Londesborough Court Limited

William Wilberforce

Inspection report

West Green
Pocklington
York
North Yorkshire
YO42 2NH

Tel: 01759302294

Date of inspection visit:
29 October 2018
30 October 2018
05 November 2018
07 November 2018

Date of publication:
31 January 2019

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 29 and 30 October, 5 and 7 November 2018 and was unannounced. William Wilberforce is a care home without nursing for up to 64 older people, some of whom were living with dementia. There were 59 people living at the service at the time of the inspection.

William Wilberforce is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

At our last inspection we identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to person-centred care and good governance. In addition, we identified that the provider was in breach of their (Registration) Regulations 2009. This was because the provider had not submitted notifications of safeguarding incidents to the Care Quality Commission, which they are required to do by law. As a result of our findings, we rated the service overall 'Requires Improvement.'

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions, responsive and well-Led to at least good. The provider's action plan advised that the improvements they intended to make would be in place by 17 December 2018. As this inspection was brought forward, the provider was unable to demonstrate sustainable improvements in these areas. We have taken this into consideration when making our judgements and ratings for this report.

At this inspection we found continued breaches of Regulation 9 Person centred care and Regulation 17 Good Governance. In addition, we found breaches of Regulation 10 Dignity and Respect, Regulation 11 Need for consent, Regulation 12 Safe care and treatment, Regulation 13 Safeguarding service users from abuse and improper treatment, Regulation 14 Meeting hydration and nutritional needs, Regulation 18 Staffing and Regulation 20 Duty of candour. The provider had continued to be in breach of their (Registration) Regulations 2009. 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.

There were two registered managers employed by the service. 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.

We were told following the inspection that one registered manager had left the service. At the time of our inspection they had been registered at the service since 21 August 2017. This meant that since our inspection one registered manager was in place who has been registered with the commission since 9 October 2013. This person is also the nominated individual. The nominated individual is an appropriate person nominated by the provider to represent them. The nominated individual is responsible for

supervising the management of the regulated activity provided.

The nominated individual advised us they had delegated specific roles to the registered manager that was previously in post. This was because of our previous inspection findings and in order to meet the breaches of regulation. This included auditing care plans to reflect a person-centred approach and submitting retrospective safeguarding notifications to CQC. Since our last inspection the provider had employed additional staff to support with audits and had taken measures to delegate specific roles to other senior staff. These included areas such as; infection prevention and control, falls audits and analysis and Deprivation of Liberty Safeguards (DoLS) applications.

During this inspection we found multiple failings at the service and risks to people had not been mitigated. Some people were not cared for appropriately.

Where risks to people had been identified and monitoring was in place, the written monitoring records did not always reflect the practice of staff. Some risks associated to people's health conditions had no risk assessments in place to guide staff in supporting them. Measures had not always been put in place to adequately manage risks to people.

Accidents and incidents were not analysed thoroughly and measures were not put in place to mitigate repeat incidents. Staff did not always follow the provider's procedures for people that were at risk of dehydration and malnutrition and appropriate monitoring and/or guidance was not always in place to support referrals to health professionals. In addition, positional changes for people were not carried out according to the instructions in people's care plans putting them at risk of skin damage.

The majority of staff were recruited safely but there were insufficient numbers of staff to meet people's needs effectively. Some people had behaviours that challenged staff and staff were not trained in this area. The provider had identified gaps in staff's knowledge and training was being booked to support further development in this area.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible. The principles of the Mental Capacity Act (MCA) 2005 were not fully understood by staff and the correct process for making best interest decisions had not been followed.

Medicines were not managed well in every area of the service and we found multiple issues that had not been identified by the provider's checks.

Staff were described by people as being caring and we saw kindness shown to people by some staff. However, other staff did not always promote people's dignity or meet people's basic care needs in a timely way.

Care plans did not always reflect the care we observed being provided by staff and were generic and task focused. This did not encourage person-centred care practices. When people's needs had changed care plans had not been updated.

Activities were not meaningful to people living with dementia. There were no stimulating activities for people during the inspection and very few items available to encourage ad-hoc activities for those people walking up and down communal areas. The service had some characteristics of a dementia friendly environment but did not always reflect current good practice guidance.

People and their relatives knew how to make a complaint but on one occasion a relative had raised concerns to staff over several months which were not escalated to senior management to address. These issues were highlighted and addressed as part of this inspection.

There had been a lack of effective leadership and management at the service which had led to a significant deterioration in the quality of the service. This was now being addressed by the registered provider but there were still significant areas of concern. The quality assurance system was not effective. The issues found at the inspection had not always been identified through auditing and monitoring. For example; some medicines audits had not identified errors in warfarin administrations and a lack of effective monitoring of pain relief medicines. Several medicines audits were signed as completed when it was clear actions were still in progress.

Records were at times not reflective of the care people received and updated hours after staff had completed their duties.

Internal investigations into accidents and incidents had not been thoroughly completed and raised concerns in relation to the service being open and transparent. The provider has advised one of these is awaiting further investigation and they will inform us of the outcomes.

The provider had not submitted all safeguarding notifications to the local authority or CQC. This was a continued issue since the last inspection.

Improvements had been made in relation to the dining experience and the chef was aware of how to fortify diets and provided fortified drinks and finger foods for people. However, support when monitoring those people at risk of dehydration and malnutrition was poor. The systems in place did not support best practice and left people vulnerable to harm and neglect.

Servicing and maintenance of the environment had been carried out in a timely manner and infection prevention and control measures were organised, thorough and effective.

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 five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to people's health and well-being were not always identified and managed appropriately.

People were not safeguarded due to a lack of staff understanding. The processes in place to report incidents was not being used appropriately.

Staff were recruited safely but we identified issues that showed insufficient staff were available to meet people's immediate needs.

Medicines were not managed safely across the service.

Is the service effective?

Inadequate

The service was not effective.

Staff had a lack of understanding in some areas, which had been acknowledged by the Provider.

Staff had not always monitored and managed people's nutrition and hydration needs appropriately to sustain good health.

The service had characteristics of a dementia friendly environment but improvements were required to meet the needs of this client group.

Is the service caring?

Requires Improvement

The service was not consistently caring.

We saw variations in the standards of care provided to people who were living with dementia.

People's dignity was not always supported through the care they received.

Feedback from people and their relatives was mixed. Some people described staff as kind and caring, yet others felt their needs were not always met by staff.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans did not always reflect the care people received and records were not updated when people's needs changed.

Activities were in place, but there was a lack of structured positive engagement with people living with a dementia related condition.

People were supported to attend medical appointments. However, when people's dependency levels were high and risks were identified referrals were not always made to relevant healthcare professionals.

People and their relatives knew how to make complaints but complaints were not always addressed appropriately.

Is the service well-led?

Inadequate

The service was not well led.

There was a registered manager employed but they left the service after the inspection. The lack of effective leadership was identified by the registered provider and management support had been arranged.

The quality assurance system had not been regularly completed and was not effective in identifying risks to people's health and safety. Audits used by the provider had failed to identify all the shortfalls in care and safety.

Notifications had not always been made to CQC and the local authority regarding safeguarding matters.

William Wilberforce

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 checked 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 29 and 30 October, 5 and 7 November 2018. The inspection was unannounced on the first date and announced on the following three dates.

Prior to the inspection we had received a notification about an incident from the provider and a safeguarding outcomes report from the local authority which prompted our inspection to be brought forward. In addition, the provider had sent us some information in relation to a serious incident resulting in injury, which caused potential concerns around the oversight and governance of this service.

We discussed all our concerns with partner agencies including the local authority safeguarding and quality monitoring teams, community district nursing teams and the Clinical Commissioning Group.

Over the course of the four days, the inspection team consisted of three inspectors, one inspection manager, a specialist nurse advisor and one expert 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. The entire team were not always present together each day.

We reviewed notifications we had received from the provider. Statutory notifications are documents that the registered provider are required to submit to the Care Quality Commission (CQC) to inform us of important events that happen in the service. The provider had previously completed a Provider Information Return (PIR) in March 2018. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with 17 people who used the service, four relatives, three senior carers, seven care staff, five health professionals, the activities co-ordinator and cook. We also spoke with the deputy manager, registered manager and nominated individual.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at records including care plans, risk assessments, food and fluid charts, repositioning charts and medicine administration records for ten people who used the service. We observed lunchtime in each dining area and medicine administration. We also looked at four staff recruitment records, training records, rotas and other documentation relating to the running of the service such as quality audits.

Inadequate

Is the service safe?

Our findings

Following our last inspection, we identified that the provider had not been notifying CQC about safeguarding incidents. At that time we asked that these be submitted retrospectively following our last inspection in July 2018, at the time of this inspection these were still being received.

The information that led to this inspection raised concerns about how people's care was safely managed at this service. This included concerns around: pressure area care, food and fluid intake, safeguarding, accidents and incidents management (including falls), and the overall leadership of this service. We looked at these issues during the inspection and based on our findings made eight safeguarding alerts to East Riding of Yorkshire Council (who have responsibility for the independent investigation of safeguarding adults concerns in the local area). In addition, the provider submitted a further two safeguarding concerns following discussions with the inspection team.

During the inspection we received mixed feedback from people and their relatives about how safe they felt living at this service. Comments included; "I don't like it here, I don't see the staff much" and, "It's a lovely place to stay, I feel safe."

Staff we spoke with advised they would report any safeguarding concerns to the senior care staff on duty. They told us they did not feel well equipped to support people who were aggressive or violent. Not all staff working with people that may have challenging behaviour had received breakaway training, which meant they were not trained to protect people who were violent, other residents or themselves while trying to support them. Accident and incident reports showed that there were regular incidents between people and staff, which placed them at risk without appropriate training.Accident and incident reports showed that there were regular incidents between people and staff, which placed them at risk without appropriate training. For example, staff had to physically intervene when two people had started pushing and hitting each other. One person had hit a member of staff on the back of their head. A second person had informed staff they did not like water prior to consenting to a bath. The member of staff did not take any measures to mitigate potential risks. This person was known for displaying challenging behaviours and during the bathing was verbally aggressive, wanted to bite and did scratch the member of staff arm during personal care. Staff continued to rinse and dry the resident and the incident report advised they did not settle until after the shower.

Records showed that the provider had not been submitting some safeguarding notifications to CQC or the Local Authorities. We discussed our concerns with the local authority, they checked their records which showed a small number of safeguarding concerns had been received from the registered persons over the last couple of years and the majority had been referred by external health professionals. This raised concerns that staff and management did not have suitable knowledge and understanding of safeguarding procedures to raise concerns and refer to the appropriate agencies to protect people's safety. Following the inspection, the provider told us they had liaised with the local authority and received different advice on which referrals they should send to them. The provider will be working with the local authority and other professionals to make improvements in relation to safeguarding referrals being made appropriately. The

provider has assured us that all future safeguarding incidents will be sent to CQC and further training sourced for staff to ensure they understand, identify and appropriately refer safeguarding incidents correctly.

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.

The provider had a medicines policy and procedures in place. Senior staff were responsible for administering medicines to people and when necessary district nurses supported. Staff received on-line and face-to-face training in medicines administration and shadowed more experienced staff prior to administering medicines to people. One member of staff advised, "We receive a competency assessment annually," records confirmed this.

We observed medicines being administered and looked at a selection of medication administration records (MARs). We found that medicines had not always been managed safely. For example, one member of staff had contacted the district nurses one evening requesting an additional pain relief injection. Records showed that this person had not received any oral pain relief over a 6 hour 35 minute time period before the district nurse intervention. The provider investigation into this incident highlighted that oral pain relief had been offered however the MAR did not support this finding. In addition, we identified other issues around the monitoring and administration of pain relief medicines.

Some people were prescribed 'as and when required' or PRN medicines. Some protocols were in place to assist staff by providing guidance on when these should be administered and guided staff on how often people require additional medicines, such as pain relief medicines. However, the administration of PRN medicines was inconsistently documented on medicines records along with the reasons why they had or had not been administered. The deputy manager provided us with a folder of type written 'as and when required' charts which were stored in the ground floor treatment room, this meant they were not easily accessible when medicines were being administered on the first or second floors.

We found four people that had no PRN protocols in place for pain relief. In addition, three people had no protocols in place for medicines to relieve constipation and one person had been prescribed a medicine to relieve agitation/anxiety with no specific diversional techniques noted for staff to follow prior to administering this medicine. This lack of guidance for staff meant they may not know when to administer these medicines which meant that people were at risk of receiving too little, or too much, medication and that adequate systems and processes for the safe management of medicines were not always in place."

The registered provider completed risk assessments in relation to people's needs. Risk assessments had not always been reviewed regularly. Some risk assessments lacked detailed guidance for staff to follow and in other instances guidance had not been followed by staff. For example, people that were diabetic did not always have appropriate risk assessment in place demonstrating the consideration and mitigation of risks associated with their health conditions.

Where people were identified as at high risk of developing pressure sores due to poor skin integrity, we found they were not receiving appropriate care. Repositioning records were completed by staff to show that one person had been moved to alternate positions appropriately on the second day of our inspection, but our observations on that day showed they remained on their back with no positional change for over seven hours. A health professional also highlighted concerns about this person, they advised, "I am not convinced staff are completing turns for [Name]." They went on to tell us that three to four weeks ago they had seen paperwork to suggest this person had been left for four hours without being repositioned, and that they

reported this to senior management. When we spoke to the person at the centre of these concerns they said, "I haven't seen anyone for ages, I'm so lonely." Their care records indicated there were early signs of pressure damage.

The monitoring and oversight of accidents and incidents was not robust. Records showed for the period from 3 July until 25 October 2018 there had been 94 falls. We found that floor sensors in two rooms were not switched on to alert staff when people were attempting to move, people were unable to access their call bells to ring for assistance and sensor wires were laid across floors creating a trip hazard. One incident record stated, "When asked what had happened [Name] said was standing up using the table pushed the chair out behind them and the partition fell down and they fell backwards." During the inspection we observed a table pushed up to this person whilst they were sitting in a chair in their room. This caused a restriction to their ability to move. Incident records showed that this person had a total of 12 falls over a period of 96 days. The provider had not identified in any of their falls analysis that this person's sensor was switched off, that wires were across the floor of their room or that the table may be used to assist the person to stand as noted from previous incidents. This demonstrated that lessons had not been learnt from previous incidents and measures were not in place to mitigate repeat incidents of a similar nature.

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

One person told us, "Alarm response times are not good. They [Staff] will switch the alarm off, attend to a more urgent call and come back. Once they put me on the toilet, went away as I like to be left. I must have fallen asleep on the toilet because an hour later a carer returned, woke me up and told me I had been there an hour." A relative told us, "I have witnessed it taking 30 minutes for a carer to respond to an alarm call. I am even more concerned about night cover where I think there may only be two staff per floor." They also advised they had witnessed staff leave their loved one on the toilet for 20 minutes whilst they responded to a more urgent alarm.

On the morning shift on the fourth day of inspection we observed the nurse call system showing eight people calling for assistance, one of those was showing as an emergency call. Observations confirmed no staff attended the call until seven minutes after the first call for assistance was raised. The systems in place made it difficult for staff to know whether another member of staff had attended the call bell as the person that lacked capacity had the controls in their hand and had been constantly switching them on and off. Records showed the call had been attended on several occasions, but this was not the case. This meant that the records did not always provide a true reflection of times that staff attended calls. This left people vulnerable and showed the systems in place were not effective to support staff in meeting people's immediate needs.

Call bell response times and records of incidents and accidents raised concerns in relation to staffing levels. One relative told us, "Alarm response times are variable and I put this down to their being insufficient staff." During this inspection we identified several incidents where people had become incontinent because staff had not tended to their needs in a timely manner. Records of call bells showed people waiting for up to 30 minutes to be attended to. The provider informed us that for one person where records showed they had possibly waiting for 30 minutes, this may have been because staff had not turned off the call bell on attendance. In view of the feedback from the provider, people, their relatives and our observations, it was clear these records could not be relied upon. The provider did not have any measures in place to monitor the effectiveness of these call bell monitoring systems, or to check staff attendance times were reflected accurately in these records. Whilst we were speaking with one person they had asked for pain relief and we had to walk to reception before we found someone we could ask to attend to this person. This meant it may

have been some time before staff realised this person was in need of pain relief as regular observations were not in place to monitor them.

The process of determining staffing numbers by looking at dependency levels of people was not effective and did not ensure sufficient numbers of staff were consistently deployed to meet people's needs promptly. We were given two different dependency tools at different stages of the inspection process. The provider had advised the second one was currently in use. However, the calculations did not always match those detailed in people's care plans and we found several discrepancies. Due to the discrepancies it was difficult to determine whether people's behaviours and support that may be required to manage these had been taken into account as both tools were very different. Information that the provider advised was current did not match dependency levels in people's care plans that we reviewed. For example, on day one of the inspection one person was assessed as low dependency and was then changed to high despite their needs remaining the same. Information in their care plan had not been updated to reflect their current needs."

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

Servicing and maintenance checks of the premises had been completed in-house and by external contractors in a timely manner. The provider had ensured that there were appropriate plans and contingencies in place for emergency situations and unexpected service disruption. Evacuation procedures detailed the level of support people required to safely exit the service in the event of an emergency occurring.

The provider had systems in place for the recruitment of staff. Overall, we found there were sufficient and safe recruitment practices. The provider had completed Disclosure and Barring Service (DBS) checks. DBS checks help employers make safer recruitment decisions and are designed to prevent unsuitable people from working with adults or children who may be vulnerable. One recruitment file we looked at showed that complete references were not obtained and reasons for leaving employment had not been explored.

Infection prevention and control procedures were robust and well managed. The service was immaculately clean throughout.

We discussed our concerns with the provider throughout the inspection and during feedback. Following the inspection, we wrote to the provider to make them aware of our immediate concerns and requested an action plan detailing the measures they were taking to mitigate the immediate risks to people's safety.

Inadequate

Is the service effective?

Our findings

Staff completed inductions in line with the care certificate standards. The Care Certificate is a minimum set of standards expected from all health and social care providers. The provider told us they had identified a lack of staff knowledge in some areas and were in the process of arranging additional courses for staff to attend. We identified staff had gaps in knowledge around the mental capacity act and consent, distress reaction training and safeguarding practices.

Staff we spoke with advised they received regular supervisions and felt supported. Where appraisals had not yet been completed the provider sent evidence to show that these were scheduled for six members of staff. The provider had identified that the staff responsible for completing supervisions were not confident in carrying them out correctly and so had arranged for additional training in this area to support them.

We did see some competency checks completed by senior staff but these did not include sufficient detail to show areas of competency checked. For example; "[Name of staff] supported the resident with application of topical medications, continence needs, nutrition and hydration." This did not include sufficient detail to confirm staff were competent. No other details were documented such as for the application of topical medicines: the initials or an identification code for the resident, details of how the resident was supported with applications of topical creams, what they were, whether they had been applied as detailed on instructions and whether the providers policy around topical cream administration was adhered to. A second example advised; "[Name of staff] has been observed using the correct PPE and correct hand hygiene." No details were recorded to identify the person they were supporting and which PPE was worn (apron, gloves, etc). The reasons for wearing PPE/hand hygiene, such as in between assisting with personal cares or prior to assisting with the delivery of meals were also not recorded. Following the inspection the provider advised they have generic competency indicators that have been identified for all care staff to achieve in a particular area. They have been written with the consideration of the Knowledge and Skills Framework (KSF). These are incremental to support staff development and succession planning. The KSF encourages personal development by supporting staff through the use of various methods such as, annual reviews, constructive supervisions, shadowing of experienced staff to learn new skills. The observations we reviewed all lacked specific details and none identified where improvements could be made to encourage staff development.

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. The provider showed us documentation to show that DoLS applications had been re-submitted prior to their expiry date.

It was not clear how conditions on DoLS were being adhered to. For example, one person's care plan detailed conditions that were in place as part of their DoLS and stated, "There needs to be a risk assessment and plan in place to manage challenging behaviour towards staff and residents which needs to be via a best interest meeting then monitored and reviewed." The risk assessment for this person had not been reviewed for three months. The risk assessment in place did not highlight circumstances when the person was likely to display more challenging behaviours such as during personal cares. The diversionary techniques advised to encourage a quiet walk away policy. However, accident and incident records clearly showed this person was distressed during personal cares and had tried to harm staff. The actions recorded as taken by staff had not de-escalated the incident and showed staff continued to wash this person even though they were displaying what was described as "Offensive language" and "Signs of aggression." The incident report advised the person did not like to feel wet, yet this was not recorded in the care plan or risk assessment to support staff and options considered with health professionals, so that staff could support them effectively.

Five people had bed rails in place and some had been assessed as lacking capacity to make significant decisions for themselves. We requested to see the best interest decision for bed rails and were told by staff that other health professionals had ordered the beds; staff understood those professionals would do the best interest meetings. After further conversations with staff they confirmed there had been no best interest decisions in place to consider least restrictive options prior to the use of bed rails. Decisions had been made internally and did not always have any input from other parties. This meant that they were not valid decisions as they had been made with no input from families or relevant health and social care professionals who knew the person best.

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

The service had electronic systems in place to record information about people's care and support needs. However, we found during the inspection that staff were not always able to gain access to a working computer system. One senior member of staff tried to load information from three different laptops and computers and was unable to do so. No paper records were available to support staff to know people's immediate needs when they were unable to access computer records. The handover documents which were used to communicate information between shifts lacked detail about people's needs. They contained minimal information such as discussions with the GP surgery around medication changes, district nurse visits due, notes to advise the care plans had been updated following a fall and change in needs (No details of the changes were noted so that staff were unaware of what these were). We found staff were not always aware of people's immediate needs and different staff told us conflicting information in terms of whether people were diabetic, on a soft diet or having difficulty swallowing. We discussed our concerns with the provider. They told us they had purchased some portable computer equipment for staff to use for recording, updating and viewing information. We saw one member of staff using portable computer equipment during the inspection. The provider also advised that they were awaiting a demonstration for a new computer system they were considering and acknowledged that the current system was not as effective or streamlined as they would like. The provider was also reviewing systems that were in place to ensure staff were fully aware of people's current needs and reviewing care plans so that records were current. These improvements were on-going and being addressed by the provider.

The environment needed further improvement to support those people living with a dementia related condition. For example, we did not see any rummage boxes for people to use. Rummage boxes hold different activities or items that people can pick up and use when they are passing. We observed people walking around the service with no purpose and constantly asking staff for reassurance. People were finding it difficult to orientate themselves around the premises and staff were having to support them. The provider had different items around the home, but these were more on display rather than practical items people could pick up and utilise. There was a lack of signage and use of personalised items to support people with cognitive impairment to navigate back to their bedrooms independently.

People who could communicate their wishes chose where they would like to eat their meal. We observed people being served in their bedrooms and in each of the three dining rooms. The dining room tables had table cloths and cutlery settings. The food looked appetising and staff showed people plated food choices for them to decide which they would prefer. People told us, "The food is okay," "We can have ice cream any time we like" and, "The meals are not bad, but not great. I go to the restaurant most days, but I don't enjoy it. I used to be on a nice table and then I was moved." There were hot and cold options available for people to choose from. Staff supported those that required assistance to eat and drink in a patient and respectful manner. We saw that drinks and liquid supplements were offered during the day. However, we observed one person in the dining area choking each time they had a drink. These concerns were not highlighted by senior staff so that this person was monitored and appropriate referrals made to health professionals. We discussed this with the provider and asked them to consider their needs and if any referrals to professionals were needed.

Food and fluid charts were in place for this person but recordings were poor as charts were not always fully completed. The person's care plan stated the recommended daily intake as 1.5 – 2 litres of fluid, yet there were no goals on the fluid charts to guide staff. We found fluid chart entries were not always 'totalled up' at the end of each shift and analysed by senior staff to identify where people should be given further fluids throughout the next shift to ensure they did not become dehydrated. Food charts were also not completed accurately, there were no portion sizes offered which made it difficult to know how much people were eating and whether additional fluids had been consumed. This person had not received regular support to eat and drink during one day of the inspection and on three occasions we had to ask staff to administer fluids as the person was thirsty. There were no guidelines in place for staff to recognise when people were not reaching their daily fluid intake, making it difficult to know when they needed to refer to health professionals to support them.

This person's records showed they had lost 23 kilograms in weight over 46 days between September to October 2018 and had difficulties swallowing medicines in October 2018. When asked the provider advised no referrals had been made to the dietician or speech and language therapists. Since the inspection the provider has advised the weight loss was due to the use of certain medicines. However, this information was not available at the time of the inspection and was not recorded in the care plan notes or medical information provided at the time of inspection. In the records we viewed there were no explanations as to why this person had not been referred to a dietician and the staff we spoke with could not advise why this decision had been made. The provider had failed to follow their own recommendations that stipulated this person should be referred to a dietician. We asked the provider to review people deemed high risk and to follow their own recommendations for referrals to the dietician

Some relatives were concerned about fluid intake and monitoring. One relative told us, "I am very concerned about [Name's] fluid intake. I bring in small bottles of water and half the time there isn't a plastic glass in the room and [Name] can't drink out of the plastic bottle. I often go and get a glass myself." In addition, records showed the provider had identified other people that were at risk of dehydration or

malnutrition and these people were not being monitored, weighed or referred to appropriate health professionals in line with the provider's recommendations.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Meeting nutritional and hydration needs.

Following the inspection, the provider told us they had reviewed each person's needs in relation to nutrition and hydration so that appropriate monitoring could be put in place and any referrals to health professionals made.

Requires Improvement

Is the service caring?

Our findings

People's dignity was not always protected and their privacy respected. We observed two people in a state of undress. Staff nearby were slow to react to their needs and protect their dignity. For one person there was a lack of regular observations of them in their bedroom, despite their inability to use their call bell effectively. Accident and incident records highlighted instances when people living at the service had walked into other people's rooms causing disturbances. We identified three incidents where one person had entered another person's room on two occasions and were found in a state of undress, they also entered a second person's room on one occasion and were found by staff in a state of undress. The provider advised that behaviours that challenge are referred to the GP to make referrals to the Clinical Psychiatric Nurse (CPN). The provider advised they worked with the CPN to avoid repetitive behaviour through monitoring.

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

People felt their preferences were not always considered. One person told us, "I need help with bathing. I would prefer a female member of staff to assist me, but others who make a fuss get one and then people like me end up with men. I am treated with dignity but would just like a woman." The person agreed to discuss this with the provider. Another resident said, "I would like to go outside in the garden, but no one has asked if I'd like to go. I sit in the lounge, but none of the carers come and sit or talk to me."

Other people told us that staff were friendly and kind towards them. One person said, "The majority of staff are very friendly" and a second person advised, "Staff change frequently, some are strange, most of them kind." Relatives advised, "They [Staff] are very good, but there is a high turnover." Relatives told us they had been included in discussions about their relative's care. One relative said, "[Name] has been here for a year and I was involved in the initial care planning and have had two reviews since."

We observed some positive interactions between staff and people living at the service, such as relaxed conversation and some humour between people sitting together and staff as they were passing by. We observed one person being encouraged by staff to play ball exercises. Staff spoke kindly to them and when they were called away asked another member of staff to take over. The activities person was warm and had a lovely manner with people. One person was asking to go home and another person was banging on the table. The activities co-ordinator distracted them by using information detailed in their care plan to advise them their relative would be visiting, which appeared to have a calming effect on them. However, this level of compassion was not practiced throughout the home. We observed some people living with a dementia related condition speaking to staff and needing reassurance. Some staff appeared too busy and did not take the time to reassure them which heightened their anxiety. One member of staff responded to a person that wanted to go home, by advising them their house was sold and they couldn't go home. Staff were not practicing the advice and guidance as detailed in the person's care plan and they continued to walk around anxiously. This meant that communication with people living with a dementia related condition was not always appropriate, some staff did not appear to fully understand their needs or how to manage their anxieties.

Staff tried to encourage people to be as independent as they could be. We observed a member of staff assisting a person to the dining area. Staff woke them up gently and placed their walking frame in front of them and encouraged them to put their hands on the frame to get up. Staff commented that they were a bit wobbly, to which the person replied, "That's because I've just woken up." Staff assisted them to the dining table, but could have considered giving the person longer to wake up and prepare themselves before attempting to stand.

The provider had information available on local advocacy services, should people or their families wish to access them. Advocates represent people and ensure they have time and space to express their views in relation to all aspects of their care and support needs.

Inadequate

Is the service responsive?

Our findings

At the last inspection we found the provider was in breach of regulation 9, person-centred care, this was because treatment did not meet people's needs or reflect their personal preferences. Following that inspection, the provider sent us an action plan detailing how they planned to improve person-centred care by 17 December 2018. At this inspection we found that the provider had failed to address or implement any sustainable improvements in this area.

Practices were task orientated and did not reflect person-centred care. Care planning documentation did not always reflect the care that was being provided to people and people did not always receive care that reflected their preferences. We saw examples of people's needs changing but their care plans had not been updated to reflect their current needs. Some people's care plans detailed creams they were having administered, but staff told us these were not being used. One person had a boot to protect their foot detailed in their care plan, staff told us this had not been used for some time. Some assessments of care had not taken specific issues around people's care into account, such as support required for diabetes and continence care. In addition, staff were not always aware of people's needs in relation to their dietary requirements, or were not following their own recommendations to monitor people that were assessed as high risk of falls, malnutrition, dehydration and/or pressure sores.

Care plans were not always developed on admission into the service. One person had a one-page profile in place which had limited information to guide staff on their needs, any risks and preferences. They had been admitted into the service in July 2018 and care plans were not developed until October 2018. When questioned staff told us this person was admitted on respite and therefore care plans were not developed straight away as they may leave the service. Their current care plans did not detail all their health conditions. This meant no information was available to inform staff of signs to look out for and how to best manage them.

Care plans and risk assessments had not always been evaluated monthly or when people's needs changed. Four people's care plans identified that they were at risk of malnutrition and dehydration. The provider's recommendations stated they required food and fluid monitoring and to be weighed regularly, this was not being done.

A lack of effective communication between the staff meant people were at risk of not receiving appropriate care and support. For example, one person's care plan identified that they were independent with all eating and drinking. However, the cook told us they were on a soft diet and required full assistance to eat and drink and the registered manager told us they were on a normal diet and had no issues with swallowing, even though records showed the person had difficulty swallowing for some time.

Since the inspection we asked the provider to identify all those people at risk so that appropriate measures are put in place to monitor and support them. This has been completed and the provider is in the process of reviewing all care plans and associated documents to ensure they are reflective of people's current needs.

We observed the activities co-ordinator encouraging people to participate in some activities during the inspection. People that were independent told us they may have a game of dominoes. One person told us, "At Christmas time the brownies come and do a badge presentation and we have a saxophone player comes twice a week." On one day of the inspection an entertainer had come into the service and staff told us that relatives often visited to take their loved ones out for the day. One relative told us, "I know the activities co-ordinator spends one-to-one time with each person going into their room and I know they have spoken with [Name]. But because there are so many people there is a very long period of time until you see them again. And I'm not sure what they do with the information they collect. [Name] has never been encouraged to attend activities."

People expressed to us that staff did not always have time to spend with them or to chat with them. People nursed in bed were socially isolated and only visited when they required care to be provided. We saw limited evidence to show that people were supported to access local facilities or participate in activities that interested them. The provider advised the activities co-ordinator had been and was still in the process of speaking with people to find out their interests and likes so that this could be addressed for everyone living at the service. Following the inspection the provider advised that both the activities co-ordinator and staff spend one to one time with people depending on their preferences.

Activities for people living with dementia were limited and although we did see some positive interactions, this was limited to the time care staff had in-between their daily routines. We did observe people sleeping a lot, displaying repetitive behaviours with no positive interactions from staff to reassure them. Accident and incident records showed regular altercations between people living at the service, these were all indications that there was a lack of meaningful stimulation for people.

Communication care plans were in place, but contained very little detail on how people would like to be supported to communicate. Observations showed that this was sometimes an issue, one person was trying to get assistance from staff for several minutes, but was unable to catch their attention. Records did not capture details about conditions that affected people, one person had a condition that affected their hearing and the communication care plan stated, "I have a hearing impairment called [Name of condition]. There is a leaflet about my condition in my care file." It did advise of aids in place to support the person and some information about how to support the person. However, staff would have benefited from knowing more about the condition and how it affected the person's ability to communicate.

Care plans were in place for end of life care. Where appropriate there was an advanced care plan in place and anticipatory or 'just in case medicines' were in place. One person had their preferred place of care identified. However, we did note some poor practice around end of life care provision where it had been questionable whether people were receiving dignified and pain free care and support in their final days.

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

People knew how to raise concerns or complaints. They told us they would speak with a member of staff or the manager. However, one relative told us, "[Name] does not feel safe." They told us their loved one lived with a dementia related condition and that they had raised concerns with staff over a period of months and that no action had been taken. They told us the issues made their relative fearful. This meant that staff had failed to take steps to address the immediate issues which had a significant impact on this person's well-being. We discussed these concerns with the provider and they addressed these during the inspection.

Inadequate

Is the service well-led?

Our findings

At the last inspection we found the provider was in breach of regulation 17, good governance, this was because systems in place to monitor the quality of the service did not always highlight areas that required improvements to be made and records relating to people were not always accurately maintained. Following that inspection, the provider sent us an action plan detailing how they planned to improve the service, the majority of dates extended to 17 December 2018. However, for those requiring a longer financial and time commitment such as technology we were advised improvements may not be in place until 31 March 2019.

At this inspection we found the provider had not made sufficient improvements in areas that were detailed as being the first priority in their action plan. In addition, the provider had not notified us of some safeguarding incidents since our last inspection. This resulted in a continued breach of their (Registration) Regulations 2009, which will be dealt with outside of this inspection process.

Staff and health professionals told us there had been a high turnover of staff in this service since our last inspection. However, we saw that some of the more senior staff had been in post for a considerable amount of time which provided some stability in the service. They were able to share their knowledge with new members of the staffing team. The provider told us they were taking steps to look at different ways of recruiting suitable staff and were also using regular agency staff when required. At the time of this inspection we were advised that only one person was employed through the agency all other staff were employed by the provider.

There was a quality assurance system in place but this was not used effectively. A lot of the issues we raised during the inspection had not been identified in audits completed by the service. For example, the registered managers had not monitored the standard of care that people had been receiving to ensure the support they were given was effective in meeting their needs. In addition, people who displayed behaviours that challenged staff had been identified but actions had not always been taken to put the correct support in place for them when their needs changed. We found some incidents that highlighted areas of risk, but no actions had been taken to mitigate these. This demonstrated that lessons had not always been learnt to improve people's safety. The levels of staff required to provide safe care and support had not been identified appropriately using the provider's own tool. This meant that the audits and oversight of the service was not robust. This had resulted in a situation where the basic care of people had deteriorated and placed people at risk.

Another person had a total of 12 falls over a period of 96 days, yet no regular observations were in place and risks identified in previous incident reports were not always been addressed. This meant that the provider did not always have oversight of all the risks we identified and could not be sure that action had been taken to reduce the risk of similar incidents recurring.

Regular 'huddle' meetings were held between shifts to handover important information to staff. Staff meetings had been held regularly and records showed discussions around different topics to raise awareness, such as nutrition and hydration. Residents and relative's meetings had not been recorded since

July 2018. However, following the inspection the provider advised they had a relative's meeting on 26 October 2018 which had not been made available to inspectors at the time of this inspection as it had not been typed up. The provider advised they had some information jotted in their notebook which they formalised and sent to us to show they had spoken with various people living at the service. We spoke with people living at the service and one person we spoke with advised, "We have a resident's meetings every four weeks." This showed that the provider was actively seeking people's feedback about the service.

Audits were not effective in driving improvements throughout the service. The provider told us that they had identified concerns since our last inspection. However, we saw little to no improvement across the service in the three months since our last inspection. Records showed that some audits had not been completed since July 2018, some of these related to checks around people's nutrition. We highlighted issues around nutrition during this inspection. The providers recent 'Service Improvement Plan' advised that some care plans had been reviewed and improved in relation to person-centred care. However, we found that further work was still required for those care plans already reviewed. The provider had identified issues and put some measures in place to address them. These included implementing more regular checks for medicines administrations on a daily, weekly, monthly and quarterly basis. We found the provider had not highlighted and in some cases not identified the errors and issues we found during this inspection. This demonstrated a clear lack of awareness and oversight on the part of the provider.

There had been a lack of effective leadership and management oversight at the service by both the registered manager and provider. Risks had not always been mitigated and people's dependency levels in their care plans did not match those on the dependency tool we were told was being used to calculate staffing levels. We saw evidence that some people were not cared for appropriately. Records were generic, inconsistent, contained contradictory information and were not contemporaneously maintained. Staff knowledge in some areas was poor and people had not always been safeguarded from harm. Care was task focused and staff did not always have time to spend with people. Audits had not identified all the concerns we raised during the inspection process. The registered provider had failed to ensure that they were meeting all the Regulations.

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

The monitoring and oversight of accidents and incidents in the service was not robust and did not mitigate risks to people. We identified a number of repetitive falls and overall a high number of falls within this service. Issues we found had not always been identified by the provider's audits and investigations. One incident clearly stated that the person had an unwitnessed fall and was expressing pain, yet care staff had hoisted them into bed. This person had been later diagnosed with a fractured pelvis. CQC received this information from a notification sent to us by the provider and requested further information to be sent by a certain date. This took over a week to obtain, and involved subsequent emails being sent to the provider. The outcome from the provider's initial investigations was not satisfactory or thorough and posed more unanswered questions as to staffs' understanding and integrity. The provider told us they were still investigating this issue and will inform us of their final outcomes. Duty of candour is in place to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment. This incident demonstrated that the provider had failed to comply with the duty of candour regulation which is a requirement of registered persons.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) 2014. Duty of

candour.

Staff told us they felt supported by the current registered manager. They told us they received regular supervisions every six to eight weeks and daily conversations including regular management meetings. These meetings had addressed issues and concerns raised since our last inspection, staff were working as a team to make gradual changes within the service. Staff meetings had been held at similar intervals and any important information discussed; such as issues with floor sensors had been discussed as part of this inspection process to ensure staff were switching them on so they would alert staff when people were moving to prevent falls.

The provider had limited evidence to show that community links had been made with other organisations. People living at the service did advise that outings were not regularly if at all organised at the service. Following the inspection the provider advised they have made arrangements for small group excursions to a local attraction and to the church.

Partnership working with health professionals had improved since our last inspection and although some health professionals raised their concerns with us, overall some advised that they had a better working relationship with the service. We did not see evidence that the provider was working in partnership with the local authority to ensure safeguarding referrals were made appropriately. The local authority shared our concerns in relation to the lack of reporting safeguarding incidents. Following the inspection, the provider told us they had previously liaised with the local authority and followed the advice provided to them. However, repeat incidents involving the same person had not been referred to the local authority for them to monitor the provider's management of these incidents.

Following this inspection CQC has attended a strategic meeting with other agencies, such as safeguarding and the Clinical Commissioning Group to share our concerns about the service. Since the inspection the local authority has met with the provider to ensure they have a clear understanding of what is expected in terms of making correct referrals to them.

The provider made some immediate improvements following our initial feedback to ensure people's safety and sent us an action plan to tell us what they would be doing to address other areas of concern. This information and any supporting evidence has been taken into account when making the judgements and ratings in this report.

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 person had failed to notify CQC without delay of safeguarding incidents.

The enforcement action we took:

Urgent NoD to restrict admissions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive person-centred care and treatment that was appropriate and met their needs.

The enforcement action we took:

Urgent NoD to restrict admissions with additional conditions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not treated with dignity and respect at all times.

The enforcement action we took:

Urgent NoD to restrict admissions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Staff did not always act within the principles of the Mental capacity act 2005. The best interest decision making process was not followed.

The enforcement action we took:

Urgent NoD to restrict admissions.

Regulated activity	Regulation

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Delivery of care and treatment was not always based on risk assessments that balanced the needs and safety of people using the service with their rights and preferences. Care and support was not always carried out in accordance with the Mental Capacity Act 2005. Unlawful restraint was used by staff.

The enforcement action we took:

Urgent NoD to restrict admissions.

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 Delivery of care and treatment was not always based on risk assessments that balanced the needs and safety of people using the service with their rights and preferences Care and support was not always carried out in accordance with the Mental Capacity Act 2005. Unlawful restraint was used by staff.

The enforcement action we took:

Urgent NoD to restrict admissions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People who used services did not always receive adequate support with their nutrition and hydration to reduce the risks of malnutrition and dehydration while they received care and treatment.

The enforcement action we took:

Urgent NoD to restrict admissions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective governance, including assurance and auditing systems or processes in order to assess, monitor and drive

improvement in the quality and safety of the services provided.

The enforcement action we took:

Urgent NoD to restrict admissions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The provider did not act in an open and honest way with relevant persons in relation to the care and treatment provided to service users in carrying on a regulated activity. Investigations into serious incidents were not carried out in accordance with this regulation.

The enforcement action we took:

Urgent NoD to restrict admissions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of people. Staff had not received the training necessary for them to carry out their role and responsibilities.

The enforcement action we took:

Urgent NoD to restrict admissions.