Mrs Bimla Purmah

Angel Court Residential Care Home

Inspection report

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West Midlands
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Tel: 01922633219

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13 November 2018

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 16, 17 October and 13 November 2018. At the last inspection completed in June 2018 we found the service was rated as 'requires improvement'. They were not meeting the regulation around effectively managing and governing the service. The service left special measures due to the improvements identified during that inspection. At this inspection we found the provider had failed to sustain and continue making improvements. The quality and safety of care provided to people had deteriorated significantly. They continued to fail to meet the regulation around effectively managing and governing the service and we identified further breaches of regulation. The service re-entered special measures.

Angel Court Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing 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. The care home accommodates up to 25 older people. At the time of the inspection there were 23 people living at the service, many of whom were living with dementia.

People were not protected from the ongoing risk of potential abuse. The provider had failed to ensure robust systems were in place to identify potential abuse, ensure it was reported and investigate the concerns. The provider had failed to ensure robust plans were in place to protect people from further harm. People were also exposed to the risk of harm due to the provider's failure to ensure their risk management processes were robust. People did not always receive topical creams as prescribed. People were also not protected by effective processes to control the risk of infection.

People were not supported by sufficient numbers of suitably trained, experienced care staff. The provider had failed to ensure training and supervision was effective and equipped staff with the skills they required to support people.

People's human rights were not upheld by the effective use of the Mental Capacity Act 2005. People's day to day health needs were not always met and instructions given by healthcare professionals were not always followed. People's nutritional needs were not always fully understood and monitored by care staff.

People were not supported in a caring, dignified and respectful way. People's independence was not always promoted. Effective systems were not in place to ensure people were communicated with effectively and given maximum choice and control.

People were not always fully involved in the development of their care plans. People's needs were not always fully assessed and care delivered was not always in line with individual needs. People were not given access to sufficient activities and leisure opportunities tailored around their unique preferences.

People were not being supported in a service run by a provider who was keen to improve the quality of

service provided to them. People were not protected by robust governance and quality assurance systems. The provider continually failed to identify the areas of improvement required within the service. The provider did not proactively seek feedback from a range of sources with a view to identifying where improvements could be made and constructively use this feedback to improve the quality of care provided. The provider failed to recognise and take responsibility for the failings within the service.

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.

The provider was in breach of the regulations surrounding person-centred care, dignity and respect, the need for consent, safe care and treatment, staffing, effective governance and fit and proper persons employed. You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to the more serious 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 were not protected from the ongoing risk of potential abuse. People were also exposed to the risk of harm due to the provider's failure to ensure their risk management processes were robust.

People did not always receive topical creams as prescribed. People were also not protected by effective processes to control the risk of infection.

People were not supported by sufficient numbers of suitably trained, experienced care staff.

Is the service effective?

Inadequate

The service was not effective.

The provider had failed to ensure training and supervision was effective and equipped staff with the skills they required to support people.

People's human rights were not upheld by the effective use of the Mental Capacity Act 2005.

People's day to day health needs were not always met and instructions given by healthcare professionals were not always followed.

People's nutritional needs were not always fully understood and monitored by care staff.

Is the service caring?

Requires Improvement

The service was not caring.

People were not supported in a caring, dignified and respectful way.

People were not communicated with effectively and given

maximum choice and control. People's independence was not always promoted.

Is the service responsive?

Inadequate

The service was not responsive.

People were not always fully involved in the development of their care plans.
People's needs were not always fully assessed and care delivered was not always in line with individual needs.

People were not given access to sufficient activities and leisure opportunities tailored around their unique preferences.

Is the service well-led?

Inadequate

The service was not well-led.

People were not protected by robust governance and quality assurance systems.
People, staff and others were not fully engaged in the development and improvement of the service.

The provider failed to recognise and take responsibility for the failings within the service.

Angel Court Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 16, 17 October and 13 November 2018 and was unannounced. We completed the third day of inspection as we received further concerns following our initial visit about the quality of care provided and staffing levels within the service. The inspection team consisted of three inspectors, an assistant inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

As part of the inspection we reviewed the information we held about the service. We looked to see if statutory notifications had been sent by the provider. A statutory notification contains information about important events which the provider is required to send to us by law. We sought information and views from the local authority. We also reviewed information that had been sent to us by the public. We used this information to help us plan our inspection.

During the inspection we spoke with 11 people who used the service and four relatives. We spoke with the registered manager who is also the provider. A new manager was in post during the first two days of the inspection who we spoke with. They were no longer in post when we returned for our final day of inspection. We spoke with two health and social care professionals and 17 members of staff including the cook, care staff and two senior care staff who were acting deputy managers. We carried out observations across the service regarding the quality of care people received. We reviewed records relating to people's medicines, 13 people's care records and records relating to the management of the service; including recruitment records, complaints and quality assurance records.

Inadequate

Is the service safe?

Our findings

At the last inspection completed in June 2018 the provider was rated as requires improvement for this key question. At this inspection they had failed to make the required improvements and the quality of service had declined. We found they were not meeting the regulations around safeguarding people, safe care and treatment and ensuring there were sufficient numbers of suitably skilled care staff.

People told us they did not always feel safe within the service. One person told us, "I should feel safe here shouldn't I?! You should feel safe in a place like this but I don't. I have had someone come into my room at night. I am frightened but I tell them to get out." We looked at people's daily care records and there were no incidents of people entering into other people's rooms recorded. However, we observed one person entering into someone's room during the inspection. Care staff also confirmed that people could enter into other people's rooms. We looked at the care plan for the person we saw walking into another person's room and saw this behaviour was known. Their care plan confirmed they could enter into rooms and it stated they could move and take personal possessions. We saw there were no guidelines in place around how to manage this behaviour to prevent distress to this person or others. Despite care staff intervening in the incident we saw they did not document this incident and it was not reported to management. As a result, appropriate investigations were not completed and action was not taken to safeguard people from further distress.

We found people were not safeguarded from potential physical harm or emotional distress due to the poor management of behaviours that could challenge. We observed multiple incidents during the inspection where people threatened others; some of these were threats of physical violence. We found these incidents were not documented by staff and they were not reported to management or the local safeguarding authority. Investigations had not been completed and action was not taken to safeguard people from harm. We spoke to the social worker for a person involved in the altercations we saw. They confirmed the events we saw had not been reported and staff were not able to recall the nature and frequency of the events we described. Appropriate action had not been taken to safeguard people from further harm.

Care staff we spoke with were able to describe signs of abuse and how they would report these concerns. They were also able to describe how they would recognise incidents involving behaviours that could cause harm or distress as potential safeguarding concerns and how these would be reported. However, we found in practice, these concerns were not being recognised as potential safeguarding issues. They were not reported and recognised and the provider had not developed systems to ensure people were protected from the risk of ongoing harm. As a result of the failure to recognise that these incidents resulted in people being exposed to harm or the risk of harm no action had been taken to mitigate the risk of incdients reoccurring.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment

People did not share their views around how safe they felt within the service. A relative however told us, "We

do not think this place is safe for [our relative]". We looked at how the provider ensured people were kept safe from harm while living in the service and found significant concerns about the provider's risk management systems.

People were not sufficiently protected from the risk of physical or emotional harm due to the poor management of behaviours that could challenge others or that indicated distress. We saw multiple incidents during the inspection of people having altercations with other people within the service. This included multiple threats of physical violence. We saw care staff did not have the skills to safely deal with these incidents when they arose, they were not recorded and no consideration was made to the required actions to prevent reoccurrence of these incidents. We saw some people's care records stated they had been in a 'good mood' and there were no concerns when we had observed behaviours including threats to others. Care staff we spoke with did not understand how to identify triggers of behaviours which may assist in preventing incidents from arising. They also did not understand how to safely manage these incidents when they did occur. For example; one member of staff told us they would get in the middle of two people if they tried to hit out at each other, which could potentially have caused them personal injury and would not deescalate the behaviour. We saw care plans did not contain guidance around how to manage behaviours safely. We were told by staff that care staff had recently completed training regarding the safe management of challenging behaviour. We found from our observations and discussions with care staff this training had not equipped the staff team with the skills they required. The provider had failed to ensure there were robust plans in place that protected people from the risk of ongoing harm. They had failed to ensure that all incidents arising were recognised, reported and used to gain knowledge about how risks could be managed in the future.

People were not protected from the risks associated with skin damage. We found four people had breakdown or damage to the skin which had not been managed safely. Care staff we spoke with were not aware of who had damage to the skin and what action they should be taking to support these people safely. For example; one person had skin damage noted within their care records and we saw a healthcare professional had been consulted. The professional had advised the person should be repositioned every two hours and that their heels should be lifted when they were in bed. The person's care plan did not reflect this requirement, care staff were unaware of the requirement and the person's care records confirmed this had not been completed. We saw other people had seen health professionals regarding skin concerns, care staff were not aware of these people's needs and their records did not reflect the required care had been provided. This included the application of creams to areas of damaged skin.

We found people were not sufficiently protected from risks that may arise in the event of a fire. Care staff we spoke with were not able to tell us what action they should take in the event of a fire. One staff member told us there were zones within the building that people should be moved to which would allow time for the fire service to arrive. All other care staff were not aware of these zones and told us they would evacuate people but were not sure how they would do this safely. One staff member said, "I haven't been told [about fire safety plans]. Another staff member said, "If they had a wheelchair we'd get them down step by step", which could cause the risk of increased harm to both the person and themselves. We saw people had Personal Emergency Evacuation Plans (PEEPs) in place although these contained directions to use safety equipment that was not present in the service. We saw these evacuation plans advised that everyone would need the assistance of at least one member of staff to be evacuated in the event of a fire, however there was no plan in place to outline how this would be achieved given there was only a maximum of four care staff on duty at any time. We saw an overall fire evacuation plan was in place although this was not clear and contained several methods of evacuation without specifying in what circumstances each should be considered and used. We saw a prior fire safety audit had been completed by an external company and had identify numerous areas of significant risk. The provider did not provide us when asked of clear evidence to confirm

these actions had been addressed. Because of the issues we found, we notified the Fire Safety Officers at West Midlands Fire Brigade of our concerns.

People were not always able to share their views around how care staff managed their medicines. One person told us, "I have to take tablets and I just take what I am given. They do it – I don't know what for." We found the provider was not ensuring that medicines were consistently managed effectively. Care staff we spoke with did not always have the knowledge they required around people's needs and what action they needed to take in the event of concerns, for example, refusals of medicines. Where there were concerns about the effectiveness of people's medicines, advice had not been sought from appropriate professionals. For example; one person was prescribed sleeping tablets at night. Care staff told us, and records confirmed, that the person rarely slept well at night and was awake walking throughout the home at night. Care staff had not consulted the person's doctor to seek further advice as their medicines were not being effective.

While we saw areas of good practice within the medicines management within the service we found there were issues with the management of the administration of creams. During the first two days of the inspection we raised concerns that the administration of creams was not being recorded. There were no current medicines administration records (MARs) in place. When we had looked at the prior month's records we saw that creams were not always being administered as prescribed. Where creams were to be administered on an 'as required' basis there was no guidance in place for care staff around when, where and how the creams should be applied. When we returned on our third day of inspection we found no improvements had been made. We found creams were also not being administered where people had skin damage which could result in the risk of further damage to the skin of these individuals. The provider's systems had not identified these concerns resulting in people people exposed to the risk of harm. We saw some people were self administering medicines although robust risk assessment was not in place to manage any associated risks. The provider's medicines audit stated there was only one person within the service who managed their own medicines. However, we saw from medicines administration records that four person administered their own creams. Care staff told us how another person administered all of their own medicines and another administered their own thickener that was added to their drinks. We saw one person who administered their own medicines had tablets in a glass on a table in their room and were not securely stored away. This posed a risk to others as we were told people wandered into the bedrooms of others. This risk had not been assessed by the provider and the management of people's prescribed medicines required strengthening.

The provider was not managing risks associated with people's nutrition effectively. People's needs around texture modified diets and the use of thickeners in drinks to prevent choking were not clearly identified and followed. We saw where there were inconsistencies in staff knowledge and care records for one person which could pose the risk of unsafe food items or drinks being given to them, this had not been identified. We saw this person, who it was confirmed, required thickener in their drinks being given a drink without any thickener. This increased the risk to the person of choking. We saw multiple people within the service were losing weight. Care staff were not aware of who was losing weight within the service or the actions they should be taking to safeguarding these people. When we returned for the third day of our inspection, we saw some improvements had been made to the recording of people's food intake. However, these records were not being monitored and care staff continued to lack knowledge around who needed additional monitoring, support and who was continuing to lose weight.

We found the provider was failing to protect people against the potential risk of the spread of infection. Care staff we spoke with were not aware of who the infection control lead was within the service. We found areas of the service were unclean, multiple toilets did not have soap available within them throughout the inspection and had open bins without lids. We found cleaning records were not completed during the first

two days of our inspection. We saw records had been implemented when we made our final visit although these were not completed and they were not monitored by the provider. We found some areas within the service had an overpowering smell of urine. These rooms were unoccupied during the inspection and the provider gave assurances they were replacing flooring. We found the laundry did not have separate areas for incoming soiled laundry and clean laundry.

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

We looked the provider's recruitment systems to see how they ensured appropriate staff members were employed. We found the provider did not have safe systems in place to ensure effective pre-employment checks were completed. We saw the provider was completing basic checks such as reference checks and checks with the disclosure and barring service (DBS). DBS checks enable an employer to review a potential staff member's criminal history to ensure they are suitable for employment. We found where staff had disclosure regarding their criminal history, suitable risk assessments were not completed and safeguards were not always robust to ensure people living in the service were protected. We found references were not always completed with the aim of checking a potential employee's suitability to work. The provider had failed to ensure a full employment history had been obtained. They had failed to ensure that a reason for leaving was sought and obtained where staff had worked in care previously. They had also accepted references provided by managers and employees of Angel Court that had previously known potential staff members rather than seeking robust references from the employer. We also found where volunteers were engaged, the provider had also failed to ensure the appropriate checks were completed. They had failed to assess if they were suitable to work with vulnerable people. The provider had failed to ensure people were suitably protected.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Fit and proper persons

People were not able to share their views around staffing levels in the service. Staff members gave us mixed views on staffing levels. Some staff told us they felt there were enough although others told us there were not. Night staff told us they did not have enough staff when they needed to support someone who required two care staff as there were only two staff on between 8pm and 8am. They said they were sometimes not able to support those in communal areas as they were supporting others. These staff told us that multiple people already up at the point of this discussion had required two staff members to support them. We confirmed this when we reviewed rotas and daily care records for these periods. Some care staff told us the new manager had taken action to improve staffing levels. However, when we returned on the third day of our inspection this manager was no longer in post. We saw the staff signing in sheet demonstrated there had been less staff members working on multiple days leading up to the inspection than the provider stated were required to keep people safe. A staff member confirmed this was reflective of the situation within the service.

We saw the registered manager was not always ensuring there were sufficient numbers of suitably skilled staff available to support people. On the first day of the inspection we saw that two of the staff on shift were new to the service and had less than a week's service. They had not yet received any induction training or competency assessments from the provider. A third staff member on shift was an apprentice who required supervision and support. While the provider stated they had sufficient staff as they required four care staff to provide support to people, we found most of the staff were not sufficiently experienced and trained. We saw this issue remained when we returned on the third day of inspection. We found the apprentice who required support and supervision for all aspects of personal care was being supported by a new staff member who

again had received no induction or other training from the provider. The person they were supporting was shouting out to say one of the staff members was hurting her while they were supporting her to get dressed. The provider had failed to ensure people were supported by sufficient numbers of suitably skilled and experienced care staff.

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

Inadequate

Is the service effective?

Our findings

At the last inspection completed in June 2018 the provider was rated as requires improvement for this key question. At this inspection they had failed to make the required improvements. We found they were not meeting the legal requirements around ensuring the appropriate legal consent to care had been obtained and that care staff had the skills and knowledge needed to care for people effectively.

Staff were not supported to develop the skills and knowledge that they required to provide effective, skilled care and support to people. We saw from staffing information given to us by the provider that over a third of the staff team had started within the last three months of our inspection. Half of the staff team had started within 12 months of the inspection. Care staff told us the induction given to staff was brief. One staff member told us their induction took, "About 20 to 25 minutes". They told us that so many topics were covered they could not recall the content. They said, "[The provider] covered a lot of things, I can't remember". Care staff were not aware of the Care Certificate which is a national quality standard for the induction and basic knowledge care staff should have in order to provide effective care. We saw from staff records that the induction of staff was completed and signed off within a day which does not fall in line with the comprehensive 12 week requirements of the Care Certificate. Some care staff did not have any induction recorded or signed off within their records.

Care staff gave us mixed views around the training and support they received overall. One staff member told us they felt training was okay. Another staff member however told us they felt they had little training and support. They told us they felt the only things they learned were those they went and sought out themselves. We looked at the training records given to us by the provider and saw that multiple key areas of knowledge had been delivered in a one day training session. For example; moving and handling, infection control, health and safety, food hygiene, medication, safeguarding, Mental Capacity Act, Dementia, First Aid, Fire, Equality and Diversity were all delivered in one day. This would mean that these topic areas would not be covered in any detail and this was reflected in the poor care delivery we saw during our inspection. We saw care staff did not have the skills and competence required to support people effectively. We found new care staff had not received any training by the provider and the provider had not yet obtained evidence of their training from prior employers. We found the cook had not completed food hygiene training with the provider and they did hold a valid certificate from their prior employer. We confirmed with the provider they did not have a structured programme of competency checks in place to ensure care staff were providing effective care. One member of staff said the management did not complete competency checks and told us, "We check each other on shift". The provider had failed to ensure there were systems in place to ensure care staff were providing safe and effective care.

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to

take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). 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 had the appropriate legal authority and were being met.

Care staff we spoke with did not understand the basic legal requirements of the MCA and how they should make decisions on behalf of people who lacked capacity. We saw one person was refusing several medicines and told the inspection team they were feeling pain. The medicines they were refusing may have alleviated the person's pain. Care staff told us they were not certain if the person had capacity to understand their medicines could help with their pain. Despite this uncertainty, care staff had not followed the steps to assess the person's capacity. In the event they determined they lacked capacity, they had not taken steps to make a decision to protect the person in their best interests in line with the law. We saw one person was receiving medicines covertly and the steps required by the MCA had not been followed. Staff we spoke with were not aware of the legal requirements they needed to meet in order to administer medicines covertly. We found numerous other decisions had been made about people's care without the correct steps being followed under the Mental Capacity Act (MCA). This included the use of bed rails, sensor mats and people's personal care. The provider confirmed one person refused to eat certain food types and wanted to eat food that increased their risk of choking. The provider confirmed the person lacked mental capacity to understand the risk they posed to themselves, although they had not taken the steps required by the MCA to make a decision in this person's best interests.

We found staff were accepting authorisation and consent around people's care from those who did not have the required legal authority to provide this consent. Care staff told us one person's daughter made all of their decisions on their behalf. We found this family member did not have the legal authority to make these decisions. The provider, when asked, was not able to confirm who had a Power of Attorney (PoA) in place and began to obtain this information during the inspection. They had not considered who should be lawfully providing consent prior to taking direction around decisions for those who lacked capacity.

This was a breach of Regulation 11 of the Health and Social Care Act Need for Consent

We saw the provider had made applications to deprive some people of their liberty in order to protect their health and wellbeing. However, and staff team did not fully understand the reasons they were making these applications. Some care staff told us they would apply for a DoLS when they had made a decision in someone's best interests and did not realise they may not be depriving the person of their liberty. Care staff we spoke with also did not have an understanding around who within the service had a DoLS in place or in progress. Care was being delivered in a restrictive way without care staff understanding if these restrictions were lawful or not. We saw many applications to deprive people of their liberty had been granted by the local authority. However, the knowledge of the staff and management team was insufficient and put people at risk of unnecessary restrictions.

People were not always happy with the food they ate. One person told us, "I hope the food is hot today, I don't like it cold and it usually is." Another person told us they preferred brown bread and this was not made available to them. We saw people were given a choice of two meals at lunchtime but they were not involved in designing the menus that were available within the service. We saw people's basic nutritional needs were mostly being met although multiple people were gradually losing weight within the service. We highlighted this concern during the first and second day of the inspection and improvements were then made to food monitoring records. However, during our final day of inspection we found care staff were still not aware of

who was losing weight and whose food intake should be monitored. We found people continued to lose weight and this weight loss was still not being picked up by the provider. Care staff were not always aware of people's support needs and we saw the support people received during mealtimes was not always effective. Some people were left sitting without support with full plates of food and their meals were taken away without any assistance from staff being offered. Some of these people had concerns with the stability of their weight. People were not always being supported effectively to ensure their nutritional needs were met.

People mainly were not able to share their views around the support they received to maintain their day to day health. However, one person told us, "I don't see the doctor. Only once when I came in. I think that's bad, I think we should be checked on especially as feel awful today and my head is bad." Another person told us they had a headache although when we offered to get support from care staff for them they told us, "No point!". We found staff did seek support for people from healthcare professionals although this was not always as prompt as it could be. They also did not always follow instructions given by healthcare professionals effectively. For example; staff had arranged for one person to see a medical professional as they were refusing medicines and told us they were in pain. However, they would not see the professional for five days and care staff had not considered how the person's needs could be managed during this time. We found further examples of where professionals such as district nurses and speech and language professionals (SaLT) had given instructions relating to people's skin integrity and nutrition and these were not being followed by care staff. People were not always supported effectively and proactively to manage their day to day health needs.

We saw the environment within the service was not in line with best practice guidelines around dementia friendly environments. We found decoration within the service was poor and maintenance was not prioritised by the provider. For example; we found a toilet door had a broken lock during our initial visit, and this remained during our last day of inspection. We saw examples of people's dignity compromised as a result and this had not been identified by the provider and recorded in the maintenance records for repair. We saw a broken set of empty drawers in the corner of the lounge during the first two days of our inspection and this also remained during our final visit. We saw while some rooms had a photo of the person who lived there on the door, others did not. Signage was poor and did not help promote the independence of people living at the service.

Requires Improvement

Is the service caring?

Our findings

At the last inspection completed in June 2018 the provider was rated as requires improvement for this key question. At this inspection they had failed to make the required improvements and we found the provider was not meeting the regulations regarding dignity and respect.

People gave us mixed views around how caring the support was that they received from care staff. One person told us, "It's OK here and they look after you and help you if you ask. If I have a bath they wait outside the door". Another person told us, "They do not look after me at all well here and I feel very ill today." We saw while most staff were supporting people with good intentions, they did not have the skills to recognise when care delivery was not dignified or respectful. For example we saw one person walking across the communal lounge to the toilet with a large wet patch where they had been incontinent of urine. Care staff provided support for this person to go to the toilet. Two members of care staff had a conversation through an open toilet door while this person used the toilet. We then saw the person supported to walk back across the lounge with the large wet patch remaining on their trousers.

We saw multiple further examples of people's dignity being compromised. For example; everyone within the service was required to eat from plastic plates and to drink from plastic cups. We asked a member of staff if they were aware of a safety requirement for this and said not. We saw one male within the service was given a child's pink plastic cup with a children's image on it and we confirmed with a member of staff that a baby's double handed cup was used for another person to drink from. We saw people's quilts and bedlinen were thin and worn. We saw people's ensuites did not always have towels available for them. We saw one person's pyjama bottoms had their name visibly written in black ink on them. We saw care staff had not been equipped with the skills to communicate with people in a dignified and respectful way. One person was becoming agitated waiting for their lunch and was told by care staff, "You're not the first and not the last". We saw further examples of care staff infantilising people, for example, when people displayed behaviour that could challenge others or indicated their distress. We saw care staff chastising people for their behaviour and saw care plans required people to apologise for their actions.

On the third day of our inspection we saw no improvements had been made. One person was seen to be sitting in very dirty clothes at 6.45am and remained in these clothes until 8pm that evening. We also saw this person sitting in a communal area with their continence pad visible above their trousers and staff failed to recognise this. We saw one person walk in on another person using the toilet on the ground floor where the provider had failed to fix a broken lock. We also saw multiple examples of care staff communicating with people in a disrespectful way. For example; we saw one staff member waking people up for no reason and then walking away. We saw another staff member tell a person who was distressed and had just been involved with an altercation with another person they did not have time to speak with them as they needed to complete paperwork.

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

We saw the provider had not ensured people were communicated with in an effective way that maximised their independence and enabled them to be fully involved around choices about their day to day care and activities. While we saw Punjabi speaking staff were available within the staff to assist with communication for Punjabi speaking people; we saw the communication needs of others had not been considered. For example; another person spoke another language and their communication needs had not been considered. An external activities person was in the service and care staff had not made them aware the person did not speak English.

While we saw some examples of positive interactions between care staff and people. For example we saw when one person was transferred using a hoist that care staff took their time and explained to the person what they were doing and why. We saw other examples that were not positive and demonstrated a lack of consideration for people within the service. We saw TV channels were selected without consulting people within the room. We saw the provider opened a cupboard catching someone on the back of their head. This was barely acknowledged despite the person saying, "Ouch, I would like to keep my head, thank you!". We also saw the cleaner spraying air freshener heavily in corridors and heard one person commenting on the 'awful' smell.

We saw people were supported to be in contact with their families and to receive support from them around their care and support needs. People's relatives and those who were important to them were able to visit the service without any unnecessary restrictions.

Inadequate

Is the service responsive?

Our findings

At the last inspection completed in June 2018 the provider was rated as requires improvement for this key question. At this inspection they had failed to make the required improvements. The provider was not meeting the requirements of the law around providing person-centred care.

Most people we spoke with either were not able to share their views or were not aware of their care plan. One person who care staff told us had full mental capacity did tell us they had been consulted about their care. We found care staff had begun to work through care plans in order to make improvements, however, these improvements were ineffective. For example; one staff member told us they had worked through one person's care plan to remove inconsistencies and we saw this had been updated. We found as staff were underskilled these updates were not effective. This revised care plan did not effectively outline the person's needs and care staff were not aware of the content. One part of the care plan stated the person had a DNACPR in place. This is a formal, legal instruction to say the person should not be resuscitated. We saw the legal documentation was not present in the person's file. Following investigation, the provider confirmed this was an error and the person did not actually have a DNACPR. This inaccuracy in the care plan could have resulted in someone not attempting life saving action.

We saw further examples of where people's needs had not been appropriately assessed, their personal preferences or needs were not considered and where care staff did not fully understand their needs. For example, on the first day of the inspection we saw nine people were up in the lounge at 7.15am fully dressed. Following concerns being received about people being got up at 5am against their wishes and our initial observation, when we returned on our final day we looked into this concern further. When we arrived at the service at 6.45am, seven people were up and fully dressed. Despite care staff advising that they would only get people up if they wished to rise, we saw care records that contradicted this. For example; one person's care plan stated they liked to wake at 9.40am. Another person's care plan stated they liked to wake between 8.30-9.30am. We saw an incident record for the day prior to our inspection that outlined someone had demonstrated 'aggressive' behaviour towards care staff when they tried to assist them to rise at 5.45am. When we raised this issue with the provider they did not provide assurances that this practice would be addressed.

People were not able to share their views around whether the personal care provided was in line with their preferences. However, we found from what care staff told us and by reviewing records that people's preferences were not taken into account. On the first day of our inspection the domestic staff told us they were required to assist someone with a shower that day. As they left for the day they told us, "No I haven't had time he will have to wait till Friday". This meant a wait of a further three days. Another staff member told us when the new manager had been in post for a short time they had made improvements in this area. They told us, "When [manager name] was here, he was improving different areas… He was offering people a shower every day". On the last day of our inspection we saw a staff member walking round with a napkin with four names listed on it. They told us they selected a few names each day and would offer a bath or shower. If these people refused they would simply select someone else at random to offer this to. The provider had failed to ensure that the preferences of people drove the care practice within the service. They

had failed to ensure people's preferences were understood and support was offered that was in line with these preferences.

Care staff did not know and understand people's unique needs. We saw one person's care plan outlined they had become fearful of their religion and we confirmed this with the person's social worker. We asked multiple staff members about this person's religion and beliefs and nobody was aware of this issue. One staff member said, "I'm probably not the best person to ask". Another person's care plan indicated their legs should be elevated. We asked a member of staff if this was accurate and they confirmed it was. We saw throughout the inspection care staff did not encourage this person to elevate their legs despite them being swollen. Another person's care plan outlined that English was not their first language. It said they could understand a few basic phrases of English but otherwise communicated in their first language. We asked a member of care staff about this and they told us the person spoke very little English and mainly spoke in their first language. We asked how the person communicated their needs and they shrugged and said they were not certain. We observed this person's communication following this and attempted communication and found they did not communicate in English. We raised this concern with the provider and they did not accept that this was a concern. After discussion they did agree to try to obtain some picture cards and develop some basic phrases that would aid their communication.

We saw one positive example of someone's advance wishes regarding their medical care were planned for and respected due to their religious beliefs. Overall we saw people were not respected as individuals, very minimal information was known about people's life histories and little action was taken to understand and support people maintain their beliefs. One person told us, "I devoted my life to the church and I am a roman catholic. The priest used to come and see me…he doesn't come now and I really miss that". We found the service had not considered if people may be lesbian, gay, bisexual or transgender (LGBT). While there was reference to sexuality in the equality policy, there was explicitly no reference to this within the provider's statement of purpose or within care plans.

People told us the provider had not ensured leisure opportunities were developed around their personal preferences. One person told us a planned cinema trip had not taken place as the new manager had planned this then subsequently left. Another person told us before they moved to the home they had liked to go out, play cards and play dominoes. They told us they only watched television now they lived at the service. A third person told us there were not many activities so they made their own entertainment. We saw from another person's care plan they had enjoyed bird watching prior to living at the service. No effort had been made to support this person to continue this hobby. Care staff we spoke with told us there wasn't enough for people to do within the service and this mirrored our observations during the inspection. One staff member said, "It's one of those homes where everyone sits there, they don't do anything". We saw minimal staff interaction with people during the inspection. We saw there were some efforts by care staff to complete activities such as painting nails. We also saw on the third day of the inspection a volunteer activities coordinator was working within the service. However, the activities planned were not based around a structured plan built around people's individual preferences. We did see that an outside activities company had been engaged for the first time on the final day of the inspection. People did engage and appeared to enjoy this activity. We found however that care staff did not support the external company effectively. Where one person became distressed by the activity initially, care staff were not present to help alleviate the person's distress and the external organisation were required to manage this issue. Another person was not able to communicate due to a language barrier and again the external organisation were required to manage this as care staff were not present to offer advice and support.

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

People did not share their views around the complaints systems in the service. One relative however told us they did not feel their concerns had been listened to and responded to appropriately. We saw the provider had a complaints policy on display in the reception area of the service and an 'easy read' version of this policy was available. We saw the provider had a complaints file with concerns recorded that had been raised by the local authority in addition to some complaints around missing items. We saw that some concerns we were made aware of were not recorded in the complaints file. We saw there was no analysis of the findings of complaints. They were not being used to identify areas of improvement required within the service and to improve the quality of service provided to people living at the service.

Inadequate

Is the service well-led?

Our findings

At the last inspection completed in June 2018 the provider was rated as requires improvement for this key question. They were not meeting the regulation around the effective governance and management of the service. At this inspection they had failed to make the required improvements and they continued to fail to meet this regulation.

People were not able to share their views around the effective management of the service. Relatives gave mixed views about how effective the provider was. Some relatives spoke highly of the provider while others did not. One relative told us, "If [the provider] talks to you, it's through the hatch from the office. If she is here at all as she is always at the other home which I understand is in trouble. She is just not approachable. The bills are always on time though". Again while some care staff spoke highly of the provider, others did not. One member of staff told us the provider did not want to spend money. They told us the new manager had assisted in getting more basic items such as cups for people although they had now left. Another member of staff told us, "I think it's badly run". A third staff member told us they were not sure who was managing the service. They told us, "Have we even got a new manager?!". We found there had been a high turnover of managers within the service. The provider did not take responsibility for the issues witin the service and continued to blame prior management or staff for the failings in the care being delivered to people.

We found the provider had failed to ensure records within the service were clear. For example; where safety concerns had been identified the provider stated issues had been resolved or there had been an error. However, there was not clear written evidence to confirm this. On the first day of our inspection we found a safety check for a bath hoist stated it was unsatisfactory. The provider had not identified this until we raised the issue. Following investigation the maintenance company stated they had issued this certificate in error and completed a new check on the equipment. We found the most recent gas safety tests had highlighted concerns with the cooker. The provider told us this was not currently being used so it posed no risk to people. We saw a sign in the kitchen that outlined if the cooker was in use the window and door should be kept open. Care staff and the cook confirmed the cooker was used and we were told that the provider had said it was fine to use this equipment. There was no clear written evidence to confirm the cooker did not require repairs to ensure it was safe to use. We saw some maintenance had been identified as being required on the lift within the service. The recommended date for completion had passed. The provider stated the required work had been completed but was not able to produce written evidence that this was the case. The provider also confirmed there were no risk assessments completed for the environment within the service. They said, "I will need to do one". Records confirming risk assessments had been completed on certain pieces of equipment were also not available. We found where bed rails were being used, risk assessments had not been completed to ensure associated risks had been considered and minimised, for example, risks due to entrapment or bruising. We found further issues with records within the service; for example relating to water temperatures, complaints and people's personal finances.

We found audits and governance checks were ineffective and did not identify the issues we found during the inspection. The most recent health and safety audit did not identify the concerns we found with the safety of the cooker. It also did not identify potential issues with test completed for legionella. We found the provider

had been required to complete a second sample due to concerns raised on the initial test. This was later identified to be clear although the audit did not identify the ongoing concerns. We found the infection control audit did not identify concerns we found such as the lack of soap or open bins being used. The local authority's infection control team echoed our concerns with the provider failing to identify areas of improvement required. There were further areas the provider had failed to identify, including inconsistencies with food intake monitoring records, concerns around the recording of creams and care delivery failing to meet people's needs. For example; instructions given by healthcare professionals around skin integrity were not followed. The provider's skin integrity audit stated there was no skin damage in the service and we found this not to be the case. Several people had seen district nurses in relation to their skin and potential pressure ulcers. Where issues were identified insufficient action had been taken. For example; the kitchen audit identified all staff must have food hygiene training by October 2018. When we returned on our final day in November, this had not been completed. The provider had submitted an action plan to CQC following our initial two days of inspection. When we returned we found several actions the provider had stated had been addressed were not and issues remained. We found ongoing issues in multiple areas, including behaviour management, fire risk assessments and cleaning within the service.

The provider had also failed to ensure effective systems were in place across the service. We discussed an example of a recent disciplinary issue. We asked the provider for their disciplinary policy and they were unsure where this was. After investigation and identifying the existing policy we found this was not being followed. We also asked the provider for a policy around the use of CCTV within the building. The new manager and the provider both produced different policies. Both of these policies related to various documents including assessments around the need for CCTV and the impact on people living at the service. The provider was not able to produce these and confirmed they had not been developed. The provider felt the CCTV was not intrusive as only they accessed the footage from their mobile phone. They were not able to evidence they had involved people in the decision, gained their consent and considered the security of the footage and the images of people being recorded. The provider told us following the inspection they had taken a decision to remove the CCTV.

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

The provider was failing to ensure they engaged with people, relatives, staff and external professionals in order to drive improvements within the service. We saw residents and relative's meetings had been held but they were not used as an opportunity to find out where the service needed to improve. For example; we saw at the most recent meeting families had been asked to sign care plans but there was little evidence of the provider seeking people's views. Care staff meetings were minuted but not all staff said they were involved. One staff member told us, "I have to find out for myself what's happening". Care staff overall felt their views were not sought and used to help drive improvements within the service. Health and social care professionals we spoke with also felt the provider did not engage with them effectively.

Duty of Candour is a requirement of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that requires registered persons to act in an open and transparent way with people in relation to the care and treatment they received. We found that the provider was not working in accordance with this regulation within their practice. The provider was not open to receiving negative feedback about the service and did not take responsibility for the failings within the service. Where issues had been identified either by the commission or by others, the provider did not take the feedback constructively and use it as an opportunity to make improvements within the service.