

Old Village Care Limited

The Old Village School Nursing Home

Inspection report

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Ratings

Overall rating for this service

Inadequate



Is the service safe?

Inadequate



Is the service effective?

Inadequate



Is the service caring?

Inadequate



Is the service responsive?

Inadequate



Is the service well-led?

Inadequate



Overall summary

We carried out an unannounced comprehensive inspection of this service on 08 and 10 June 2015. After that inspection we received concerns in relation to the provider's ability to meet the needs of the people who lived at the home, particularly with regard to their safety, nursing requirements and the management of their medicines. As a result we undertook a focused inspection to look into those concerns. However due to the level of concerns identified during the inspection process we also looked at 'caring' and if the service was being well-led.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Old Village School Nursing Home on our website at www.cqc.org.uk

Following our inspection in June 2015 the overall rating for this provider was 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.

Summary of findings

- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

During this inspection we found that there had been no improvement in the areas that we looked at and we are taking enforcement action.

The Old Village School Nursing Home provides a service for up to 60 people. The home is divided into three units providing personal and nursing care to older people and younger adults; including those with high care needs as a result of neurological conditions and those who need care at the end of their life. An on-site physiotherapy department provides some people with individual physiotherapy and rehabilitation programmes. At the time of the inspection there were 50 people who lived at the home.

The home had a registered manager. However, the registered manager had been absent from the home for three months at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The home was being managed by the provider's operational manager at the time of the inspection.

People did not always feel safe at the home nor did they always receive care at the time that they needed or wanted it. Staff did not always respond to people's needs or calls for assistance. People were fearful and felt degraded by some of their experiences.

People were at serious risk of harm. Personalised risk assessments were not always sufficiently detailed or accurate and had not been reviewed regularly to ensure that no changes had occurred. Not all risks people encountered had been identified or recognised so that action could be taken to minimise them. People's medicines were not managed, stored or administered safely.

People were not always assisted to eat their meals, and people who received nutrition and hydration by way of percutaneous endoscopic gastrostomy (PEG) tube did not always receive this in the correct volumes.

People's capacity to make and understand decisions was not always assessed and documented appropriately. Decisions made on people's behalf in their best interests were not always documented so there were risks that they would not be protected within the legal framework to protect their rights and best interest.

Care plans did not always reflect the care provided and had not been updated when people's needs had changed. So there was a serious risk that their needs would not be provided in a consistent way that had been planned for.

People's dignity and privacy was not respected and they were often left for unacceptable periods without receiving the care they needed. Their dignity was compromised and they did not receive the care that they required.

We were so concerned about the poor quality of the care being provided that we immediately notified the local authority and clinical commissioning groups. Due to the number of safeguard referrals other professionals started to review the care for all those using the service. These reviews identified serious levels of staff incompetency, poor attitudes to people and a lack of care.

During this inspection we identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We took enforcement action and there are currently no people living at the home.

The enforcement action that we took was subject to an appeals process. The provider was not entitled to carry on Regulated Activities during this process. The appeal was allowed by the First Tier Tribunal (Care Standards) and the Regulated Activities are now subject to the following conditions imposed by the tribunal:

1. It shall be a condition of the registration of the provider in respect of the Home with immediate effect that the provider shall not admit as a service user to the Home more than two service users in any period of 7 calendar days computed consecutively from 1 March 2016 for the first four weeks.

Summary of findings

2. After this initial four week period the number of admissions will be increased to a maximum of three service users per week for the next 20 week period.
 3. A named consultancy company is appointed by the provider under a management agreement to provide professional management services for the purpose of carrying out the accommodation together with nursing or personal care and treatment for disease, disorder or injury (as defined under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014) for a minimum period of 18 months.
 4. A named person will undertake the day to day management of the Home for at least the first 18 months of operations and apply to become registered with the Respondent. Any subsequent person who is identified to become the registered manager will not be appointed as such until the CQC has registered that person in respect of the Home.
 5. A named member of the consultancy company is appointed by the provider as a manager of the provider under a management consultancy agreement to oversee the day to day management of the Home and provide the role of Nominated Individual for a minimum of 18 months. They will visit the Home for a minimum of five days per week in the first four weeks of operation and a minimum of two days a week for the next two months and one day per week thereafter; and in each such month prepare and provide a report to the Board of Directors of Old Village Care Limited with a copy to the CQC.
 6. Before the admission of the first service user to the Home upon reopening, the Home shall have in place sufficient numbers of suitably qualified, competent, skilled and experienced staff who are permanent employees of the provider so that there are on duty at the Home between the hours of 8am and 8pm not less than four staff and between the hours of 8pm and 8am three such staff dedicated to direct service user care of whom one on each "shift" is a first level registered nurse.
 7. When further admissions are made that would require an increase in staffing levels, admissions will pause whilst suitable additional suitably qualified trained care staff are recruited.
 8. Temporary staff engaged by an agency shall only be used in cases of necessary absence of permanent staff due to sickness, leave or sudden and unexpected absence or departure.
 9. Any service user to be admitted to the Home will be admitted after a pre-admission acceptance by the Home manager, on a pre-arranged date and time with a member of the care team allocated to complete all admission paperwork upon their arrival. A 72 hour care plan will be created to bridge the gap between admission and the completion of a full care file. Following 72 hours after admission the Home manager will verify in written form to the named consultancy company that all required documentation is in place (for the period for which their management agreement is in place).
 10. Service users will be admitted to locations within the Home in the following order:
 - a. Woburn Unit – Ground Floor
 - b. Knebworth Unit – First Floor
 - c. Old School Unit – Ground Floor
 - 11 Before any service user is admitted to the Home, the Director of Old Village Care Limited will undertake the following training:
 - a. Safeguarding;
 - b. dignity in care;
 - c. moving and handling;
 - d. dementia;
 - e. infection control; and
 - f. COSHH
 - 12 For the period that the named person is appointed Nominated Individual, the Director of Old Village Care Limited shall also attend the Home with the Nominated Individual at least three times per month to observe and learn from her the skills of supervising day to day management.
- This service will remain in special measures. Services in special measures will be kept under review. The expectation is that providers found to have been providing inadequate care should have made significant improvements within a timeframe of six months. 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.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

People were at serious risk of harm as their care and welfare was not managed by competent staff.

Appropriate referrals had not been made to the safeguarding authority when concerns of suspected abuse had been brought to the manager's attention.

People's medicines were not managed, stored or administered appropriately.

There were insufficient competent, suitably qualified staff to provide safe care and treatment to people.

Inadequate



Is the service effective?

The service was not effective.

People did not receive the correct amount of food or fluids and were not always assisted to eat their meals.

The requirements of the Mental Capacity Act 2005 were not followed.

People were not protected from serious harm as staff failed to recognise when their condition changed and needed medical intervention.

Inadequate



Is the service caring?

The service was not caring.

People were not treated with dignity and respect.

People had to wait unacceptable lengths of time before staff responded to their calls for assistance.

Inadequate



Is the service responsive?

The service was not responsive.

People did not receive the care and treatment they needed at the times that they needed or wanted it.

People did not have access to hobbies or interests that were meaningful to them.

Inadequate



Is the service well-led?

The service was not well led.

People were recruited without the knowledge of the management team.

The provider's continued to breach the regulations despite being informed that they should not do so.

There were systemic failings at the home and a lack of commitment to make improvements.

Inadequate



The Old Village School Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 03 and 06 August 2015, and it was unannounced. On 03 August 2015 the inspection team was made up of two inspectors, one of whom was a pharmacist, and an inspection manager. On 06 August 2015 the team was an inspector and an inspection manager.

Before the inspection we reviewed the information available to us about the home, such as notifications. A notification is information about important events which the provider is required to send us by law. We also reviewed

information about the home that had been provided by commissioners, staff and members of the public. Commissioners purchase services on behalf of people from the provider.

During the inspection we spoke with three people who lived at the home, one relative, two nurses, one member of care staff, the acting manager and the two deputy managers. On 06 August we also spoke with the provider, the manager and two deputy managers and five visiting health and social care professionals who were involved in carrying out care reviews and assessments of everyone living at the home. Over both days, due to the complex needs of some individual residents which meant they were unable to communicate their needs, we carried out observations of the interactions between staff and the people who lived at the home.

We reviewed the care records and risk assessments for four people and checked medicines administration records on the three units. We reviewed information on how the quality of the service was monitored and managed.

Is the service safe?

Our findings

During our inspection on 08 and 10 June 2015 we had raised concerns about inadequate risk assessments with the provider and identified breaches in the regulation. At this inspection we found that effective action had not been taken to address these failings.

We saw that care records included personalised risk assessments for each person and actions to be taken by staff to reduce the risk of harm to people. These included the risks associated with people being assisted to move around the home, the risk of falling and the risk of them developing pressure related areas on their skin. However these were not detailed enough nor were they reviewed and updated to ensure that staff knew what care and/or treatment they needed to ensure risks were reduced and kept to a minimum where possible.

We saw that no risk assessment had been carried out when one person had developed a pressure area on their foot due to slipping down in their bed. We also found that no risk assessments had been completed following changes to people's health and their discharge from hospital. One person had a serious Grade 4 pressure ulcer but there was no risk assessment that identified how their risk of developing further ulcers should be managed.

People told us that they did not always feel safe, although one relative told us that they had no concerns about the safety of their relative who lived at the home. One person told us that they had recently been admitted to hospital following staff giving them too much medication. They said that the majority of care staff did not know what they were doing and that, "All the good carers are leaving." They also said, "I think they just pay lip service."

The lack of risk assessment left people at risk of serious harm and a visiting healthcare professional told us that as part of their assessment process they had identified serious shortfalls in the equipment needed to manage people safely. Due to these risk factors and the risks to individuals they had immediately ordered large quantities of safety equipment to manage the immediate risk to people.

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

During our inspection on 08 and 10 June 2015 we had raised poor staffing levels with the provider and identified breaches in the regulation. At this inspection we found that effective action had not been taken to address these failings.

People told us that there were insufficient staff available to care for them and, as a consequence, they did not get the care they needed. One person told us, "Their biggest problem is night time. There are not enough carers. It's been short everywhere. There is a dearth of carers." Another person told us, "The shortage of staff is terrible." They also told us when they had been in the garden enjoying the weather that staff had ignored their cries of help even ignoring their banging on the window even when walking by. They said "I was left in the garden for two to three hours with [another person] and not a soul came near us. The side door was closed because of the wind and this frightened [the other person]. It frightened me too. [The other person] was tapping on the window to come in. I was shouting for the nurse. Eventually someone came but by then [the other person] was crying and cold." The relative who had no concerns about safety at the home commented, "There should be more staff. They are quite often short. Quite a lot of time [relative] is on [their] own."

One person told us that at the time of our visit on 08 June they usually had to wait for care for up to 20 minutes when they rang their call bell. Since then the time where they had to wait for their call bell to be answered had increased to an hour and a half. Another person said that "I think they [staff] think I am an inferior being" in relation to their care needs being met.

Because of the way staff were deployed throughout the home, people were often unattended in communal areas. One person told us about a recent incident when a person was in the lounge and was screaming and crying. They said, "There was not a member of staff around to comfort [them]. I shouted and they came and put [them] to bed. That is how they comfort you. [put you to bed]"

They went on to say that they could not ring a bell in the lounge to call for assistance as these were only available in the bedrooms. They told us, "If a nurse goes by and you shout they ignore you. It is degrading." They also told us, "My call bell is pulled out at night. There is nothing in the socket. I tried to put the pin in the socket but could not. It

Is the service safe?

often happens. The carers pull the pin out.” This meant that the person was unable to summon help if they needed it during the night. We brought this to the acting manager’s attention who understood this practice was unacceptable.

One person told us that there were a lot of agency staff employed at the home and this meant that they had to explain things to new staff who did not know them. They told us, “They have to come and ask me where my tablets are.” A nurse told us that the competency of the agency nurses had improved as they were now using agency nurses who were experienced in caring for intensive care patients. A member of the care staff told us that the current staffing levels were not good. They told us, “I don’t think the staffing levels are safe. Six people is safe, particularly as we now do the tea and coffees.”

One visiting healthcare professional describe the standard of nursing care as shocking and totally unacceptable. They recalled an elderly person calling for help because they couldn’t see, had no call bell and being ignored by staff. They had to intervene. They went on to say that their own community nursing staff supporting the service felt professionally compromised by the actions of nursing staff at the home. They told us that one person who received continuous oxygen therapy had been found blue and in distress as the night nurse on duty had not taken the necessary steps to replace the empty oxygen cylinder. The person had no speech, was unable to call for assistance and was completely dependent on staff for all their needs. The healthcare professionals visiting the home had to intervene to make the person safe.

On 03 August we were informed that due to staff sickness the home did not have sufficient care staff on duty across the units and that staff from other units had been moved round to cover. The provider had been unable to secure additional staff. The nurse on one high dependency unit confirmed that they were working with one less member of care staff than they expected as they had needed to send a staff member to cover the other high dependency unit which was short.

On 06 August we spoke with the manager and deputy managers about staffing cover for the weekend. They were unable to provide detail of the nursing cover required and thought they only had five nurses to provide care across

the weekend. They had tried but had not been successful in obtaining agency cover. We could not be satisfied that sufficient staff would be on duty to carry out the nursing and personal care.

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

During our inspection on 08 and 10 June 2015 we had raised medication failings with the provider and identified breaches in the regulation. At this inspection we found that effective action had not been taken to address these failings.

Nurses told us that their competency to administer medicines had not been assessed during their employment at the home. Although we were told there was a medicines management policy, it wasn’t available at the home and the deputy manager hadn’t seen it.

The systems in place to monitor the supply and administration of medicines could not be audited because of poor recording and it was not possible to check if the stocks of medicines held in the home were accurate. This also meant staff could not demonstrate that people received their medications when they needed them.

The nurse with responsibility for ordering medicines from the pharmacy could not provide a clear description of the process. They relied on staff telling them when supplies had run out. Some medicines had run out on the morning of our inspection and the nurse was unable to offer an explanation as to why this had happened. This meant that unless further supplies were obtained that day people would not receive the medicines that they had been prescribed to maintain their health. We made the deputy manager aware of this shortfall so it could be rectified. This had been a specific issue raised at our June inspection.

Nurses told us that they gave medicines according to the medicine administration record (MAR) chart and not the label on the medicines pack. We found discrepancies between the instructions on the MAR chart and those on the medicine label. The MAR charts were hand written by nurses with no second check, and although the intention was that a doctor would sign them as correct, this didn’t always happen. This increased the risk of errors occurring in the ordering process and during the administration of people’s medicines.

Is the service safe?

We observed that staff administering medicines did not follow basic administration procedures, such as washing their hands before and after administering eye drops and ensuring that cups that had been used for dispensing medicines were kept separate from unused cups to ensure that each person received their medicines in a clean cup.

There were missing staff signatures on medicine administration records (MAR) that confirmed staff had administered the prescribed medicines and there were no robust audit systems established to monitor these errors. This was an issue identified at our June inspection.

Staff did not routinely write on the dates when bottles of medicines were opened even though some medicines, such as eye drops, have to be discarded within a certain time after having been opened. At our inspection in June we had specifically fed this back as an issue that needed addressing with nursing staff.

Tablets were crushed and administered via PEG tubes with no assessment of whether they were suitable for use in this way. The properties of some tablets are affected by

crushing, and they may not be effective. There was no evidence that a pharmacist had been consulted to ensure the medication was suitable to be crushed and administered in this way.

Some people were prescribed medicines which were only needed occasionally or in an emergency, for example to treat seizures. Nurses were not able to tell us what some of these medicines were for or when they would use them, and there were no protocols or other guidance available to support them to give them consistently and correctly. Without knowing why an “as required medicine” was needed it is unlikely that it would be administered as the need for it was not identified.

Despite our feedback that large quantities of medication were held in stock unnecessarily little had been undertaken to rectify this. On 03 August we continued to find significantly large quantities of medication being held.

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

Is the service effective?

Our findings

People told us that staff did not have the skills to care for them. One person told us, "I had my catheter changed here and they put the wrong dressing on it." They went on to tell us that this had resulted in them getting very sore. When the dressing was removed during a hospital visit it was found that the skin beneath the dressing had blistered.

Staff we spoke with told us that the manager had arranged training in a variety of areas. Training had included sessions on dignity in care, dementia awareness, wound care and record keeping. One member of the care staff told us that they had received training on tissue viability but added "I have not been to the other training, such as record keeping. It is my choice not to go. I don't even know if my name is down for any."

A nurse told us that they had been to recent training sessions. However they were not aware of the re-validation process for nurses which was due in 2016 or how the provider would support them with this to ensure their skills and competencies were up to date and relevant for the work they performed. The nurse told us that overseas qualified nurses had been employed initially as carers until they obtained their United Kingdom registration. Once successful these newly qualified nurses gained experience from shadowing the experienced nurses before taking on the role. This meant that their training was carried out by nurses who lacked competency themselves so unacceptable unsafe practices were continued and accepted by the staff team as normal.

On the 06 August 2015 healthcare professionals conducting assessments of people's needs informed us that they had identified a pressure ulcer which needed a dressing. Dressings used to treat wounds should be sterile until opened at the time of use and then used on an individual patient to reduce cross infection risks. Any unused dressing should be disposed of. The nurse from the home provided a dressing that had already been opened and partly used.

This failing to ensure that nursing staff were competent to deliver their role is a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

At our inspection in June 2015 we identified that the provider was failing to meet people's need for sufficient

food and fluid. At this inspection we found that the arrangements for the provision of meals, snacks and drinks was not effective because people did not receive them in a planned organised way that met their needs

A relative told us that "The food is excellent. There is not a lot of choice but [relative] is not fussy. Anyway [they] would not be able to choose. [They] have put a bit of weight on." However, one person told us that the food they were given was often unappetising. They told us, "They have new rules and regulations. They can't microwave my food any more so I get it lukewarm. Yesterday I had egg on toast and by the time they cut it up for me it was cold." We observed the lunchtime meal on one unit and saw that staff supported some people who ate in their room. However, not everybody who required this assistance received it. One person who had their meal placed in front of them in the lounge area was left for over 30 minutes unable to eat it. When asked, the kitchen staff told us that the person had to wait until the care staff had assisted the people who were eating their meals in their rooms before they could be given assistance.

Another person had refused the meal given to them and had been given their alternative choice, which was soup. However, the bowl was placed in front of them with a warning that it was hot and nobody checked whether the person was happy with it or had eaten it. We saw that they had two small spoonful's and left the rest.

The dining area was functional with plastic covered cloths on the tables however no condiments were provided. The tables were not set and people were only given cutlery to eat their food at the time they were given their meals. One person had been given a serving spoon to eat their dessert with. They were unable to eat the food easily and eventually gave up trying to do so. People were not always provided with drinks to accompany their meal or access to water so they could help themselves where they were able.

People's access to adequate food and fluid was compromised because the management of people's needs was reliant on care staff. Care staff had been given the responsibility to ensure that people had drinks throughout the day in order to prevent dehydration. This was so they would know who had drinks and when. This was to manage a risk of some people choking. This meant that people had to wait to have a drink until a member of the care staff was available to get it for them or assist them to

Is the service effective?

drink it. We saw that people on one unit had been given their morning drink and a snack at 12 noon when lunch on the unit was served just before 1pm. Therefore people were not hungry when their meals were given to them.

People who received food and fluid via percutaneous endoscopic gastrostomy (PEG) tube did not receive their food at the correct amount and regularly received too little fluid which was not given at the times that their care plan specified. One person was recorded as receiving 1700mls of fluid on 01 August 2015 instead of the 2450mls that they should have had. On 02 August 2015 records showed that they had received 1100mls. Staff could not tell us if this was a recording issue or confirm if these figures were accurate which meant they could not demonstrate the person wasn't at potential risk of dehydration.

The failings to ensure people had sufficient food and fluids was a continued breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection on 08 and 10 June we had identified that people's rights were not protected by assessments under the Mental Capacity Act 2005 (MCA) when they were required. We were given assurances by the provider at the time of the inspection that assessments would be undertaken and referrals made where individuals needed external input. For example decisions about whether people should be resuscitated in the event of their collapse were not made following the legal guidelines, meaning their wishes may not be respected. Staff had received training on the requirements of the MCA, and the associated Deprivation of Liberty Safeguards. However, care records showed that staff had made decisions as to people's capacity without being qualified to do so or with the involvement of other professionals. One person's record stated, "[Name] can make simple decisions but does not have the mental ability to make complex decisions." There was no assessment to evidence this statement within

their care records or any record of decisions that had been made to provide care in their best interests. There were no assessments in place to indicate who had the authority to make complex decisions on their behalf. Key decisions were not appropriately recorded within the correct legal framework with forms being signed by individuals who did not have the legal authority to do so. We raised this with the acting manager and they acknowledged that further work was needed to address this

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

Whilst a GP visited the home on a regular basis and saw the people living at the service, visiting health professionals found people had not had their healthcare needs identified and treated in a timely way. Although a visiting GP had told us that there had been recent improvements in the level of care, one person was identified as being unwell and visiting professionals had to intervene. They had to call for medical care as staff at the service had failed to identify deterioration in their condition. The person was subsequently admitted to hospital.

Another person who only had sight in one eye was found by visiting healthcare professionals to have an untreated eye infection which meant they were unable to open their other eye. The person was unable to see at all as a consequence.

For another person the staff had called a tissue viability nurse to advise them on the management of a person's wound yet they had failed to deliver the care prescribed. This information was in the person's record but care plans and information for care staff on new timings of position changes had not been implemented. This left the person at risk of further skin breakdown.

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

Is the service caring?

Our findings

Although a relative told us that they were "Happy with the care", people told us that the staff were not caring and their dignity and respect was often compromised. One person told us how staff had ignored them banging on the window to be let in from outside. Another person communicated that they had been given medication that they didn't take but staff had ignored them and forced them into their mouth. Staff continued to do this even when they spat them out, so in the end they had to swallow them; they didn't know what they were for.

Staff spoke to people across the lounge without approaching the person and responding to them directly. The conversation was therefore shared amongst everyone in the room, was not personalised and gave no opportunity for private comments, questions or discussion. Staff engaged in tasks without any dialogue with the person concerned, such as removing dinner plates and drinks without asking people if they had finished. Opportunities for positive social interaction and inclusion which demonstrated an interested and caring approach were missed because staff focussed on completing tasks rather than on the person.

Another person told us, "I wasn't properly put to bed. I asked for a nurse but they said they had got something better to do. They were dealing with other patients and I was left in my room like a naughty child. It was degrading." They also told us, "I was left in an armchair from nine thirty in the morning until five or six at night without being moved. My bottom was killing me and I was dying to go to the toilet. They knew but forgot and would not let me go to the toilet and said I had to use a bed pan. It was too embarrassing for me."

Additionally staff did not always have regard for people's dignity. For example, when a visiting professional asked that a person be provided with assistance with their personal care, staff told them they would sort the person out later when the person went to bed. This meant the person would have been left in soiled clothing for several hours in an undignified situation but also at risk of urine and faecal burning of the skin. Healthcare professionals informed us that during their assessments of people they had identified that some people had skin with evidence of urine burning.

Another person who was extremely frail and unable to see did not have access to their call bell as it had been removed. They couldn't summon assistance as their room was located at the end of a corridor and their calls for help were less audible and ignored by staff. When this was pointed out a call bell was provided.

Professional visitors also shared their concern about how people's privacy and dignity was not being respected at the home. They had witnessed a commode being placed in the centre of the lounge and people who required the toilet were placed on the commode and screens pulled round whilst they used it. They had intervened to stop this. Staff did not understand why this should not happen. In another case a person shared that they were made to feel "Totally embarrassed" by an aspect of their care which staff did not recognise or respond to with any empathy or understanding.

The provider had not ensured that the service was caring because they had not recognised the poor practice in relation to people's rights, privacy and dignity. They had not taken any action to ensure that people were treated in a respectful manner.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Is the service responsive?

Our findings

People were not safeguarded from abuse and improper treatment. People told us they did not receive the care and support they needed at the times that they wanted it. One person told us, "I don't get my night time tablets until 12.30 or 12.45 in the morning." They went on to say, "Every night is the same. I am always the last." They also said they needed to be assisted with a two stage procedure on a daily basis to manage a specific condition but that the second stage did not always happen." They told us that being left to soil themselves was degrading for them. A relative told us, "I am concerned about the toilet arrangements. It is a long time between them coming to see [relative]. Sometimes they wet themselves

Healthcare professionals assessing one person's needs identified that they had an untreated grade 4 pressure ulcer. This level of ulcer being the most invasive of body structures and required planned nursing intervention to manage healing. This person had no care plan in place and no wound management plan to aid healing and to prevent the risk of infection. This lack of treatment left them at serious risk of harm. The healthcare professionals had to intervene to dress the wound and to detail a plan for the wound management.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they were not supported to maintain their hobbies and interests. One person told us, "I would like something to do. I have only had one film since I have been here." There was an activities coordinator at the home but there was little interaction between them and the people who were sitting in the lounge area of the unit they were on. They increased the volume on the television, although no one had requested that this be done. They failed to check whether people wanted to watch the programme that was on or indeed wanted the television on

at all. Throughout the afternoon a sports programme was playing but no one sitting in the lounge area was engaged with it, it did not prompt any discussion or comment within the group.

People and their relatives told us that they had been involved in deciding what care they were to receive and how this was to be given. One relative told us that they were aware of their relative's care plan but were not involved in any reviews of this as it was dealt with by another relative. The care records we looked at confirmed that assessments of people's needs had been made before they had been admitted to the home. However the care plans did not always reflect all the person's needs. One person was receiving one to one care, but this was not specifically supported by their care plan. Other care plans we looked at had not been reviewed on people's return to the home following an admission to hospital so it was not clear if their needs had changed.

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

People told us that they were aware of how to make a complaint. One person had been in the process of making a written complaint to the senior staff at the home when we spoke with them. They handed the complaint to an inspector who handed this to the acting manager. Later in the day the acting manager and one of the deputy managers confirmed that they had spoken with the person and were looking into their concerns.

One visitor told us that some staff didn't understand the communication needs of people and a person had been left without their request being answered. They did raise this and felt action had been taken to address their complaint.

Despite a complaints process being in place the opportunities for people's views to be listened to were limited. The provider had failed to recognise poor care and had not taken opportunities to talk with people using the service to find out their views and act on any shortfalls to improve people's experience.

Is the service well-led?

Our findings

At the time of our June 2015 inspection we were given assurances by the provider that they would take action to make improvements at the home. However we received information that the service was not making the necessary changes to improve the quality of care. After the first day of the inspection we were so concerned we wrote to the provider asking them to tell us urgently of the actions being taken to address our concerns. This action plan was not submitted by the timescale of 06 August 2015. We also shared our concerns with other statutory agencies.

On the 03 and 06 August inspection there was a continued breach of regulation 17. The registered manager continued to be absent and the management team were unable to implement or sustain improvements. Whilst training had been offered and staff confirmed this, it was evident from our findings during the inspection, and those of other health and social care professionals at the home that staff had not taken learning from it. The culture within the home was not positive as staff did not understand or recognise how their poor practice affected those who were reliant on their care. The leadership had been unable to secure staff acceptance of the need to make changes. This left staff providing very basic task orientated care, which neither met the health or social care needs of people.

Staffing levels were inadequate and on the 05 August the home was completely dependent on care being delivered by agency nursing staff who were unfamiliar with some of the complex care people needed. They were not supported by up to date and current care plans, despite our previous findings that care plans were significantly out of date and action was needed. This left very vulnerable people at risk of inadequate or unsafe care.

There was no action plan in place to address the concerns we and other professionals had raised. The staffing arrangements were not stable and continued unacceptable practice by staff was apparent.

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

We found that there was a general disregard at director level of the importance of ensuring that the service was safe and run in the best interests of people using it. For example despite identifying to the provider that they were

breaching regulations on safe recruitment at our June 2015 inspection, a cleaner had been recruited by one of the company directors without the manager's knowledge. The person had not been recruited correctly and within the necessary recruitment processes in place to protect people. We spoke with the provider's nominated individual about this unacceptable practice on 04 August and received assurances that the director would no longer be involved, yet on 06 August a further person attended the home having also been recruited by the same director without any proper process having been followed. They were again sent away. The manager informed us that the service did not have any cleaner vacancies. Despite assurances that the director concerned would step back from being involved on a day to day basis they continued to attend the home between the 04 and 06 August and continued to be at the home and actively involved directing staff.

We saw that the leadership of the service was chaotic with directors of the company undermining the attempts by the management team to introduce changes and yet sought to blame them for the failings. There were overwhelming systemic failures which had led to the serious shortfalls in people's care with the potential for serious harm to come to people who were vulnerable because of their dependence on others to meet their needs. The provider had failed to ensure that there were robust governance systems in place that worked to pick up shortfalls and improve the quality. Audits that did take place were not effective at identifying the root cause of issues and putting in actions to address them effectively.

In addition the provider was unable to work effectively with healthcare professionals who attended the home to review the care needs of people living there. They advised that the provider actively shared information with staff that unsettled the arrangements and destabilised the cover that the management team had tried to put in place. On 06 August 2015 the management team shared with healthcare professionals that they felt unable to remain at the home any longer. When we attended to inspect the service they had agreed to remain in the short term however the situation remained fragile and they were unable to make any commitments about the actions they would take to secure the stability of the service.

This was a breach of Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.