Diamond Care (UK) Limited

PineHeath

Inspection report

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15 November 2016

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 10 and 15 November 2016 and was unannounced. Our previous inspection carried out on 15 and 16 January 2015 had found that there were three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to premises maintenance, infection control concerns and care records.

This November 2016 inspection found that these concerns had not been addressed or where they had been addressed the provider was still in breach of the same regulation for other reasons. In addition we identified further serious and multiple concerns. The provider was now in breach of a total of nine regulations. We have also made a recommendation that the provider reviews staffing arrangements.

Pineheath is a residential care home for people who do not require nursing care. It is registered to accommodate 42 people. At the time of this inspection there were 40 people living in the home, three of whom were in hospital at the time. Some of these people were living with dementia.

There was a registered manager in post. 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.

This inspection was brought forward following concerns received about the home's heating and hot water supply. When we commenced our inspection on 10 November the home had been reliant upon portable heaters to heat the home as the heating had failed on 30 October. Despite the use of portable heaters one person had been admitted to hospital with a low temperature.

On the first day of our inspection we found that whilst some parts of the home were warm, others were cooler. The provider had failed to obtain sufficient quantities of thermometers to monitor temperatures in the home and the monitoring that had taken place was not robust. The hot water was being supplied by immersion heaters. However, these did not ensure an adequate supply of hot water at suitable temperatures. We found that several windows were in a poor condition and allowed streams of cold air into the building.

By the second day of our inspection an emergency boiler had been installed which supplied heating to the home. The home now was warm. However, the hot water supply issues remained. North Norfolk District Council's Environmental Health team issued two improvement notices in relation to the water supply.

On the second day of our visit we widened the scope of the inspection. We found considerable concerns in relation to cleanliness and infection control in the home. We referred these matters to Norfolk County Council's public health team for care homes.

We identified scalding risks in the home and areas of risks specific to individuals. People's medicines were not being appropriately managed.

Staff training needed improvement and knowledge and application of the Mental Capacity Act 2005 was poor. Many people in the home were living with varying degrees of impaired cognition, but no mental capacity assessments had been undertaken.

Whilst some staff promoted good practice, others did not. We observed that some people's needs were not adequately identified or responded to during our inspection.

The provider was minimally engaged in the day to day running of the home. They visited fortnightly but did not undertake any documented reviews to determine whether the care and support people received was satisfactory. The provider did not oversee any of the audit arrangements in the home. The manager received little support or guidance from the provider and no supervisions or reviews of their management of the home. Both partners in the business told us they felt that the home provided a good service for people.

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

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The provider had failed to ensure a safe environment for people to live in. Widespread concerns were identified in relation to the hot water and heating systems, a lack of maintenance of window closures and risks of scalding from unprotected pipes.

There were considerable cleanliness and infection control risks in the home.

Risks specific to individuals were not always mitigated or acted upon.

Medicines were not safely managed.

We could not be confident that incidents were referred to the local authority's safeguarding team when necessary.

Is the service effective?

Inadequate

The service was not effective.

Staff training did not ensure staff had the knowledge and skills they needed to support people effectively.

There was limited understanding and little application of the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. When people lacked capacity, relatives, staff and other health and social care professionals were not always consulted and involved in making decisions in people's best interests.

People did not always have access to drinks and where necessary people were not always supported with their meals.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Some staff treated people with consideration and kindness but others did not and were not observant or responsive to people's

needs.

The poor condition of the premises did not promote people's dignity and respect.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care and treatment was task centred rather than in response to people's individual needs and preferences.

Formal complaints were managed and responded to appropriately.

Is the service well-led?

Inadequate

The service was not well led.

The provider had poor oversight of the service. They carried out no documented assessment of the service provided for people and provided little support to the manager.

The systems to assess the quality of the service provided were not effective. Action was not always taken when areas for improvement had been identified.

PineHeath

Detailed findings

Background to this inspection

The inspection of Pineheath was carried out on 10 and 15 November 2016 and was unannounced.

The inspection was prompted in part by the notification of one person's admission to hospital. During our inspection we were notified that the person had passed away. Their death is subject to a criminal investigation and as a result this inspection did not examine the circumstances in relation to this particular individual.

However, the information shared with CQC about this person's death indicated potential concerns about the management of the failure of the heating and hot water systems in the home. This inspection considered those risks.

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.

On the 10 November 2016 the inspection team consisted of one inspector and an inspection manager. On the second day of the inspection an expert-by-experience was also present.

During this inspection we spoke with ten people living in the home, relatives of three people and five staff members, the manager and the maintenance staff member. After the inspection we held a meeting with the provider. We also spoke with the visiting GP and liaised with the local authority and the Environmental Health team due to the concerns in the home.

We made general observations of the care and support people received at the service throughout both days of our inspection. We looked at the medication records for 11 people and care records for seven people. We viewed records relating to staff recruitment as well as training and supervision records. We also reviewed a range of maintenance records and documentation monitoring the quality of the service.

Inadequate

Is the service safe?

Our findings

Our previous inspection in January 2015 found that the provider was in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was due to unsafe flooring in some parts of the home. This inspection found that the flooring concerns had been remedied, but identified other concerns in relation to this regulation.

Prior to this inspection we had been advised of significant problems with the heating and hot water supply to the home. Both boilers, which had been run alternately, had failed and were beyond repair. The service was relying on three recently purchased and installed immersion heaters for the hot water and on various oil filled radiators, fan, convection and halogen portable heaters situated throughout the home.

The first day of our inspection found that whilst the immersion heaters provided hot water, the supply was not consistently hot. One person told us, "It's not hot enough for me to have a shave." A staff member told us, "The water in the taps isn't hot enough so we haven't tried to shower or bathe people. We're assisting people with strip washes and topping up water from the taps with hot water from the kitchen." We tested a number of tap outlets throughout the day and many were barely lukewarm. The maintenance staff member advised us that the heavy demand in the morning meant that the hot water run out, but that in the afternoons there was more hot water available again. The manager told us that a few people who got up early were able to have a shower before the water started to run colder and that they would look at staggering people's bath and shower times to when there was a more reliable supply of hot water. Staff told us that despite the installation of the immersion heaters they needed to supplement the water from the taps with water from a hot water point in the kitchen on the ground floor and an electrically powered hot water tureen on the first floor. This was to ensure that the water was hot enough to be used to provide personal care for people and for cleaning the home.

The day after the first day of our inspection an emergency temporary boiler was installed which provided central heating to the home. The manager had been sourcing the purchase of a boiler that would permanently supply hot water and heating to the home. However, no quotes had been obtained for this and no order had been placed. Consequently, the home would be using the immersion heaters and emergency boiler for heating on an indefinite basis.

On the first day of our inspection we checked the windows in each bedroom and all communal areas. Approximately 12 windows were in need of urgent repair. These windows either did not close properly or were not secured flush to the frames when closed. Some windows had gaps between the window and the frame of up to 1 cm through which the outside was visible. Constant streams of cold air were coming through these windows.

Whilst the flooring concerns had been remedied, the provider had failed to ensure that there were suitable arrangements in place to permanently supply the home with adequate supplies of hot water and heating and ensure the maintenance of the windows. Consequently, they were still in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our previous inspection in January 2015 found that the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was due to infection control concerns. This November 2016 inspection found that the infection control concerns remained. This inspection also identified further breaches of this regulation.

The risk of legionella had been poorly managed in the home. The home had tested positive for legionella in 2015 which had only been brought to our attention during this inspection. Whilst some remedial action had been taken at the time further water sampling had not taken place to help determine whether the bacteria had been eradicated.

The recent change to the three immersion heaters had increased the risk of the legionella bacteria because water temperatures in the home were not within a safe range that would inhibit the growth of the bacteria. A full risk assessment had not been undertaken by a suitably qualified person since November 2014. North Norfolk District Council's Environmental Health Team issued an improvement notice in relation to water control risks in the home on 22 November 2016. The provider had advised us that a full risk assessment for legionella had been arranged and the water supply was due to be connected to the emergency heating boiler. This would improve the water temperatures in the home which in turn would considerably reduce the risk of legionella.

The poor maintenance of windows in the home meant that people were at risk of being cold. There were considerable drafts from the defective windows. The drafts from these windows and the risks this posed to people's welfare had been exacerbated by the recent central heating failure.

On the first day of our inspection, which was the day before the emergency heating boiler was operational, we heard people saying that they were cold in the dining room. One end of the dining room, which contained kitchen hotplates, felt warm. The other end, where a thermometer was in place, varied between 17C – 19C the four times we checked throughout the day. This was not warm enough for people.

The communal lounge was consistently warm throughout the day. Most people who chose to stay in their rooms had heaters. However, we observed one person asleep in the chair in their room. They did not have a heater or a thermometer. The manager told us that this person had declined a heater. Most of the people in their rooms told us that they were warm enough. If people were not in their rooms then their heaters were moved in to the hallway outside their room to help heat the corridors. However, the corridors were not adequately heated and there was no heat in bathrooms or toilets.

Despite the complete failure of the main boilers on 30 October 2016, the manager had still been purchasing thermometers on 10 November 2016. Records showed that for the night of 9 November 2016 the temperature in 15 rooms where people were sleeping was not recorded due to a lack of thermometers. This meant the provider could not be assured that room temperatures were within a warm and safe range for people when the central heating had failed.

The source of heating for the two shower rooms was heated towel rails. On the second day of our inspection when the home had heating again we found that these were extremely hot to the touch and posed a risk of scalding. A corridor leading to the activities room had exposed hot water pipework at foot level where protective cladding had come away. There was also an unprotected vertical hot water pipe which was also extremely hot to the touch in this area. Some of the portable heaters whilst in operation had very hot surfaces. People had not been protected from the risk of burns or scalds.

One person told us that on the evening of 9 November 2016 there was no electricity to the sockets in their

room and this was not restored until the maintenance staff member came in to work the following morning. We established that this fault affected four rooms. The manager told us that staff had not alerted the maintenance staff member at the time. Had they been aware they would have attended the home to remedy the situation. This meant that people had been left in semi darkness and without heaters in their rooms overnight.

We found considerable issues relating to cleanliness and infection control in the home. In both shower rooms the grouting between the floor and wall was black. Several rooms and areas in corridors smelled of urine. The upstairs sluice room was unclean and there were considerable lime scale deposits around the taps. Some toiletries were kept in a cupboard in the sluice room which put them at risk of cross contamination. Toilet seat risers were indelibly stained and several carpets were unclean. A strip light fitting in one person's room contained debris and a large number of insects.

One person had been recorded as having six falls in a three month period between August and October 2016. They had not been referred to the falls team for an assessment. One of the falls was recorded as the person having 'rolled out of bed'. However, records showed that there were bed rails in place at the time. The manager was not able to explain how this fall had occurred under these circumstances and had not made any enquiries about the incident. The person's falls risk assessment had not been reviewed since any of the falls had occurred.

We observed that the same person had a pressure relief cushion in their room. However, they were not sitting on it. We found that there was no pressure area risk assessment or related plan of care to manage this risk in their records.

The risk assessment process in place for identifying people who were at risk of not eating or drinking enough was not fit for purpose. The risk assessment considered weight loss to be a risk, but did not take into account the risk of a person not being within a healthy weight range in the first place. One person who had continually been losing weight, albeit slowly, with a decreased appetite and complaining of nausea was scored as at low nutritional risk. If the service were to rely upon this risk assessment the person could continue to deteriorate without staff being prompted to take action. This was discussed with the manager and appropriate interventions were subsequently taken to support the person's welfare.

We observed that drink thickener, a prescribed item, was left unsecured in the dining room. Several people who were mobile and living with dementia resided in the home. There was a risk that if someone accidentally ingested this substance their airway could become blocked which could prove fatal.

We found several concerns in relation to the management of medicines. There was no risk assessment process in place for people who wished to self-administer their own medicines. The MAR (Medicines Administration Record) chart for one person's prescribed medicine indicated that on several occasions they had not received their medicine as it had not been required. However, this medicine had not been prescribed on an 'as required' basis. This had meant that the person had not always received the necessary treatment for their health condition.

Several small plastic bags containing tablets were awaiting return to the pharmacy. However, the circumstances under which the medicines required returning were not always recorded. Some bags were labelled 'unknown'. During our inspection we observed one person, who was confirmed as living with dementia, with a pot of tablets on the table next to them. These were indications that staff were not ensuring that people took the medicines they were administering. There was an additional risk that other people could ingest medicines not intended for them.

One person's supply of a topical cream had run out and their MAR chart showed 'course completed'. However, a senior carer told us that they thought it was more likely that this was an ongoing prescription that had not been re-ordered. This was subsequently confirmed. Consequently, this person had not received their medicine as prescribed.

Carry forward totals were not recorded on the MAR charts for most boxed medicines. This meant that we were not able to reliably determine whether the stock levels held by the service were correct or whether people routinely received their medicines as prescribed.

These concerns meant that the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Training Records showed that approximately half the staff needed training in safeguarding. This was planned for in coming weeks. The staff we spoke with understood what concerns could require a safeguarding referral to be made to the local authority. However, we could not be confident that safeguarding referrals would be made when necessary. We checked whether the local authority had been made aware of two incidents we saw recorded, but the local authority had only been made aware of one of them. This meant that the local authority had not been able to intervene as necessary or provide support and guidance to staff help reduce the risk of harm to people.

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

We received mixed views about whether they were enough staff to meet people's needs. Some people told us that they had to wait for staff to assist them on occasions. One person said "Around tea time it's very hard to get any help." However, others were more positive. One person told us, "They do try and come reasonably quickly."

Staff we spoke with told us that there were enough of them on duty to meet people's needs with the current amount of people living in the home. At the time of our inspection there were 40 people living in the home, including three people who were in hospital. The manager advised that there were seven staff on duty for the morning shift, five staff members for the afternoon shift and three or four staff on duty overnight. Staffing rotas showed that the service usually maintained these staff numbers. For the month of October 2016 eight night shifts had three staff members and four of the 62 day shifts were one staff member down.

We observed that during the day there was no permanent staff presence in the lounge where there were up to 12 people seated much of the time. During lunch time we saw that one person was being assisted to eat by another person living in the home. When we reviewed the person's care records they stated that the person was blind and needed staff to support and encourage them with meals. This had not been provided.

The manager told us that they used a staff dependency tool to help determine how many staff were required. However, this was a simple list of how many people required the support of how many staff members. It did not provide any guidance on how many staff would be required to meet the individual needs of the people in the home.

We recommend that the provider review their staff deployment arrangements and utilise a suitable dependency tool to assist in determining appropriate staffing levels in the home.

Inadequate

Is the service effective?

Our findings

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA.

Staff were not meeting the requirements of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLs) and associated Codes of practice. Several of the people living in the home were living with dementia and may not have had the ability to make their own decisions or had fluctuating ability to do so. We did not find any mental capacity assessments in the care records we reviewed. The manager confirmed that none had been carried out and that training in mental capacity and DoLS had only recently commenced in the home.

One person's records showed that a family member had power of attorney for health and welfare. However, there was little evidence of their involvement in care planning for their family member. Another person's care plan stated that if the person declined to have a shower then they could be told that their relative would not be taking them out. This had been arranged with the person's relative in advance. Some people had signed consent forms for staff to be able to share their information with health professionals. However, we saw no evidence that steps had been taken to ensure that the person understood what they were signing for and that they were able to provide informed consent. There was no reference to any decisions being taken in people's best interests as required by the MCA.

Some staff had a general understanding about the need to obtain people's consent, but others did not. We saw that people were not always asked for their consent before support was provided. For example, clothes protectors were put on some people before lunch without any conversation with the person having taken place.

The manager told us that they had submitted DoLS applications to the local authority in relation to some people living in the home. However, the manager was not clear about the restrictions that were in place that necessitated the referrals. Nor had the service assessed people's capacity to make decisions in relation to any restrictions that may have been necessary to keep them safe.

These concerns constituted a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were considerable gaps in the training staff had received. This created risks for people in relation to their welfare, safety and the environment.

There were some night shifts where no staff member had received up to date training in emergency first aid. The COSHH (Control of Substances Hazardous to Health) training for all domestic staff was out of date. Over half of the staff had not undertaken recent Health and Safety training and 45% of staff were in need of fire training. Only seven care staff had received training in responding to challenging behaviour. Approximately half of the staff team required training in safeguarding, the MCA and challenging behaviour, although this training was imminent. However, the widespread shortfalls in training put people at risk of receiving support from staff which was ineffective or unsafe.

Whilst the vast majority of staff had received up to date moving and handling training we observed one staff member instructing a person to get up from their chair in the dining room by putting their hands on their walking frame. This staff member did not know how to get the person safely to their feet and had placed the person at risk of harm. This did not follow good practice. It took another staff member to correct the instructions being given to the person before the person was able to get up.

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

Staff told us that they received quarterly supervisions and appraisals. We saw records that supported this. One staff member who had not worked in care previously told us about their induction and the training they had received. They told us how they had shadowed an experienced staff member and had to complete certain training before they were able to work alone. They told us that they had felt confident that they had received adequate training and support before working unsupervised.

Most people we spoke with were positive about the food. One person told us, "We always get enough to eat and drinks come round before 11am and at other times in the day." Another person said, "The food comes and I think it looks nice, but I've lost my appetite at the moment." A third person told us, "The food is good, mind you it depends who's on of course. I can't have dairy, so they put almond milk in my tea. They'd fetch you something extra if you wanted it." One person said, "I do get enough to eat and they bring drinks around the rooms. Fresh fruit and vegetables would be nice, but we seem to have carrots and peas with everything."

We observed that people in their rooms had drinks available at all times to them. However, this wasn't the case for those in the lounge. The lounge was fairly small for the amount of people it accommodated at times, which was up to 12. This meant that in order to have enough lounge chairs for people to sit in, they were compromised for space for tables to put drinks on.

Twenty people took their lunch in the dining room. The food looked and smelt appetising and people's meals were individually plated up and taken to them. Some people needed staff assistance to eat, but there were not enough chairs for staff to sit on to be able to assist people comfortably. Consequently, staff either stood over people or got down on their haunches. One staff member got up to stretch briefly and complained about their back aching. We saw that people's desserts were distributed before they had finished their main course which had the effect of rushing people with their meals.

We observed one person sitting in the lounge with both their main course and dessert in front of them. They hadn't eaten much and were falling asleep. Staff were assisting other people to come back in to the lounge after they had had their lunch in the dining room. Another person living in the home began helping this

person to eat their pudding. Their main meal would have been cold. This person had not received sufficient encouragement or support from staff with their meal. When we looked at the person's care records we found that they had a visual impairment. Their nutritional care plan stated that the person could not see and needed staff to tell them what was on their plate, where their cutlery was and establish whether their food needed cutting up.

People told us that they had good access to health professionals. One person told us, "The GP comes on a Thursday. I had ear problems and asked staff to book me in. I got some drops which sorted them out." Another person told us, "The optician makes regular visits and the chiropodist who are very good." A third person said, "The GP comes out weekly or when we need them."

The service had engaged the services of a physiotherapist and an occupational therapist who attended the home on a regular basis to support people with their mobility and advise people and staff accordingly.

However, health professionals were not always promptly engaged to support people. One person had not been referred to the falls team despite several falls. Another person told us that they were due a visit from the chiropodist. The manager told us that the chiropodist had last attended some people in the home on 7 October 2016. However, there was no confirmed date for them to come in to the home again as they had been unwell. The manager said that they would look in to this and make alternative arrangements if necessary.

Requires Improvement

Is the service caring?

Our findings

We received mixed views from people about the staff that supported them. One person said, "The night staff are brilliant. If I want something done I ask them. They're very good." Another person told us, "The night staff are very good, they're pretty good in answering the buzzer too." One person stated, "Staff more or less listen and they can be quite patient. They're very good with respect." Another person told us, "Caring? It depends who is on." Other comments included, "Most of the staff are okay", "Staff have helped me a lot since [close family member] died" and "The mature staff are okay."

We also received mixed views as to whether people were involved in planning the care and support they required. One person stated, "We don't talk about this much as staff are always busy." Another person said, "Not really. Staff don't have the time." A third person said, "Staff tell me, not me tell them. C'mon they say, you've got to get up." Another person said, "I think they know what my needs are by now." A relative told us, "In the beginning we went through the care plan and decided what was needed."

We observed that staff practice was inconsistent. We saw examples of good and poor practice. Some staff were caring and considerate towards people, getting down to a person's level, maintaining eye contact and time to say what they wished. We saw staff comforting people when they were upset, encouraging them and chatting companionably with them. However, we also saw that some staff ignored people who obviously required assistance or were distressed.

During lunch we saw that some staff were not engaging with people they were assisting to eat their meals. There was little, if any, conversation. One person was sitting with their head in their hands sobbing, but other than a change of meal, staff offered no comfort or support. Eventually the staff member administering medicines came to assist the person.

After lunch one person remained seated in the dining room. We observed them picking food off the floor and wiping it over their clothing. Several staff had walked by before one stopped to attend to the person.

We saw one person standing up in the lounge. They had a biscuit in their hand and were eating it. They needed assistance as mucus was running from their nose on to their food which they were eating. Staff had not been available to assist the person until we found a staff member.

One person wished to transfer from a wheelchair to a lounge chair, but they did not have the strength to push themselves up from the wheelchair. They had been unwell recently, and whilst now recovered, had not yet regained their normal strength. The person was becoming increasing upset and on the third attempt cried out loudly. The staff member said, "I'll let you catch your breath and I'll come back later" and then left. The person was still upset. They had been offered no re-assurance or the use of equipment to help them move to the chair.

Staff did not consistently demonstrate that people's privacy and dignity was maintained. The smell of urine in the main lounge, where people spent a lot of time, was not very dignified for them. Some of the chairs in

here were badly stained. One had a wet patch on the seat. We observed one person lying naked on their bed with their door open to the corridor. The poor condition of the premises was not indicative of a service that cared.

These concerns constituted a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

Some people's experience of care was task centred rather than focused on them, as individuals. Their preferences were not always taken into account. One person told us, "Staff told me that I said I wanted to be got up at 6am. I don't remember this. The night staff get me up before they finish their shift. It makes it a very long day getting up that early." Another person told us, "You just get what they can do for you." One person said, "I wish someone would help me comb my hair." A further person told us, "A staff member told me that they'd be back to cut my nails but they didn't come back."

People's care records were inconsistent. This put people at risk of not receiving care and support to meet their individual needs. One person's moving and handling care plan stated that they needed staff assistance to go to the toilet. However, an incident report for a fall they had whilst accessing the toilet without staff stated that they were usually self-caring. Another person's care plan gave conflicting information about whether they needed assistance with brushing their teeth.

Some care records did not contain specific or clear enough guidance for staff to be able to support people effectively. One person's records showed that they did not always respond positively to staff. However, there was no guidance for staff on how best to respond to the person's behaviour. Another person's care plan stated that staff needed to use a stand aid to help the person stand up 'until the person became more confident and able to stand and move safely' and that staff were to 'encourage the person to stand and encourage their independence when it was safe to do so.' The person had experienced several falls and their care plan had not been reviewed for 10 weeks. There was no consistent or up to date plan of care to meet the changing person's needs.

One person had complained of nausea to us on the first day of our inspection. Records showed that a few weeks earlier they had felt nauseous and had been found to have an infection. We raised our concerns with the manager that the person might be poorly again. They said that they would ask the GP to visit. The GP did so and prescribed an anti-sickness medicine on 11 November 2016. However when we spoke with the person on our second visit on 15 November 2016 they told us that they were still feeling nauseous and had little appetite. No further intervention had been requested from the GP. The person's food intake was not being monitored despite them losing weight and having had a poor appetite for some time. We were not satisfied that the necessary steps to support this person's welfare were being taken.

These concerns constituted a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Due to the heating issues in the home the activities room had been closed for much of November due to its location. Normally the service had a good range of activities for people to participate in if they wished to do so. However, some people who chose to stay in their rooms told us that they felt a bit lonely sometimes. One person told us, "The staff have no time to chat." Another person said, "I wish it wasn't so quiet up here [top floor]. I don't see anyone, the staff have no time."

People told us that they would speak with the manager if they had any concerns. One person told us, "I was treated badly by one carer. That carer is not allowed to come into my room anymore." A relative told us that they had raised some concerns about a staff member with the manager which had subsequently been resolved. We reviewed the complaints received by the service and found that the manager took appropriate and timely actions to remedy concerns raised.

Inadequate

Is the service well-led?

Our findings

Our previous inspection in January 2015 found that the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to the accuracy and completeness of care records. This November 2016 inspection found that these concerns still remained.

A monthly review chart showed that one person's care plan had been reviewed in September 2016. However, when we looked at their care plan it had last been reviewed in August 2016. We also found recording errors in relation to the management of people's medicines.

The audits in place did not identify the issues we found at this November 2016 inspection. For example, the falls and incidents audit didn't tally up how many falls people had had, or identify that one person had not been referred to the falls team. There was no assessment of overall themes and trends. There was little detail recorded about individual incidents. Often no details were given of the assistance provided at the time, whether the person had sustained an injury or whether any follow up actions were required.

Another example was the weekly maintenance checklist which was completed by the maintenance staff member. This was not signed off by the manager or provider and there was no system to check whether issues requiring attention were rectified. The poor condition of some of the windows in the home had been recorded as far back as April 2016.

There was no scrutiny of whether systems in place to identify risks to individuals were effective. For example, the nutritional screening system in use was not fit for purpose. There was no system to determine when people's nutritional intake needed monitoring.

The provider had not taken prompt action to identify and remedy environmental or individual risks in the home that had put people at risk of unsafe or inappropriate care.

These concerns meant that the provider was still in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider is required by law to notify the Care Quality Commission of significant events including serious injuries and any allegations or instances of abuse. We identified several notifiable incidents which should have been reported to us. These included safeguarding incidents and events that prevented the safe operation of the home. This indicated that the provider did not have systems in place for identifying when notifiable incidents had occurred, or for ensuring the necessary notifications were carried out. The manager was unaware that such notifications needed to be made.

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

We met with the provider following our inspection to discuss recent events at the home and the concerns we had found. They told us that they attended the home once a fortnight. They told us that during this visit they

would walk through the premises with the maintenance staff member and discuss any issues in relation to the premises. They told us that they met with the manager and talked with them about the home and dealt with bills that needed paying. They said that they 'knew for a fact' that they provided good care at the home. However, they carried out no formal auditing or monitoring themselves and did not review those checks that were carried out to determine their effectiveness.

The provider over relied on the manager. The provider had not identified the poor practices in place in the service. They were insufficiently aware of how the service operated and had not ensured that suitable and effective systems were in place to meet people's needs and drive necessary improvements forward. The manager received little guidance or support from the provider in relation to the practical day to day running of the home and had not received any supervisions.

Staff were supportive of the manager. Meetings were held on a regular basis with staff. Minutes from the meetings showed that people were able to express their views and raise queries which were responded to. Their suggestions were sought on how to improve the service. The last meeting for people living in the home was in September 2016. The manager had engaged people living in the home well. Their input was sought on a range of topics including what they would like to spend a sum of money raised on and staffing levels. People had been encouraged to advise the manager of any long waits for assistance.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered persons had failed to ensure that notifications regarding specific incidents were submitted to the Commission. Regulation 18 (1)

The enforcement action we took:

On 22 November 2016 a notice of decision was issued to prevent admissions to the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured that care and treatment was provided met people's needs or reflected their preferences. Regulation 9 (1)

The enforcement action we took:

On 22 November 2016 a notice of decision was issued to prevent admissions to the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had not ensured that people were treated with dignity and respect Regulation 10 (1)

The enforcement action we took:

On 22 November 2016 a notice of decision was issued to prevent admissions to the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not acted in accordance with the mental Capacity Act 2005. Regulation 11 (1)

The enforcement action we took:

On 22 November 2016 a notice of decision was issued to prevent admissions to the home.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not doing all that was reasonably practicable to assess and mitigate the risks in relation to people's care and the safe management of their medicines. Regulation 12 (1)

The enforcement action we took:

On 22 November 2016 a notice of decision was issued to prevent admissions to the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not ensured that systems were followed to ensure that service users were protected from abuse. Regulation 13 (1) (3)

The enforcement action we took:

On 22 November 2016 a notice of decision was issued to prevent admissions to the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had not ensured that the premises was properly maintained. Regulation 15 (1)

The enforcement action we took:

On 22 November 2016 a notice of decision was issued to prevent admissions to the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that systems and processes were in place to demonstrate effective governance of the service. Regulation 17 (1)

The enforcement action we took:

On 22 November 2016 a notice of decision was issued to prevent admissions to the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that staff were supported with approrpate training. Regulation 18 (2)

The enforcement action we took:

On 22 November 2016 a notice of decision was issued to prevent admissions to the home.