. The way people expressed themselves on these occasions demonstrated their anxiety. The atmosphere in the room was not calm or relaxed.

Within the home there was a 'female only' unit, because some people living there had past experiences that made then unsettled and uncomfortable in the company of males. The deputy manager agreed that the male member of the CQC inspection team should avoid the unit. However, throughout our first and second visits we saw both male staff and men who lived in the home on the 'female only' unit. On the first and second visit, we saw four men sitting in the lounge and no staff present. When a member of staff did arrive on the unit, they were male agency staff. They brushed past one of the women without speaking to them or offering reassurance, which clearly startled the person. This person's relative told us male service users often entered their family member's room causing them anxiety, which was not being monitored. They said, "I

have been here when a male resident has come into her room and sat in her armchair and not moved." They told us staff were not responsive, because they were not always on hand to prevent situations escalating. Relatives were concerned because they did not want to leave their family member with uninvited guests.

Improvements were required in reviewing and updating people's care plans, to minimise the risks of people being supported inappropriately. Care plans sampled were not sufficiently detailed to provide staff with important information to provide person centred care. Staff's understanding of the support people received was not consistent. We asked to see a care plan for one person whose behaviour could challenge other people. Their care plan explained they could behave in a way that challenged others, but there was no risk assessment or information that explained the risks they presented to themselves, or to others.

Another care plan we reviewed stated the person 'likes to join a walking group'. Our observations of this person during our visit showed they could not stand or move without two staff to assist them. The person was required significant support with their continence but this was not reflected in the care plan.

We looked at a care plan for a person identified as at risk of falling. Staff told us they used a stand aid hoist to mobilise the person, but this support was not included within the care plan. The care plan also stated the person could use the stairs, but this was not correct and the risks to this person mobilising had not been assessed. Care plans for diabetes did not record whether people received important support with oral care, foot care and regular diabetic reviews. Some staff's knowledge of people was limited, especially around certain health conditions such as good catheter care management and diabetes. Conflicting or a lack of information had potential to put people at risk of receiving inappropriate care.

One staff member said, "Care plans are not updated, sometimes we don't know what to do." Electronic devices were used by staff to access people's care plans and risk assessments. Staff told us, "Sometimes we are in trouble as 'devices' can be broken or there are no batteries." Staff did not know who maintained the devices or who to report issues to. We saw staff were not confident in using the electronic devices, or in accessing and finding people's important care information on them, even though they had been provided training. One staff member said, "We have had training, but it is hard to use as we are sharing and need them to work." Throughout our first visit we saw staff asking each other, "Can I borrow yours?"

There were activities for people to do, as groups, such as bingo, and external singers came to entertain people which people enjoyed. However, people were not supported to follow their own individual interests or participate in activities that were meaningful to them. One person said, "I don't know of any day trips or outings, I don't go out. People do come in to entertain and I do join in, there is never much happening though. I used to like to read." They told us they had not been offered 'audio books', but would be interested in using them. There were limited opportunities for staff and people to talk and spend time with each other, which people said they enjoyed, but staff were not always available. We discussed the limited social opportunities provided to people living with dementia with the provider. because they did not support good dementia care. The provider agreed to improve stimulation and opportunities for staff to spend quality time with people.

A visiting healthcare professional said, "Underlying care here is very good…my concerns are that there are different levels of dementia care required here…residents have complex needs and I don't think I would put a relative here as its too much for the carers." This matched the views of relatives we spoke with.

The lack of person centred care and support for people is a breach of Regulation 9, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our first two inspection days we wrote to the provider about some of these concerns and they told us about the improvements they planned to make. We returned on 4 April 2018 to satisfy ourselves sufficient measures had been taken. We found some improvements had been made although monitoring of the improvements had not yet been embedded in every day practice. Staff told us the staff level on Angel Beck had improved the atmosphere and gave them more time to respond to people's needs, although there was still limited staff involvement with people to keep them engaged and stimulated. Records showed night staff continued to put people into this room. We reminded the provider of their obligation to regularly review people's dependency and to evaluate staff levels to ensure they were able to be responsive to people's identified needs.

Care plans had been identified as an area for improvement by the provider's external auditor on 4 January 2018 and subsequently, by us and the local authority following our visits. Quality assurance teams from the local authority were providing support to staff to make those improvements which was agreed, was a work in progress. However, we saw one care plan that we were told had been updated, still lacked detailed information for staff such as what to do, how to reduce the person's anxiety, and what caused the person to become anxious. The care plan did not describe any known practices or interventions that were successful and resulted in a good outcome for the person.

'Grab sheets' supposed to give a picture and current knowledge of people's care needs, to help new or agency staff, had been implemented. However they were not simple to understand. One grab sheet was 22 pages long and did not provide staff with a short summary of the person's basic needs. Others were of similar size. The area manager agreed improvements were needed to give staff a 'snapshot' of needs.

Some of the information shared with us before this inspection visit indicated concerns with the number of deaths at the home. The local authority commissioners told us GPs had no concerns with the reported deaths at the home or how people had been supported. When we asked one visiting health care professional how they would describe the end of life care provided, they were complimentary. They told us of one person who had been extremely poorly for a long time and said, "As far as we are aware, they have cared for [person] beautifully." They went on to say, "End of life care, they will manage that quite well." We saw compliments from families had been received when people had been cared for at the end of their life. Comments included, ''He was well cared for and comfortable in his quiet familiar room and I was so pleased it was such a peaceful, tranquil and dignified passing' and, 'He was cared for by the very caring, professional staff at the home'. The care planning system had an end of life care plan if people expressed a wish to discuss this.

People knew how to complain and for people who were not able to complain, family members said they would raise any issues. Across three inspection visits, we had mixed feedback from people. People felt any issues they had raised had been dealt with, others found a lack of improvements in the service they had received. We asked for records of complaints but were not given any information so we could not be sure how many had been received, how they were responded to, and whether people were satisfied with their response and any learning that came from those investigations prevented similar complaints from reoccurring.

Inadequate

Our findings

At our last inspection in June 2016 we rated the provider as 'Good' under the key question 'Is the service Well Led?" At this inspection, we found a number of shortfalls and concerns that identified the systems and processes were ineffective and therefore the rating has changed to Inadequate. The provider's systems and processes were not sufficient to ensure risks to people's safety were minimised or to ensure they received effective and responsive care. People's emotional wellbeing was not taken into account when planning their care and support and staffing was insufficient to promote a caring and culture and ethos.

At the time of our inspection visits, the registered manager was on a temporary leave of absence so was unable to be present. The deputy manager had resigned from the service prior to our first inspection visit. The home was being managed temporarily by an interim deputy manager supported by a management team, who were all newly employed by the provider in the last couple of months.

We looked at the systems the provider used to ensure the service was safe and to monitor the quality of care provided to people. We found people's health and well-being was not sufficiently protected as the provider had failed to implement systems and processes to make sure people received the care and support they needed. The provider did not have effective and robust systems and processes to assess, monitor and improve the quality and safety of the service people received.

The management of the staff on each floor and specialist unit was not effective. People did not receive the individual care they needed and were not protected from unnecessary risk. On occasions there were no staff present in the specialist units to prevent some people's behaviour from escalating that had potential to put others at risk. For example, the deputy manager told us there was a 'female only' unit but during our first inspection visit, we saw men were sitting in the lounge and male agency staff were working in this unit. The management of this unit was not effective because staff were not always present to ensure people's emotional distress was minimised when males entered the unit.

The provider had not ensured that staff had sufficient skills and training to be effective in meeting people's needs. The staff training schedule showed some staff had not had refresher training in line with the provider's expectations. Some staff supported people with catheter, diabetes care or people who presented behaviour that challenged others. Staff told us they would benefit from training in these areas, but we found training had not been planned. Following this visit the provider confirmed training in these and other areas was planned to be provided for staff.

The provider did not maintain accurate and complete records in respect of each person using the service. We found a variety of care records we sampled were not reflective of people's individual risks and the care they received. The general manager told us the registered manager completed audits and they checked to ensure they were completed and actions were taken. We asked for records of provider, general manager and registered manager audits. We were given some records for July and October 2017, but were not given any records that showed checks had been made in 2018. The general manager said they had completed checks but agreed they were not always recorded and could not be made available to us. They told us, "I do the audits and I sign them off." We asked for the last few months audits and they said, "I can't find them, I am annoyed." They even told us, "I have heard some audits have been shredded."

The general manager acknowledged the home was not managed effectively. They said, "This used to be a lovely home but could be run better. It has declined in the last year or so." The general manager cited changes in care staff being recruited and good care staff leaving which had impacted on the service.

The directors told us they used an external auditor who completed a series of checks and audits that assured them, improvements were being identified and actions taken. They said it was the responsibility of the general manager to check the registered manager had taken action in response to the external audits. The last audit the external auditor had completed on 4 January 2018 identified a number of shortfalls that we found. The general manager told us they had not checked that particular audit whether actions been taken which meant their quality monitoring systems was not effective.

The management at the home did not encourage, promote and listen to feedback to drive and sustain improvements in the service. Relatives told us whenever they raised concerns, little or no action was taken. Relatives shared their concerns and frustrations with us. One relative said, "When I do raise concerns to management, they are met in an aggressive, authoritative way. I have heard management speak very abruptly to foreign staff, but the care staff are lovely." Relatives lacked confidence in how management responded to concerns. A relative shared their experiences in raising care related issues, saying, "Management do not deal with things in a sympathetic way, for example, I asked for a mattress for mum as she falls out of bed, but felt I needed to push for something to happen, they were very rude." They explained, "I would like to feel able to go to someone and feel supported and listened to so that my [relative] gets the care she needs." They told us their relative required fluid monitoring but said, "[Name] had pneumonia a while back and had a paper chart for their fluids to be filled in but it never got filled, so I would do it."

The staff team told us they felt undervalued and fearful in raising concerns or ideas for improvement. Staff spoke of an atmosphere of fear and recrimination which meant they did not escalate their concerns. Staff told us the management team were not approachable. They told us, "The staff are lovely but unfortunately the management are terrible" and "The way we get spoken too is so wrong in my eyes. I think their job position has gone to their head."

Staff felt relieved the provider had started to take action, but it was clear from their comments that there needed to be changes to the culture and ethos of the home. One staff member told us, "Everybody is glad this is happening with the management going. I think it will improve the running of the place. A lot of things aren't working at the moment that need to be changed. The atmosphere is loads better since some people have gone."

This was a breach of Regulation 17 HSCA RA Regulations 2014 Good governance

Just prior to our inspection visit on 8 March 2018, allegations had been made concerning people at the home being exposed to potential harm. The investigations into these allegations remained on going at the

time this report was written. Staff told us there had been a staff meeting on the Tuesday before our first visit, when they had been updated about the safeguarding concerns and how this had temporarily affected the management at the home. Staff felt the home had settled down in the last few weeks. One staff member told us morale was "better now" and went on to say, "It is much calmer to work here now and you don't feel on edge." This staff member felt that whatever had happened in the home, staff needed to work together to ensure good outcomes for people. "It is not about management, it is about these people being cared for and looked after." Another said, "It is okay. It is better now. The atmosphere is better now, everybody seems a lot happier now."

When we asked what had improved the atmosphere they responded, "Members of staff have gone." Another member of staff said, "It feels different. It is as though that weight has been lifted. It is nice to see staff smiling again and if they are happy the residents pick up and are happy as well." Another staff member told us morale was, "Mixed. A lot of people would like to get things off their chest."

Following our inspection visits in March 2018, the provider sent us an action plan telling us of their planned improvements. We returned for a third inspection day in April 2018. We found some areas had improved, such as increased staff on Angel Beck and PRN protocols provided information for staff on when to give 'as and when required' medicines. However, the staff practice and culture of the home meant these improvements were not always followed by staff and the lack of oversight, meant we could not be assured actions taken had led to substantive improvements within the home.

We found the provider had not sent us statutory notifications for important and serious incidents. At our inspection visit on 4 April 2018 we identified two safeguarding incidents and two serious injuries that we had not received statutory notifications for, which was the provider's legal responsibility to do. The area manager told us the interim deputy manager knew what to notify us of, but this was not being done. Failures to notify us of serious injuries and safeguarding incidents had prevented us from monitoring the service effectively.

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

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 18 Registration Regulations 2009 Notifications of other incidents The registered persons failed to notify the Commission without delay of important or serious incidents which was their legal responsibility to do so.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured people received care that met and supported their individual preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing arrangements were not consistent to ensure there was sufficient numbers of suitably qualified, competent and skilled staff to meet people's care and welfare needs.

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 11 HSCA RA Regulations 2014 Need for consent People did not receive their care and support in line with MCA legislation and staff did not follow these principles. Records of best interest decisions were not recorded, or involved people, family or advocates.

The enforcement action we took:

We issued an urgent notice of decision to impose a restriction on their registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured risks to the health and safety of people were assessed and managed so they were in receipt of safe care and treatment. The provider had not ensured they had done all that is reasonably practicable to mitigate such risks. Medicine management was not effective to protect people from potential harm. Regulation 12 (1)(2)(g).

The enforcement action we took:

We issued an urgent notice of decision to impose a restriction on their registration.

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

	The provider had not always taken appropriate action without delay to safeguard people from the risk of harm.

The enforcement action we took:

We issued an urgent notice of decision to impose a restriction on their registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People were not protected as the provider had not ensured quality assurance systems identified the areas of improvement required. The provider had failed to asses, monitor and mitigate risks relating to people's health, safety and well-being using the service.

The enforcement action we took:

We issued an urgent notice of decision to impose a restriction on their registration.