Yorkvalley Limited

Haven Lea Residential Care Home

Inspection report

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Date of inspection visit:
23 June 2017
26 June 2017
28 June 2017

Date of publication:
06 February 2019

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 23, 26 & 28 June 2017. This first day of the inspection was unannounced.

Haven Lea Residential Care Home is registered to provide accommodation and personal care for up to 26 adults. The service is located in the Whiston area of Merseyside and is close to local public transport routes. Accommodation is provided over two floors. These floors can be accessed via a stair case or passenger lift. There were 20 people using the service at the time of our inspection.

A registered manager was in post at the time of the inspection visit. They were registered with the Care Quality Commission in October 2016. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The last inspection of the service was carried out in December 2016 and we found that the service was meeting all regulations. However at this inspection we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 management of medication was unsafe. People did not receive their prescribed medication at the right times. Medication administration records (MARs) for some people had been signed to indicate they had received prescribed medication which was not given. Handwritten MARs had not been signed by two staff to ensure the accuracy of the information recorded and some MARs did not provide instructions about the use of medication. This put people's health safety and wellbeing at risk. Immediate action was taken on the first day of inspection to improve the management of medication.

The premises were unsafe. There were hazards both inside and outside of the premises which had the potential to cause people harm. This included the unsafe storage of harmful substances and obstructions which placed people at risk of slips, trips and falls. External doors, including a fire door, were left open and the areas were unsupervised. This placed people's safety at risk. Action was taken on the first day of inspection to improve the safety of the environment.

The cleanliness and hygiene of the service was not maintained and clinical waste was not secured. This placed people at risk of acquired infection. Areas of the service, including the kitchen, food stores and floorings on corridors and people's bedrooms were unclean. The clinical waste storage container kept at the front of the building on a space open to the public not secure. The lid on the container was open and there was no lock fitted to it. This increased the risk of the spread of infection. The Euro bin was secured by the second day of inspection.

The recruitment of staff was not always safe. Recruitment records for nine members of staff working at the service did not evidence that checks required by law were carried out on their criminal record.

New staff had not received a thorough induction into their roles and there was a lack of initial and ongoing training for all staff. Staff had not received an appropriate level of support to enable them to discuss their performance, training and development needs. Staff were given the responsibility to carry out tasks without being provided with the relevant training and support. This meant that people were not supported by staff that had received the right training and support

People who lacked capacity were not fully protected because staff lacked an understanding of the Mental Capacity Act 2005 and the associated deprivation of liberty safeguards (DoLS). Staff were unsure which people had an authorised DoLS in place and what is meant for people.

There was a lack of stimulation for people and opportunities for them to engage in things of interest. People spent most of their time sat in the lounge either watching the television or sleeping. The environment lacked items of interaction and stimulus to help engage people.

Personal records belonging to people were left unsupervised on a table in the communal lounge areas which were accessed by visitors to the service. Items belonging to people who no longer lived at the service were left in bedrooms which other people now occupied. People's clothing was not stored in a dignified way; laundered clothing was left in an unoccupied bedroom which smelt strongly of urine. This meant that people's confidentiality, dignity and privacy were not respected

Pre-admission assessments did not contain sufficient information about people's needs and care plans were not in place for people's needs which were identified. Aspects of people's care were not monitored in line with their care need requirements. This included fluid intake, weight, positional changes and skin integrity. This meant that there was a risk that people's needs were not assessed and planned for

There was a lack of management oversight at the service. The registered manager delegated the task of carrying out audits and checks across the service to staff that were not appropriately skilled and qualified. The checks were not carried out as required which meant risks to people's health and safety were not identified and mitigated. Records were not maintained securely, accurate and complete.

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.

Prescribed medication was not given to people at the correct times and medication administration records did not reflect the correct information.

A lack of security of the premises put people's health and safety at risk.

Hazards across the service had the potential to cause people harm.

People were not fully protected from abuse or the risk of abuse because staff were not fully aware of how to safeguard people.

The recruitment of staff was not safe .

Is the service effective?

Inadequate

The service was not effective.

People did not receive safe and effective care to meet their needs.

The monitoring of people's care had not taken place as required.

People who lacked capacity were not protected in line with the Mental Capacity Act 2015.

People received care and support from staff that had not received an appropriate level of training and support for their roles.

Is the service caring?

Inadequate

The service was not caring.

People's confidentiality was compromised because their personal records were not always securely stored.

People's personal belongings were not treated with dignity and respect.

There was a lack of dignity and respect with regards to people's personal space and communal areas.

Is the service responsive?

Inadequate

The service was not responsive.

People's need were not properly assessed and planned for.

People did not receive safe and effective care to meet their needs.

There was a lack of stimulation for people and the opportunity to engage in activities they enjoyed.

Is the service well-led?

Inadequate

The service was not well-led.

There was a failure to monitor and assess the quality and safety of the service resulting in risks to people not being identified and mitigated.

The registered manager failed to oversee the quality and safety of the service and there was a lack of scrutiny by the registered provider and a lack of accountability.

Records required by regulation were not securely stored, maintained, and complete and kept up to date.

Haven Lea Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered 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 over three days, the first day was unannounced. An adult social care inspector and a pharmacist inspector carried out the inspection on the first day; the second and third days of the inspection were carried out by one adult social care inspector.

We observed the interaction between people who lived at the service and staff and we spoke with seven people and two family members. We spoke with the registered provider, registered manager, general manager and staff who held various roles including, care staff, kitchen staff and domestic staff.

We looked at areas of the service including the communal lounge and dining room, bathrooms, bedrooms, the kitchen, laundry and outside areas,

We reviewed a number of records, including care records for six people who lived at the service and three staff files. Other records we looked at which related to the management of the service included quality monitoring audits and safety certificates for equipment and systems in use at the service.

Before our inspection we reviewed the information we held about the service including notifications that the registered provider had sent us. We also looked at information we received from the local authority and members of the public. This included concerns which they raised with us about the service. We looked at those concerns as part of this inspection.

Inadequate

Is the service safe?

Our findings

Although people told us they felt safe we found that the service was not providing safe care. People's comments included, "I feel much safer than I did when I lived in my own home" and "Yes, I feel quite safe here".

Prior to this inspection we received concerns about the management of medication and the safety of the environment. We looked at those concerns as part of this inspection.

An external review carried out by the local authority's medicines management team in April and May 2017 highlighted concerns, particularly with record keeping and administration of medicines. We found ongoing concerns around the management of medicines

We found that whilst some medicines were stored securely in a locked trolley and cupboards in an office with a key coded lock others were not stored securely such as those stored in the fridge.

Room temperatures were recorded daily in May and June 2017 and were within recommended limits, apart from two consecutive days in May 2017, where the temperatures were recorded as being above 25c. No remedial actions were recorded. We checked medicines that required refrigeration and found records were not completed properly as only the current temperatures had been recorded. Maximum and minimum temperatures should be recorded in accordance with national guidance. The staff did not know how to operate the thermometer to obtain the maximum and minimum temperature. The fridge used to store medicines was not lockable. This meant we could not be sure the medicines stored in the fridge were safe to use.

We observed medicines being given to people, and saw that medicine continued to be administered throughout the morning as staff encountered constant interruptions. This meant that medicines were not always given on time and mistakes were more likely to happen.

We spoke with the member of staff responsible for medicines and looked at how medicines were managed for eight of the 21 people living at the service. We found concerns about some aspect of medicines handling for each of those people. Medication administration records (MARs) included personalised information to support staff on how to give people their medicines, all had allergy details completed and displayed a photograph of the person. However, we found medication records that were unsigned and handwritten records were incorrect and had not been checked by a second person, which is required to ensure the accuracy of the information recorded. We also found that medicine instructions were not consistent as they did not match the previous month. One person had six medicines with no specific directions about how often they were required. There were gaps in recording when medicines had in fact been given. Stock and records were compared balances did not match for six medicines, meaning some medicines had not been given as recorded, including one person's antibiotic. We also found one person had more than one chart for the same medicine. Staff had signed both charts on six days to indicate medicines had been given. This meant records did not reflect medicines that people had received. Medicines were not always given as

prescribed by the doctor, for example, an inhaler prescribed twice a day had only been given once a day for 19 days in June 2017.

People were prescribed medicines to be given "when required" (PRN). Some PRN care plans had sufficient detail to ensure these were given safely. However, one person's care plan stated double the strength and frequency of the prescribed medicine record.

We saw some recording of times when medicines containing paracetamol were given, but this was inconsistent. This did not ensure that a safe time interval was left between 'when required' doses. One person had been given two strengths of a paracetamol containing medicine on the same day, so time recording is essential to ensure safety. We found two unlabelled creams in an unoccupied unlocked bedroom that could put other people at risk if used incorrectly.

There were no people requiring thickeners or covert medication at the time of the inspection. However, there was a lack of understanding by staff when asked about the use of thickeners and people receiving their medicines covertly.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered provider had failed to protect people from the unsafe administration of medicines.

The premises were unsafe putting people's health and safety at risk. On the first day of inspection a door leading out of the dining room onto a small stone patio was unlocked. There were two people having breakfast in the dining room at the time and other people who were walking around the service entered and left the dining room at various intervals. There were no staff present in the dining room during this period. The patio area presented many hazards such as trip, slip and falls. There were other risks identified in this area. For example, there was a dust sheet on the floor in between two garden chairs and a heavy metal sack trolley was balanced against a wall near to a garden table and seats. There were tins of paint and used paint brushes piled up in corners of the patio and on top of a tall metal cupboard near to another garden table and chairs. The metal cupboard which was unlocked contained tins of paint and other substances including paint remover and weed killer. Broken cupboard doors were leant against the metal cupboard and there were carrier bags and plant pots randomly placed around the patio floor.

This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered provider had failed to protect people from unsafe premises and equipment.

The hazards were raised with staff at the time and they locked the door. However, after lunch a set of double fire doors leading from the main corridor onto the same patio were found wide open, there were no staff present at the time. It was noted that these were also deemed to be fire doors and there was a sign stating they should be kept closed at all times when unsupervised by staff. During our visit we saw staff had placed four wheelchairs side by side on the patio near to the exit point. This was brought to the attention of the registered manager who said the wheelchairs had been taken out onto the patio to be cleaned. On the second day of the inspection the patio area had been cleared of the hazards which we identified.

The sluice rooms on both the ground and lower floor which contained hazardous cleaning substances and equipment were unlocked. A member of staff told us that they were unable to lock the sluice room doors because the coded locks which were in place had broken. Staff said they secured the ground floor sluice room by use of a slide lock. The slide lock which was fitted to the outside of the sluice room did not ensure the security of the sluice room as it was easily accessible to people and on the first day of the inspection it was unlocked. A linen room on the ground floor which contained two mop buckets full of cleaning products

was also unlocked. This was despite a sign displayed on the outside of the door with the instructions; 'Fire door keep locked'.

The doors to the laundry and hairdressing room did not have locks on and they were wide open on the first day of inspection. Both rooms were unsupervised by staff at the time. Both rooms contained potential hazards including cleaning substances, electric appliances, bottles of shampoo and aerosols. In addition the rooms had the potential to cause heat generation and the risk of fire. This meant people's health and safety was put at risk. Doors to all rooms which contained hazardous substances and equipment were fitted with combination locks and they were in use to secure the rooms on the second day of inspection.

On the ground floor there were three mattresses and a stand aid stored directly outside the door of a communal bathroom near to people's bedrooms. The mattresses and stand aid obstructed entry into the bathroom as well as presenting as a trip, slip and falls hazard. The outside of the bathroom was cleared of all obstructions on the second day of inspection.

The cleanliness and hygiene of the service and infection prevention and control practices increased the risk of the spread of inspection. Parts of the kitchen and food stores were unclean. The cook confirmed that there were no formal cleaning schedules in place for the kitchen and that they carried out cleaning tasks in between preparing meals. There was a build-up of food debris on work surfaces next to food prepared which had been for the lunchtime meal. There was a large build-up of fat and food debris on and around the deep fat fryer and cooker. Floors behind work surfaces and other appliances in the kitchen also had a build-up of grease and food debris. The food store cupboard adjacent to the kitchen was generally dusty and dirty. A large amount of dust and debris was present on the floor behind the door in the food store room. The cook confirmed that it had not been cleaned up following repairs which were carried out several weeks ago. There were also cobwebs around the window and frame in the food store and two large freezers stored in the room had a build-up of dust and food debris behind them. A small fridge and surrounding area in the dining room was unclean with a build-up of spillages and food debris. Some cleaning took place in the kitchen on the first day of inspection after we raised the concerns about the hygiene and cleanliness.

The lid was open on the Euro bin (clinical waste container), which was stored at the front of the premises on an open space. The Euro bin which stored clinical waste had no lock on it; therefore the clinical waste stored in it was accessible to members of the public. This posed a risk of the spread of infection. A lock was fitted to the euro bin and it was secure on the second day of inspection.

The floor carpet in an unoccupied bedroom on the lower floor was heavily stained and the room smelt strongly of urine. There was a clothes rail in the bedroom which was full of various items of clothing, some which were in contact with the carpet. The registered manager confirmed to us that the clothes had been laundered and were there waiting to be returned to people. Also stored in the room was a large cushion which had been removed from a sofa situated on the main corridor. The registered manager confirmed that the cushion had been put in the room as it was wet with urine. Floors along the main corridor on the ground floor were sticky and had a build-up of dirt near to door thresholds and along skirting boards. There were no formal cleaning schedules in place at the service and no evidence to show that checks had been carried out on the cleanliness and hygiene of the service.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered provider had failed to protect people from the risk of the spread of infection.

The registered provider had an accident and incident reporting policy and procedure in place to review and monitor accidents and incidents. Accident and incident records had been completed as required. Accident

records showed that people had experienced multiple falls which resulted in injuries such as cuts, grazes, bumps and skin tears. However there was no evidence to show that body maps had been used to document the injuries found on people's bodies. In addition there were no records to show that injuries sustained were monitored to ensure healing. No analysis had been carried out on accident and incident records as a way of identifying any trends or patterns and help prevent any future occurrences. This meant that people were at risk of not receiving appropriate support following injuries sustained and further risks were not minimised.

Each person had a personal evacuation plan (PEEP) which was held in their individual care file. Care files were kept in a locked cupboard which was situated in the medication room which was locked when not in use. This meant PEEPs were not easily accessible should they be needed by staff or emergency services in the event that people needed to be quickly evacuated from the building. One person who was admitted to the service two weeks prior to our inspection did not have a PEEP in place. We saw examples were PEEPs for some people had not been reviewed for over a year and in one case there was clear evidence that the person's mobility needs had changed significantly. The PEEP showed that they were able to mobilise with the use of a zimmer frame and the assistance from one member of staff. However staff confirmed and the person's care records showed that they had experienced a decline in their mobility resulting in them now being unable to weightbare, requiring a hoist to mobilise and the support of two staff for all transfers. Some people's PEEPs identified that the person was living with dementia, however there was no information about the impact this had on the person and any support they needed with this in the event of an evacuation. This put people's safety at risk in the event of an evacuation of the building.

There were no records of fire drills having taken place at the service and staff confirmed that they had not taken part in a fire drill for some time. The registered manager confirmed that there had been no fire drills conducted at the service for over eight months. A fire risk assessment had been carried out on the premises in September 2015; however it had not been updated to take account of changes within the service. For example; the fire risk assessment stated that 'At the time of the assessment all residents were classed as mobile'. This was no longer the case as it was evident through observations and reviewing care records that there were people living at the service who were unable to mobilise independently and needed the assistance of up to two staff. In addition the assessment named a member of staff, who no longer works at the service, as Fire Marshal, the member of staff left employment over six months ago. We contacted the fire authority following our inspection with our concerns about fire safety at the service.

This is a breach of Regulations 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people were not protected from receiving unsafe care and treatment.

People were at risk of not being protected from abuse. There were sufficient numbers of staff on duty to meet people's needs; however some staff were unsure about how to fully protect people and keep them safe. More than 50 % of staff had not completed safeguarding training for over two years and two members of staff who commenced work at the service since the last inspection had not completed any training in topics of health and safety, including safeguarding. The registered providers provider's safeguarding policy and procedure and those set out by the local authority were available at the service. The documents described the different forms of abuse, how to recognise abuse and the action staff were required to take in the event of them witnessing, suspecting or being told abuse had taken place. However one member of staff was unaware of the documents and where to locate them. They were unable to confidently describe the actions they were required to take if they became aware of actual or suspected abuse. Their initial response was that they didn't really know but would probably tell who ever was in charge at the time. Two staff were not aware of the external agencies who they could contact such as the local authorities safeguarding team, with any concerns they had. Prior to the inspection we received concerns that one person had left the building through an open door on more than one occasion. This was despite the person having a

deprivation of liberty safeguard (DoLS) in place to keep them safe from leaving the leaving the service without appropriate supervision.

The registered provider had a whistleblowing policy and procedure. Whistleblowing is when staff report concerns in confidence and their disclosure is protected in law. Two staff were not aware of the whistle blowing policy and where to locate it. They were unsure about whom they could speak with outside of the organisation if they needed to raise any concerns in confidence.

This is a breach of Regulations 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people were not protected from abuse and improper treatment.

Recruitment of staff employed was not always safe. We saw evidence of a check carried out in respect of three staff employed since the last inspection, including a check with the Disclosure and barring service (DBS). These checks are required by law to ensure applicants are suitable for the job and to check on their criminal record to see if they have been placed on a list for people who are barred from working with vulnerable adults. However following our inspection we were provided with information which showed nine other members of staff were working at the service without evidence in place of a check on their criminal record.

This is a breach of Regulations 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because recruitment procedures did not ensure appropriate checks were in place for staff employed to show that they were of good character.

Checks had been carried out by a suitably qualified person on systems and equipment used at the service to ensure it was safe to use and a record of the checks were kept. This included checks on the gas and electricity systems and portable appliances.

Inadequate

Is the service effective?

Our findings

Whilst people told us that they thought the staff did a good job we found that the care provided was not always safe or effective. People's comments included; "They [staff] do their best for me" "They [staff] seem to know what they are doing" and "I get what I need".

People did not receive safe and effective care to meet their needs. The monitoring of people's eating and drinking had not taken place in line with their care plan. Charts to monitor this aspect of people's care failed to provide adequate information to ensure people received effective care and support. Fluid intake charts for two people did not identify the recommended amount of fluid people were required to consume in a 24 hour period and this information was not recorded in the person's care plan. The lack of information available with regards to people's fluid take meant there was no way of knowing whether they had consumed the right amount of fluid to keep them hydrated.

Care records which we looked at for one person showed that they required assistance with regular positional changes to reduce the risk of developing pressure ulcers. Positional changes needed to be recorded onto a positional chart to evidence the care given. However there was no chart in place for this person and there was no evidence recorded within their care file to show that they had been supported with positional changes. This meant people were at risk because they were not provided with the right care and support.

One person had a wound on their left heel which was being treated by the district nursing (DN) team. The person's care plan stated that staff were to ensure that the person had a heel pad in place at all times. On the first day of inspection the person was sat in an easy chair in the lounge barefooted with both feet directly placed on the hard floor, there was no heel pad in place. A member of staff told us that the heel pad was in the person's bedroom. A DN who attended to the person on that day confirmed that heel pad must be used at all times to relieve pressure and help with the healing of the wound. The DN confirmed that they had left instructions regarding this. On the second day of the inspection the person was asleep in a wheel chair in the lounge; they were again barefooted with both their feet placed directly on the wheelchair footplates. The heel pad which should have been placed under the person's feet was over the back of an easy chair in the lounge. The person's care plan stated 'To be turned regularly', however there was no information about how frequently the person needed to be turned and no positional monitoring records in place to show they had received the care they needed. This was despite a Waterlow risk assessment for the person showing that they were at very high risk of developing pressure ulcers.

This is a breach of Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as risks to people were not assessed and mitigated and records were not appropriately maintained.

Staff did not receive an appropriate level of support for their role. There was a policy in place set by the registered provider for staff supervision; however it was not followed to ensure staff were appropriately supervised for their role. The policy stated that all employees should be formally supervised and have the

opportunity to meet on a one to one basis with their manager to discuss and reflect on their work practice. However the registered manager confirmed that they had not conducted any one to one supervisions or appraisals with any of the staff team in over six months. The registered manager also confirmed that no staff meetings had taken place during that time.

Staff provided examples whereby they felt a lack of support impacted on their ability to carry out their role. For example one staff member was instructed by the registered manager to review and update care plans however they had not received any training or support with this. The member of staff said they had not completed certain sections of people's care records because they didn't feel they had the required knowledge, skills and understanding to enable them to do this. The staff member had informed the registered manager of this however they said the registered managers response was 'just do what you can'. Another two members of the care team staff had been given the responsibility to visit people at their previous residence to carrying out a pre-admission assessment. However neither of the staff had completed any training in relation to assessing people's needs. A lack of such supervision and appraisal meant staff did not have the opportunity to discuss matters relating to their work, including their role and responsibilities, their performance and personal development.

People were not supported by staff that had completed the relevant training for their roles. Three staff that had been recruited in April 2017 did not complete an induction programme. A single document titled 'Induction' listed a range of topics including health and safety, fire alarm; sign in book, breaks, sickness and confidentiality. The document included the staff member's name, date and had ticks placed against each of the topics listed. Recruitment records showed that each of the three staff commenced work over three weeks after the date recorded on the induction document. All three staff confirmed that their induction consisted of them being given a tour of the building on the day of interview during. They said that a brief discussion took place about each of the topics listed on the induction document. They confirmed that they had not been provided with any formal training since they started work at the service. Recruitment records showed one new member of staff had no previous experience of working in a care home setting and had not completed any training relevant to their job role and the needs of the people who used the service.

The training matrix provided to us and confirmed by the registered manager as being up to date, listed 22 members of staff. However the registered manager confirmed that five staff listed on it no longer worked at the service. The three newest members of staff who commenced employment in May 2017 were not included on the training matrix. The registered manager told us that very little training had been provided to staff in the last year. The training data showed that they majority of staff had not undertaken training in the topics listed for more than two years. Topics included; health and safety, fire awareness, safeguarding, first aid and equality and diversity.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as persons employed did not receive appropriate training, support, supervision and appraisal for their roles.

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 people lack mental capacity to make particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA 2005. The application procedures for this in care homes are called Deprivation of Liberty Safeguards (DoLS). We checked that the service was working within the principles of the MCA 2005 and found that they were not.

Staff, some of who had been recently employed had not received any training in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS.

People who lacked capacity were not protected in line with the Mental Capacity Act 2005 (MCA). At the time of inspection there were seven people living at the service who had an authorised deprivation of liberty safeguard (DoLS) in place.). Staff were unsure which people had a DoLS in place and what it meant for those people. There was little information held in care records in relation to DoLS authorisations, for example, what the restrictions were to keep people safe and how staff were to manage these to ensure people's safety. Staff who had been given the responsibility to complete care records told us that they had not completed the assessments and care planning documentation about people's mental capacity because they felt that they did not have sufficient understanding of what was required.

Prior to providing care and support staff informed people about what they were about to do and gained their consent. However staff lacked knowledge and understanding about how to gain consent for other important decisions for people who lacked capacity. For example, one member of staff they would consult with family members to obtain their consent, regardless to whether the family member had the legal authority to make decisions on behalf of the person. Another member of staff said they thought it was the responsibility of the registered manager or the person in charge to decide what was best for a person.

Some people had a 'do not attempt resuscitation' (DNACPR) order in place which had had been authorised by their GP. These were put in place where people had chosen not to be resuscitated in the event of their death or in cases where they cannot make this decision themselves. A GP and other individuals with legal authority had made this decision in a person's best interests. DNACPR certificates were held in people's care files. However one member of staff did not know which people had a DNACPR order in place and they said they would go ahead and attempt to resuscitate a person even without knowing whether it was right to do so.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered provider had failed to ensure that care and treatment was provided in line with the requirements of the MCA and DoLS.

Inadequate

Is the service caring?

Our findings

Whilst people told us that the staff were kind and caring we found that people were not always treated with dignity and respect. People's comments included "They [staff] are very nice, they do their best", "I like them [staff], they are all very pleasant" and "They [staff] look after me well".

People's confidentiality was not fully protected. There was a secure office near to communal areas with a lockable filing cabinet for the safe storage of personal records. However, three files containing people's personal records were left on a table in the main communal lounge. The records included information about people's personal care routines, care interventions and details of visits people had had with external professionals. This put people's confidentiality at risk because their personal records were accessible to those who did not have the authority to access them. This included people who used the service, none care staff, and visitors who met with people in the lounge. People's personal records were made secure after we raised this with a member of staff.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as confidential records were not securely stored.

People were not treated with dignity and respect. One person had a wheelchair in their room which displayed the name of another person. The person who occupied the room confirmed that they did not use a wheelchair and that they did not know who the wheelchair in their room belonged to. They confirmed that the wheelchair had been in their room since they moved into the service over two weeks ago. A member of staff confirmed that the wheelchair belonged to a person who previously occupied the room but had since passed away. A person was watching a television in their bedroom, however there was no sound to it. A member of staff told us that they had borrowed the TV from another person who lived at the service and that there was no remote control for it.

During the inspection relatives shared concerns with us. They felt that staff showed little compassion. They told us that people's clothes, some which were stained and dirty, were 'stuffed into a wardrobe' and dentures were in a mouldy pot. Others said that rooms smelt strongly of urine. When we checked this room on the second day of inspection we found it smelt strongly of urine. We found that shelves inside a wardrobe were packed with items of clothing, some which were unclean and some clothing belonged to a person who had since passed away. There was a clothes rail with items hanging on it stored in an unused bedroom which smelt of urine. The registered manager told us that the clothes hung on the rail had been laundered the day before and had been put in the room 'out of the way'. The registered manager called upon a member of staff and requested that they ensure the clothing was returned to people. This was despite the clothing being left overnight in the room, which smelt strongly of urine. We raised this with the registered manager who then instructed staff to return all the clothing to the laundry for washing.

People did not live in an environment that afforded them respect and undermined their dignity. The wall next to one person's bed near their pillow was heavily stained, their easy chair was worn and stained and there were handles missing from a chest of drawers. A member of staff confirmed that the bedroom had not

undergone any improvements prior to the person moving in. We saw many examples of poor quality pillows on people's beds and stored in linen rooms, for example pillows in use were lumpy and thin. This could have a negative impact on a person's wellbeing.
On the first day of inspection the patio and garden areas at the back of the building and the areas at the front were unkempt. The back patio was littered with cigarette butts and empty drink cans and the litter bin was overflowing with waste. A clock in the dining room showed the incorrect time, a member of staff confirmed that the batteries had stopped working several days ago. The television was on in the lounge and at the same time the radio was playing. This lack of consideration had the potential to distract and confuse people, particularly those living with conditions such as memory loss and hearing difficulties. New pillows were purchased for people and the gardens and patio area were tidied up on the second day of inspection.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as people were not treated with dignity and respect.

Inadequate

Is the service responsive?

Our findings

People told us that there was little to do other than watch the television. People said they would the opportunity to take part in more activities.

People's care needs were not assessed and planned for. We looked at a pre-admission assessment document which had been completed by staff at the service the day before a person was admitted. The assessment document recorded a number of medical conditions which the person had including; Alzheimer's, cancer and COPD (chronic obstructive pulmonary disease). The assessment also recorded that the person had poor mobility and needed help with aspects of their personal care including washing and dressing. The assessment document did not provide any specific information about the care and support the person needed with their needs identified through the assessment. There was no care plan in place for this person to instruct or guide staff on how best to meet their needs; this was despite them living at the service for more than two weeks. When we raised this with the registered manager her response was that she did not think the person needed a care plan because they were on respite.

The weight section of a nutritional risk assessment for another person had not been completed. This was despite the initial part of the assessment showing that the person had a poor appetite and a complicated medical condition affecting food intake. The overall scoring of the risk assessment met the criteria 'Needs Monitoring' and instructions under that heading listed actions which needed to be taken including; check weight weekly and encourage eating and drinking. However there was no nutritional care plan in place for this person to instruct and guide staff on how best to meet the person's nutritional needs. Furthermore there were no records to show that the person had been weighed. The person's daily notes frequently recorded statements such as 'very little diet taken, 'poor diet' and 'small diet'. A skin integrity care plan for the same person recorded that their skin should be monitored for any marks or bruising, however there were no records to show that the person's skin integrity had been monitored.

A mental health assessment for one person recorded that they can become verbally and physically aggressive when approached by staff and can be verbally aggressive to other 'residents'. A behaviour monitoring chart was implemented for the person on 21 June 2017. However there was no care plan in place to inform staff about how best to support the person with their behaviour. Staff explained that they knew that they needed to 'calm' the person during periods of aggression. However staff were not aware of a consistent approach or specific distraction methods needed to help the person overcome these behaviours. The person's daily notes included frequent entries which included statements such as 'head butted a member of staff' 'very aggressive with staff' 'constantly swearing when assisting with personal care' 'very violent when getting up hitting and punching, head butting staff and swearing a lot'. The records did not provide any details about what action staff had taken to support the person to overcome these behaviours such as distraction methods used and the outcome for the person.

The outcome of a nutritional risk assessment carried out for one person when they were admitted to the service in July 2016 indicated that they were at low risk but that the person's weight should be checked regularly. Weight records show that the person experienced a steady decline in their weight since admission

to the service and a weight loss of 4 kgs was recorded between the months of March 2017 and May 2017. There were no further recordings of the person's weight after May 2017 and no evidence to show that any action had been taken in response to the 4 kg weight loss recorded at that time. This was despite the person's nutritional care plan stating 'report or record any changes or concerns'. The nutritional needs risk assessment which was required to be reviewed weekly or more frequent if needed had not been reviewed since 29 April 2017.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the registered provider had failed to assess the risks to the health and welfare of people. They failed to do all that was possible to mitigate and address the risks.

There was a lack of evidence to show that people and/or their representatives had taken part in the assessment, development and reviewing of people's care. Assessment and care planning documents included a section for people and relevant others such as family members to sign to show that they had taken part in the planning and reviewing people care. These sections had not been signed on any of the records we looked at. Three people told us that they did not recall ever being invited to discuss their care plans.

There were little opportunities for people to engage in both one to one and group activities. There was no person employed at the service dedicated to organising and facilitating activities for people. Care staff said they offered people opportunities to engage in activities including board games and bingo. We observed one activity taking place throughout the three days of the inspection. This was on the first day of inspection when a member of staff encouraged a small group of people to take part in a floor game. Most people spent their time either asleep or watching TV in the main lounge. People told us there was little to do other than watch TV. One person said, "I often get tired of just watching the tele" and another person said "It would be nice to do something different". Family members told us rarely saw any activities taking place at the service.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the registered provider had failed to provide people with person centred care.

The registered manager reported that no complaints had been raised about the service. The process for making and responding to a complaint was clearly set out in the registered provider's complaints procedure. The procedure clearly stated that all complaints would be recorded, acknowledged and investigated and the findings shared with the complainant.

Inadequate

Is the service well-led?

Our findings

People knew who the manager was however they said she was not always visible around the service. People's comments included; "I know who the head person is but I don't see a lot of her around" and "She [manager] pops in and out".

The registered manager was identified on the rota as working at the service Monday to Thursday each week 9 am to 4 pm and at their home each Friday. The registered manager told us that she worked from home each Friday updating policies and procedures and other paperwork. Senior care staff were appointed as the person in charge during the absence of the registered manager.

The registered manager's office was located on the lower floor. The main entrance to the service and communal areas were located above on the ground floor. The location of the registered managers office meant that she was not easy accessible to people using the service, their family members and visitors. Staff told us that the registered manager spent a lot of time in the office when on duty and that she was rarely visible in other areas of the service. On the third day of our inspection the manager's office had been relocated to the ground floor near to the main entrance of the service.

In accordance with the registered provider's policies and procedures the registered manager was required to carry out checks at various intervals on aspects of the service including the environment, systems and equipment, care planning, infection control and medication. Records to reflect the findings were to be completed and action plans set to make any improvement needed. Records showed that the required checks and audits on the service had not been carried out as required since our last inspection in December 2016.

The registered manager told us that they had nominated other staff to carry out checks on the environment; however she failed to have an overview on the checks to ensure that they had been carried out as required. For example, records showed that just one building check had been carried out in May 2017 and related only to bedrooms. The document covered things such as lighting, heating, nurse call, flooring and décor. Actions were listed against three bedrooms checked; however there were no details about who was responsible for the actions and timescales for completion. When we visited the bedrooms we found that the actions identified during the check had not been completed. This included cleaning of a stained carpet, repairs to a wardrobe, and painting of stained walls. There were no records of any checks carried out on other parts of the premises, including the kitchen, store rooms, bathrooms, and toilets, communal and outside areas. The lack of monitoring and assessing the quality and safety of the service meant risks to people were not identified and mitigated.

The registered manager confirmed that since the last inspection in December 2016 they had not carried out any care plans audit or audits on infection control and staff records.

A medication audit was carried out at the service in April 2017 by the Community Medicines Management Team. The audit identified a number of concerns with regards to the management of medicines at the

service which resulted in an overall outcome of 47% which represented poor in areas. A further spot check was carried out by the Medicines Management Team on 23 May 2017 and they identified new and ongoing concerns. The findings identified a lack of action had been taken following the audit carried out in April 2017, concerns remained outstanding. However a medication audit tool completed on 16 May 2017 by a member of staff at the service showed that all aspects of medication were checked and found to be in good order. The registered manager confirmed that they had no involvement in the completion of the medication audit carried out by staff and had not checked it to ensure it was robust. Our findings during this inspection showed that a lack of action had been taken to make improvements in relation to the management of medication at the service and mitigate risks to people's health and safety.

The registered provider had a number of policies and procedures in place to support staff in relation to good record keeping, including confidentiality and maintenance of records. In addition there were systems in place for the safe storage of records. However the storage of records did not support people's confidentiality in line with the Data Protection Act (1998). Records pertaining to people's care were not kept secure and were at risk of being accessed by unauthorised people. Care records and other records required for the management of the service were not signed and dated and some people's care records were incomplete. This included supplementary records for monitoring aspects of people's care, quality monitoring, maintenance and staff recruitment records. The quality monitoring systems for checking records failed to identify a lack of appropriate record keeping.

The registered manager confirmed that they did not carry out an analysis of accidents and incidents. Records relating to three people, who were identified as a high risk of falls, evidenced that they had encountered a combined total of ten incidents between April and June 2017. No incident/accident analysis had been completed to establish any trends or patterns in incidents that had occurred. There were no recorded action plans in place to evidence what steps had been taken to prevent the risk of repeated harm.

The registered provider visited the service regularly however he failed to understand and take accountability of the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was a lack of scrutiny by the registered provider to ensure that their systems for assessing and monitoring the quality and the safety of the service were implemented

The registered provider had a comprehensive set of policies and procedures for the service which were made available to staff. Policies and procedures support effective decision making and delegation because they provide guidelines on what people can and cannot do what decisions they can make and what activities are appropriate. However people and others were put at risk because the registered providers policies and procedures were not being followed as required. This included monitoring the quality and safety of the service, staff training and supervision, disposal of clinical waste, accident and incident reporting, cleanliness and hygiene of the service and record keeping.

This is a of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as systems and processes in place to monitor the quality and safety of the service, make improvements and ensure compliance with the requirements of regulations were ineffective. Records were not kept secure or maintained.

The rating following the last inspection was prominently displayed near to the entrance of the service making it accessible for all to see. The registered provider had notified the Care Quality Commission (CQC) of significant events which had occurred in line with their legal obligations.

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 10 HSCA RA Regulations 2014 Dignity and respect People were not treated with dignity and respect.

The enforcement action we took:

NOP to cancel provider and manager

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not receive safe care and risks to people were not assessed and mitigated.

The enforcement action we took:

NOP to cancel provider and manager

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes in place to monitor the quality and safety of the service, make improvements and ensure compliance with the requirements of regulations were ineffective. Records were not kept secure or maintained.

The enforcement action we took:

NOP to cancel provider and manager

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures did not ensure appropriate checks were in place for staff employed to show that they were of good character.

The enforcement action we took:

NOP to cancel provider and manager.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Persons employed did not receive appropriate training, support, supervision and appraisal for their roles.

The enforcement action we took:

NOP to cancel provider and manager