Shamrock Villas Limited

Connemara Lodge

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Connemara Lodge provides accommodation and personal care for up to eight people who live with mental health needs. There were 6 people in the service when we inspected on 29 March and 4 April 2018. This was an unannounced inspection.

There was a registered manager in post. The registered manager was also the provider. 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 culture within the service did not promote a holistic approach to people's care to ensure their physical, mental and emotional needs were being met. Robust and sustainable audit and monitoring systems were not in place to ensure the quality of care was consistently assessed, monitored and improved. Quality assurance systems had failed to identify the issues we found during our inspection.

The provider had failed to take the necessary actions to ensure that the risks to the health and safety of people were assessed, mitigated and reviewed appropriately.

We observed there were adequate numbers of staff on both days of our inspection however they were not always effectively deployed. Training was not sufficient to provide staff with the knowledge they need to support people in order to keep them and others safe.

People's care had not been co-ordinated or managed to ensure their specific needs were being met. Risks to people injuring themselves or others were not appropriately managed. People were not adequately protected against environmental risks. People's medicines were not managed effectively to protect them from the risks of not receiving prescribed medicines.

Whilst care staff demonstrated they knew people well and were kind in their interactions with people living at the service, the provider had not ensured the service was being run in a manner that promoted a caring and person centred culture.

Care records were not recovery focused and did not demonstrate how people received personalised care that was responsive to their needs. Plans of care used negative language and sought to impose how people should behave and what they should do.

Despite the intentions of the provider for Connemara Lodge to be a rehabilitation service, there were no rehabilitation plans in place to demonstrate what skills people needed to develop in order to move to a more independent living..

The registered manager and staff demonstrated a lack of understanding regarding the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS.) People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible.

Systems in place to reduce people being at risk of potential abuse were not robust. Staff were aware of their responsibilities with regard to safeguarding people from abuse. However, they did not recognise or understand the wider aspects of safeguarding people from risk as identified in this report.

We identified multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following this inspection we took immediate enforcement action to restrict admissions and force improvement. The commission is further considering its enforcement powers.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special Measures'. The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, it 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.

The inappropriate management of people's medicines placed them at risk of harm

People were not protected from risks associated with environmental factors, unsafe management of food and ineffective cleaning regimes.

Not all risks relating to people's care and support needs had been identified and effective control measures put in place.

There were adequate numbers of staff on duty, however they were not always effectively deployed.

Systems in place to reduce people being at risk of potential abuse were not robust.

Is the service effective?

Inadequate

The service was not effective.

Training was not sufficient to provide staff with the knowledge they needed to support people in order to keep them and others safe.

People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible.

Care and support was not provided in line with current legislation, standards and evidence based guidance.

People were not effectively supported with their nutritional needs.

People did not always have full access to appropriate services to ensure they received ongoing healthcare support.

Is the service caring?

Inadequate

The service was not caring.

Whilst care staff demonstrated they knew people well and were kind in their interactions with people living at the service, the provider had not ensured the service was being run in a manner that promoted a caring and person centred culture.

People were not always involved in making decisions about their care.

The equipment and furnishings supplied did not protect people's dignity.

Plans of care used negative language in describing people and their behaviours.

Is the service responsive?

Inadequate

The service was not responsive.

Care records were not recovery focused and did not demonstrate how people received personalised care that was responsive to their needs.

Despite the intentions of the provider for Connemara Lodge to be a rehabilitation service, there were no rehabilitation plans in place.

We were not assured that concerns and complaints were taken seriously and responded to appropriately.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had failed to take the necessary actions to ensure the risks to the health and safety of people were assessed, mitigated and reviewed appropriately.

Robust and sustainable audit and monitoring systems were not in place to ensure the quality of care was consistently assessed, monitored and improved. Quality assurance systems had failed to identify the issues we found during our inspection.

Connemara Lodge

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 29 March and 4 April 2018. The inspection team was made up of two inspectors.

Before the inspection the provider completed a Provider Information Return [PIR]. This is a form which asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also looked at information sent to us from other stakeholders, for example the local authority and members of the public.

We spoke with five people who used the service and one relative. We also observed the care and support provided to people and the interaction between staff and people throughout our inspection.

We spoke with the registered manager who is also the provider. We also spoke with five other members of staff.

To help us assess how people's care and support needs were being met we reviewed six people's care records and other information, for example their risk assessments and medicines records.

We looked at three staff personnel files and records relating to the management of the service. This included recruitment, training, and systems for assessing and monitoring the quality of the service.

Inadequate

Is the service safe?

Our findings

The inappropriate management of people's medicines placed them at risk of harm.

We checked stock levels of Diazepam for one person and found the amount recorded on the medicines administration record (MAR) as being in stock did not correspond with the amount of stock in the medicines trolley. There was a deficit of 18 tablets, which could not be accounted for. During our inspection the registered manager was unable to provide records to confirm how much stock of Diazepam had been received or provide any explanation as to where the missing medication would be. They informed us the following day that these had been found in the returns box but the poor monitoring of medicines meant they had been unaware these were missing and therefore unaccounted for until we had pointed out the discrepancy in the records.

We found a further box of Diazepam in the medicines trolley without a pharmacy label to say who they belonged to or how they should be administered. The registered manager was unable to tell us who these belonged to. The MAR chart for one person showed they had been prescribed Diazepam to be taken three times a day. There were no entries on the MAR chart to show this had been administered. The registered manager told us this medicine had now been stopped by the persons GP and we were shown evidence of this. However this was not reflected on the MAR chart and could have been inadvertently administered by staff, particularly as an unaccounted box of Diazepam was found.

Without adequate systems to monitor stock levels of medicines people were at risk of not receiving their medicines as prescribed. The service was unable to confidently tell if people had been given too little or too many of their medicines. There was also a risk that should medicines have gone missing due to error or an act of theft this would have gone undetected.

The service used a medicines system where each person's medicines were dispensed in pods specific to the day and time they were to be administered. We found a pod of medicines prescribed to support one person with their mental health and to prevent blood clots remained in the medicines trolley. However, the MAR chart had been signed to say these had been administered. This meant the person had not received their medicines as prescribed putting them at risk of blood clots and unnecessary anxiety and distress related to their mental health conditions. The registered manager acknowledged this was an error and advised an investigation into the matter would be carried out.

Some people were prescribed medicines to be administered 'as and when required' (PRN) when they became anxious and distressed. These were only to be administered after staff had first supported them with positive interventions and strategies to avoid the use of medicines being given unnecessarily. However there were no PRN protocols in place to guide staff regarding these interventions. The MAR chart for one person showed they were prescribed a particular medicine on a PRN basis to, 'Use as needed for agitation.' However, this had been given three times a day every day since the beginning of the medicines cycle on 13 March 2018. It was not recorded why the decision has been made by the person or by staff that it was needed. The registered manager told us there had been a recent change in the persons prescription so the

medicine was to be administered twice daily with additional doses on a PRN basis when required. The MAR chart had not been updated to reflect this and the absence of a PRN protocol meant the person was at risk of not receiving this medicine as prescribed or receiving more than was necessary.

One person had a skin condition, which meant their skin was often inflamed and sore. They were prescribed an aqueous cream to manage this condition. We found two open tubs of this in the communal shower room. One of these had been opened 18 December 2015 and there was no date of opening on the other. The manufacturers guidance on the tub stated, 'use within 3 months of opening.' We found other tubs of the cream in a number of different areas of the home. One tub had been used to prop open an empty bedroom's window and another broken tub was found without a lid in the person's bedroom. The cream was in a poor state, mouldy and not stored safely. The lack of safe use and storage of these creams placed the person at risk of infection, pain and the skin condition worsening. The person told us, "My skin is sore all the time." They also told us they felt low in mood and having the long-standing skin condition was frustrating.

Other areas of medicines management did not meet current NICE guidelines for the management of medicines in care homes. Further concerns included; bottles of liquid medicines with no opening dates on them, poor recording in the controlled drug register, variable doses not being recorded on people's MAR charts to show how many had been administered meaning it was not possible to check stock levels. The poor management of people's medicines meant they could not be assured they would receive their medicines as prescribed.

A medication audit had been carried out by the floor manager in April 2018 between our two inspection visits. This had not identified any of the issues found during the second day of our inspection. The audit was ineffective and not adequate for the ongoing monitoring of medicines to identify discrepancies and errors so appropriate action could be taken to keep people safe from harm.

Risk assessments did not give enough information about how staff should support people when they became distressed. More guidance was needed with regard to de-escalation techniques and other actions staff may need to take to reduce the risk of further distress in these situations. One person's care plan showed there had been a number of incidents where they had become so distressed they had grabbed staff and other people's hair. They had also made threats to harm others and broken equipment and furnishings and fixtures in the environment.

Although triggers for people's anxieties, agitation and acts of aggression were recorded in plans of care, daily records showed these had not been fully understood or acted on by staff. The care plan for one person stated they become frustrated when having to wait for food; setting off the fire alarm and throwing things. However, care records showed occasions when the person had to wait while staff went shopping for food essentials such as milk, sugar, juice as these had not been readily available. This had led to periods of anxiety and agitation, which could have been avoided.

Incidents of verbal and physical assaults on other people and staff had been recorded for six people. Incident reports showed there had been no analysis or follow up to these events to learn and develop new strategies to manage the potential reoccurrence and prevention in the future.

Entries in incident records highlighted that staff lacked understanding about how to manage high risk situations when people became anxious or distressed. For example, an entry for one person explained that they had smashed the TV in the lounge. Staff had cleared the mess then left the person to attend to others. Another person had needed to alert staff that the person was now also kicking the TV. There was no further

entry to describe what happened next. Staff had not recorded what action they had taken to alleviate the person's distress and whether or not this had been successful. The opportunity was missed for staff to learn from possible positive interventions, which could be used subsequently in similar situations to avoid distress and risk of harm to the person and others.

The provider had failed to take the necessary actions to ensure people and others were protected from the risks associated with the unsafe management of food, poor infection control and ineffective cleaning regimes.

On the first day of our inspection we found the kitchen cleaning schedule had not been completed at all that week. Records which showed what cleaning had been carried out previously were not accurate as main areas in the kitchen were visibly dirty including the oven, sink and cupboards. Staff were initially unable to locate a steam cleaner indicated on cleaning records as being used daily which was eventually found stored at the back of a cupboard behind a large supply of toilet rolls and other cleaning products. We found rotten apples in one of the cupboards and had to ask staff to dispose of them. Condiments, which should have been stored in the fridge once opened, were found in a cupboard and seen to be out of date.

Fridge and Freezer temperatures had been recorded as being the same every day for a number of weeks, which did not provide assurance these were being taken accurately each day. Staff were unable to locate a thermometer in one of the fridges and one of the freezers so were unable to demonstrate how they took these temperatures to ensure food was being stored at the correct temperature to prevent the risk of food poisoning. We asked a member of staff if they knew what temperature these should be but they were unable to tell us. Some people were vulnerable due to their ongoing health conditions which put them at a higher risk of being seriously unwell should they consume food that was not safe to eat.

Communal bathrooms contained used, unlabelled bottles of shower gel and shampoo. These where dirty and it was unclear who they belonged to. We found baskets containing toothbrushes and toothpaste and used plastic foot covers in the same basket. Plastic garden chairs had been used in shower areas and were communally used, but there were no cleaning rotas in place and they were dirty, heavily stained in lime scale and grime. En-suite toilets and showers were poorly maintained. Toilet seats did not always fit the toilet properly and were heavily lime scaled. Showers cubicles and bathrooms had some broken tiles, which had not been addressed. These issues all meant cleaning of these facilities was difficult and would make the spread of infection harder to control.

One person had a particular health condition which mean others could be at risk of infection if not appropriately managed. There were no risk assessments or care plan interventions in place to manage this risk.

In the laundry there were three buckets and mops against the wall for cleaning. A sticky label on the wall denoted whether they were to be used for bathroom, kitchen or communal areas. However, they were not colour coded and it was not clear how staff would identify which mop to use for which area. The mop heads were grey and old and put people at risk of the spread of infection should they be used in the wrong area and not cleaned appropriately.

We asked a member of staff how they dealt with laundry which was soiled with urine or faeces. They told us this would be dealt with immediately but did not have knowledge of the use of bags specifically designed to be used for soiled items to prevent the spread of infection. Another member of staff told us about these and we asked to see where they were stored. They were unable to show us as they said they had run out. There was no separate facility for washing soiled linen as there was only one washing machine in operation. This

meant people were not protected against the risk of infection due to bodily fluids not being appropriately disposed of.

People did not have appropriate beds and mattresses in place. One person had been given a hospital bed and mattress, which did not fit the bed and was over a foot too short for the frame. The registered manager told us the mattress had been swopped for another person who needed a waterproof mattress as they had become incontinent of faeces and urine. There were no mattress cleaning schedules in place. We looked at mattresses in four other bedrooms and observed they were old, stained and we could feel the springs through the mattress tops. One had blood stains, another had what appeared to be mould. The provider had failed to recognise the importance for everyone at the service to have an appropriate bed frame and their own mattress to support recovery and dignity and had not considered the potential implications for the risk of cross infection.

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

People were not protected against environmental risks. We found furniture and fittings were in a poor condition. All rooms observed were in a very poor state of neglect, both for furniture, fixtures, and cleanliness. We found broken wardrobes, which were not attached to the wall, toilet seats not properly attached, broken desks and chairs were covered in dirt and dust.

There were no window restrictors on some first floor windows, including a sash window, which could be opened wide in an unoccupied, unlocked room where we found one person during our inspection. This person had a diagnosis of schizophrenia, severe anxiety and agitation, visual and auditory hallucinations which put them at risk of falling from the window when in a highly anxious state. The care records for another person described them as having suicidal thoughts and other psychotic experiences. People had not been protected from risks associated with falling from a first floor window whether deliberately due to their mental state at the time or accidently.

There were also high-risk ligature points throughout the service which had not been identified when assessing risk to those at risk of suicide or extreme states of anxiety and agitation. For example, we found exposed hospital bed rails and ropes used for door handles easily accessible to people. The risks associated with these had not been assessed and appropriate control measures put in place to prevent the risk of harm.

Other environmental risks included a rug which one person had previously tripped over, resulting in a head injury and subsequent stay in hospital, still in situ. There had been no assessment of this risk or analysis of this incident. There were uncovered radiators and pipework with no assessment of the risk of burning or scalding. There was also no control or monitoring of water temperatures.
One person was identified as being at high risk of seizures and another had been identified as being at risk of falls. Both would have been at risk of sustaining a burn should they have fallen against a hot radiator. However, this risk had not been assessed and control measures put in place to mitigate the risk of harm.

Environmental risk assessments were not specific to Connemara or the people who lived there. For example, the registered manager told us they considered it unnecessary to monitor water temperatures due to the rehabilitative nature of the service yet the risk assessment in place indicated water temperatures should be monitored as a control measure to mitigate the risk of burns and scalds.

This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014. Premises and equipment.

Staff were aware of their responsibilities with regard to safeguarding people from abuse and told us they felt comfortable reporting concerns to the management team. However, staff did not recognise or understand the wider aspects of safeguarding people from risk as identified in this report.

People were not protected against the risks associated with anxiety and distress, including the risks associated with the use of restraint. When asked, on the first day of our inspection the registered manager did not acknowledge that restraint had been used for any person living at the service. However, care records for two people showed restraint had been used by staff. An incident report for one person states, '[Person] was escorted out of the kitchen where [they] began slapping, punching and kicking me. I restrained [person] with the aid of [staff].'

Staff had not received training in de-escalation or breakaway techniques or use of appropriate restraint as a last resort. They therefore lacked the necessary knowledge to be able to respond appropriately and safely in a situation where a person was becoming increasingly distressed and the use of these techniques were required in order to keep the person and others safe.

Systems in place to reduce people being at risk of potential abuse were not robust. We were not assured that all incidents which could constitute abuse had been appropriately referred to the relevant authorities. An incident record for one person recorded that staff had been alerted to a room by another person, and had found the person's hands around the other's neck. Notes stated that staff had to remove the person from the room. This suggested staff had carried out some form of physical intervention and restraint. There was no other entry or investigation about what had happened, whether the risk remained or could have been prevented, actions to take to mitigate future risks and what checks had been carried out on the victim and the alleged abuser. Records did not show whether the registered manager had reported the incident to the local safeguarding authority. It was also not recorded whether the victim had been offered the opportunity to report the attack to the police and whether it had had an effect on their mental wellbeing.

The registered manager and staff lacked knowledge regarding their responsibilities in safeguarding children who visit the service and protecting people who may present a risk to them. The registered manager told us a child frequently visited the service. Staff had no training in safeguarding children and there were no risk assessments in place to guide staff. In addition to the risk of verbal and physical assault from people, there was also the risk of exposure to sexually inappropriate behaviour. The care plan for one person showed they often expressed their sexuality inappropriately, It was not clear how the risk of physical or psychological harm to visiting children was being mitigated.

This is 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.

Recruitment records showed checks had not been made on new staff before they were allowed to work in the service. Appropriate background checks had only been recently completed following an inspection of another service owned and managed by the provider where it was identified checks had not been carried out. However, records showed these checks had now been completed to establish that staff members were of good character and suitable to work with the people who used the service.

We observed there were adequate numbers of staff on both days of our inspection however they were not always effectively deployed to assist people with rehabilitative activities or cleaning of the service. One member of staff told us that although they felt there were usually enough staff to meet people's needs there

were times when additional support would be beneficial. They commented, "Sometimes people need one to one support. Sometimes it can feel a little bit stretched. The last couple of weeks have been quite testing. Today is quite quiet."

Inadequate

Is the service effective?

Our findings

The provider was failing to ensure that training, supervision and appraisal of staff's competencies and skills was sufficient to provide them with the knowledge they need to support people in order to keep them and others safe. This included a lack of training in how to manage situations when people were highly anxious and distressed and training in safeguarding children, as detailed in the Safe section of this report. Following our inspection the registered manager informed us that de-escalation and breakaway training had been booked for all staff.

Most training was delivered via e-learning. The registered manager informed us staff did not like face-to-face training and only learnt from online training. In contradiction to their views, a member of staff told us they preferred face-to-face training, as they believed they learnt more. It was difficult to assess how effective the e learning had been. For example, staff had completed e learning for food and safe hygiene training, but had not identified the poor hygiene and poor practices in the kitchen. They had also completed training relating to the Mental Capacity Act and management of medicines but we found they lacked understanding and knowledge of good practice in both these areas.

This is 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 when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager and staff demonstrated a limited understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). People were not supported to have maximum choice and control of their lives and staff lacked understanding in how to support them in the least restrictive way possible.

Mental capacity assessments had not been carried out for people living at the service. Care plans showed there were restrictive interventions in place to manage people's risks. This included poor money management and the ability to leave the home when they choose to do so.

Care plans did not contain consideration of whether people had the capacity to make decisions about their health, even if these were unwise decisions, for example, to spend their money on a takeaway in the week. People were not supported to learn how to manage their money independently and to budget. Instead, they were assigned a certain amount of money a day, given by staff at the home. People had not been assessed as lacking capacity to manage their own finances or any other deficits in their capacity to make unwise decisions.

Where care plan interventions where in place to mitigate the risk of a person consuming dangerous substances, these were restrictive and had not considered the impact on the person's freedom. Interventions to manage this risk had not been documented as being made in agreement with the person. Interventions in the care plan included, "Staff will now accompany you to the shop to ensure you do not purchase…,""Staff will check your bag for alcohol and gel bottles and confiscate them off you." Whilst these interventions were designed to protect the person from harm, there was no assessment of their mental capacity.

In the care records for one person it was recorded, "Staff have decided, along with your CPN (Community Psychiatric Nurse), that it is in your best interests that your bank card is kept locked away in a safe in the office." We saw no best interest assessments, capacity assessments, multidisciplinary conversations recorded between the CPN, registered manager and person or advocacy support.

The plan of care for one person in relation to smoking stated they could not smoke because they had previously had pneumonia. The plan of care informed staff the person only smoked when elated and they were to confiscate any cigarettes. There was no capacity assessment as to whether the person had the capacity to choose to smoke. This is a restrictive practice and without an appropriate best interests assessment impacts on the person's human rights.

No assessments had been carried out to establish if DoLS applications should be made for people living at the service. However, people's liberty was being deprived in some circumstances. One person told us, "They won't let me out. I'm not happy here." Care records for another person included a plan of care which stated, 'Staff will accompany [person] at all times when you leave the building.' Care records also showed the person had been refused access to the garden to smoke a cigarette early in the morning as staff informed them it was too early. Staff had refused to allow the person out and they had become increasingly violent and distressed. We asked the registered manager why a capacity assessment or deprivation of liberty assessment had not been carried out if the person was being deprived of their liberty. They informed us they didn't believe this to be necessary as the police completed capacity assessments and had told them they could refuse to allow the person out from the building. This demonstrated a further lack of understanding regarding the MCA and DoLs as it is the responsibility of the service to carry out these assessments, not the emergency services.

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

Records did not provide evidence that people were appropriately supported to maintain a balanced diet. The daily rehabilitation sheet prompted staff to comment on whether the person had eaten healthily. In response to this staff had written comments such as 'Always encourage [person] to eat healthily.' However, the records showed the person had pizza on three occasions and vegetarian sausages on four occasions over the last 10 days. Staff told us the person refused to eat healthily however there was no indication of how staff had encouraged them to eat a more balanced diet. One daily report for the person said, '[Person] has been a bit demanding towards staff members wanting loads of food and drinks.' However, the food

recorded on the daily rehabilitation sheet as being eaten that day indicated the person had eaten very little; tea and juice for breakfast, pizza and vegetarian sausage for lunch and custard and yogurt for dinner. It was unclear what support staff had given when the person had requested additional food or how they had been supported to ensure they had enough to eat.

Care records for all people living at the service contained a plan of care regarding takeaways at the weekend which stated, 'To promote a healthy lifestyle, cooking skills and money management, Connemara staff have set in place a rule whereby takeaways are only allowed to be purchased at the weekend. Buying multiple takeaways during the week does not assist your rehabilitation progress.' This rule had been put in place universally and did not consider people's capacity to make this decision for themselves. Furthermore, the rationale behind the 'rule' was not adhered to on the second day of inspection when we arrived to find the registered manager was "treating" people to fish and chips for lunch. Inspection of the fridge showed that should an alternative lunch be required there was no fresh food in the fridge to enable a meal to be prepared. This gave conflicting messages to people and did not allow them to be involved in making their own decisions about what they would like to eat that day.

Food purchased for people to eat was not always of a good quality. For example, we observed bread, vegetables, and crisps were all bought at discounted prices as they were past their best by dates. Whilst this did not necessarily put people at risk of illness from out of date food, it added to the overall feeling of neglect for people living at the home. It also meant we could not be certain that food purchased by staff had been purchased by the choice of people living at the home or because it was discounted.

The service described themselves as providing, "Personalised care to those with acute and chronic mental health conditions….staff support service user rehabilitation." However, the service did not fit The Royal College of Psychiatrist's definition of a rehabilitation service of people with complex mental health problems. Such a service is defined as, "Providing specialist assessment, treatment, interventions and support to help people to recover from complex mental health problems and to (re)gain the skills and confidence to live successfully in the community."

People did take part in some activities to assist in rehabilitation and independent living such as cooking meals and shopping. However, none of the people living at the service attended educational or work based activities, paid or voluntary. The registered manager informed us people living at the service did not want to go into mainstream education or employment as they felt isolated and not accepted when they did. They told us there was no other opportunities for people with mental health problems and they were therefore in the process of setting up a charity to support people with mental health problems to access educational courses and employment including the running of a small shop. However, we could not find any evidence the service had looked into other opportunities to support people's recovery in the meantime. They had not for example contacted local councils and education institutions for advice to see what was available.

The registered manager had considered the possibility of one person undertaking voluntary work, but stated the person was anxious. There was no plan of care in place to demonstrate how they would help the person to prepare for such a role. The registered manager told us, "If they do voluntary work I will get them to make sandwiches and sell these from the shop so that the profit can go towards the charity when it's operating." There was no evidence recorded that this had been discussed with the person and demonstrated a lack of understanding about supporting the person to make their own choices and identify their own goals to work towards.

Staff told us people cleaned their own rooms. However, on review of people's bedrooms it was evidenced

that people were self-neglecting. Bedding in some rooms were very dirty, as were fixtures and fittings, including bedroom doors and handles. People's clothes were discarded in heaps on the floor or wardrobes. Whilst people were encouraged to do their own laundry, there was no support to help people keep their belongings in a less neglectful way. One person told us, "Look what the staff did, no respect, look at my wardrobe. I find it very upsetting that they just dump my clothes in a pile like that, it's disrespectful." It was unclear whether staff or the person had put the clothing away, however, had people wanted to hang their clothes up they would not have been able too as wardrobes contained a very limited amount of hanger's.

The registered manager told us mental health services were often unhelpful if they had concerns about people living at the home who had entered a crisis situation. They told us care coordinators and commissioners rarely visited the service and were not supportive. However, they had not documented these efforts and had not taken matters further by complaining, so we could not evidence that attempts to engage with other services had happened.

Whilst people had access to a visiting hairdresser and chiropodist at the service, access to other health professionals were limited. For example, dietitians to support healthy weight loss, support offered to people to give up smoking, and occupational therapists/ falls team to support people who had been at risk of falling.

The registered manager had not consulted people about decoration, adaptation, and design of the premises. In spite of the home being in a poor state of repair, they had focused time painting the staff office in colours that could be related to Dr Seuss stories, including a stripped red and white door. This was of no benefit to people living at the service. One wall in the upstairs corridor had a plastic coating on it. The registered manager told us people could write down how they were feeling on the wall and this could then be erased should they wish. However, they also told us the coating had not been applied correctly so once written on the pen could not be removed. There was no evidence to show how this supported people and contributed to the neglect of the general decoration.

Despite the assurance in the providers statement of purpose that, 'All bedrooms are decorated in the Service User chosen colour scheme,' All bedrooms except one were painted in the same magnolia type paint. There was no evidence care had been taken to support people to make their rooms personalised. Furniture such as beds and mattresses were not always provided with the person in mind, as discussed within the safe domain.

People had access to an activity room. This room was bright and pleasant and people living at the service had been supported to decoupage dining chairs. Whilst this was a positive idea, one chair had been decorated with negative language about how people felt about being diagnosed with a mental illness. These words were cut from newspapers, focusing on negative experiences and social isolation of people with mental health problems. Staff had not considered how it might impact people to see this negative language on a daily basis. There was no evidence that if the person had felt in this negative way, it had been explored in a sensitive environment during one to one time with staff during or after the activity. There was no evidence people had decided to decorate the chair in this way on their own or if it had been a member of staff's idea to use this negative language.

Inadequate

Is the service caring?

Our findings

Whilst care staff demonstrated they knew people well and were kind in their interactions with people living at the service, the provider had not ensured the service was being run in a manner that promoted a caring and person centred culture. We observed the registered manager on various occasions swearing loudly at staff in front of people living at the service which did not support a environment meant to help people regain confidence and self-esteem, nor was it respectful behaviour towards care staff.

The equipment and furnishings supplied did not protect people's dignity. The standard of fixtures, fittings and furnishings was poor and did not promote a culture that would demonstrate to people they were important, respected and cared for. This included stained and ill-fitting mattresses, poorly maintained toilets and sinks, broken furniture, old and frayed towels and bedlinen. The neglect of environment in all aspects, including general cleanliness further perpetrated the self-neglect displayed by people living at the service. There was a lack of meaningful support by staff to help people to manage their activities of daily living to a good standard that promoted healthy outcomes. Research by The Royal College of Psychiatrists and Mental Health Foundation concludes that poor quality environments are clinically evidenced as having a significant negative impact on people's mental wellbeing.

Plans of care used negative language in describing people and their behaviours. For example, the use of words and phrases such as, 'Misbehaviour; being rude to staff; being argumentative when did not get own way; defensive and will lie and sulk.' We challenged the registered manager about this language after reading one care plan, and they told us it was written this way so the person would understand it. However, we found negative language used in all care plans reviewed which did not focus on positive aspects to support people in their recovery, to build self-esteem and daily living skills. This was a lack of respect for people living at the service which did not support best practice for rehabilitation services in providing a culture of positive thinking to achieve successful outcomes.

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

Although the registered manager told us people were involved in planning their own care we did not find evidence to show this was the case. All plans of care included an index which people and staff were asked to sign to say they agreed and understood. However, no dates of signing had been recorded and the index did not always include all the plans of care. It was not clear when reviews took place, who with, and how people had been supported to be involved in making decisions about their care and support.

One person was in hospital at the time of our inspection and during their absence four new care plans had been written and placed into the folder that included a number of restrictive practices. This included the removal of the lock on their door for when they returned so staff could enter when they needed to complete searches of the person's room for banned items. This did not take into account the views and preferences of the person should they return to the service. It did not support recovery or take on board consent and capacity.

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

Inadequate

Is the service responsive?

Our findings

Care records were not recovery focused and did not demonstrate how people received personalised care that was responsive to their needs. Plans of care used negative language and sought to impose how people should behave and what they should do.

Plans of care did not adequately address people's mental health needs. Whilst triggers for distress were identified, guidance on how staff could help to minimise this distress lacked detail. In one person's plan of care, their mental health needs were described as "low mood, anxiety, visual hallucinations, suicidal thoughts and other psychotic experiences." It did not explore how this affected them or coping strategies the person found useful in times of distress. No positive interventions were in place to help the person express themselves when distressed or support staff to build a therapeutic relationship with them.

Entries in one person's daily notes indicated they had been distressed over a period of some months and their mental health was deteriorating. Daily care entries did not reflect they were receiving positive support. Where they had been settled, entries simply stated they had been settled, had taken their medications. There was no recording to evidence quality of life and care received. As the person became more unwell, additional restrictive interventions were put into place without the recording of their involvement and without assessment of their mental capacity.

Another person had a diagnosis of bi-polar disorder. The registered manager referred to them as being quite elated currently, but later told us they were quite low in mood. We spoke to the person who told us they were low and were experiencing distress from voices and this made them unhappy. There was no documentation in plans of care or in daily records to demonstrate how they were being supported to prevent their mood from worsening and to prevent further hospital admissions.

One person had diabetes and dietary interventions in their care plan stated, "Generally you agree with staff about what you should not eat, but there are also times when you will argue with staff and be rude. Sometimes you will sneak food into your bedroom…you will become very defensive and will lie and sulk. This affects your relationships with staff." It was unclear whether staff would remove or refuse food from the person. It had not been explored what types of foods the person wanted to eat, whether additional physical observations were needed or support gained from diabetes professionals. There was no exploration of alternative healthy options and how the person had been supported to make informed choices. This lack of positive support had potential to damage relationships between staff and the person and ultimately be detrimental to their mental wellbeing and recovery.

Despite the intentions of the provider for Connemara Lodge to be a rehabilitation service, there were no rehabilitation plans in place to demonstrate what skills people needed to develop in order to move to a more independent living. Systems for reviewing and adapting care provided were not in place. There were no details regarding people's goals and how they should be supported to attain these. There was no record of how people were progressing with their rehabilitation and the service could not demonstrate how they formally monitored and reviewed a person's progress.

It was therefore unclear how the service was supporting people with positive outcomes.

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

There was a complaints procedure in place which was displayed in the service, and explained how people could raise a complaint. Records of complaints contained very little detail and did not demonstrate how feedback received had been used to put things right and make improvements to the service. For example, one record stated, 'Safeguarding attended due to complaints that a lady had raised, all sorted, no paperwork given to us.' There was no record of the nature of the complaint, details of how this had been investigated or actions which had been taken as a result. We were therefore not assured that concerns and complaints were taken seriously and responded to appropriately.

This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Receiving and acting on complaints.

The service was not currently supporting anyone who was believed to be at the end of their life. Plans of care were not in place regarding end of life care but staff demonstrated they understood people's culture and beliefs and would respect and provide care in line with these at the end of a person's life.

Inadequate

Is the service well-led?

Our findings

Quality assurance systems were not robust and had failed to identify shortfalls and areas where improvements were needed in the service. The provider had failed to ensure there were robust systems in place for effective oversight and governance, to ensure people were living in a safe environment, supported by staff who were competent in their roles and deployed in a way which met people's needs effectively.

The provider had failed to take the necessary actions to ensure the risks to the health and safety of people were assessed, mitigated and reviewed appropriately. This had led to a failure to make the improvements needed in the service to keep people safe. This included protecting them from environmental related risks such as burns and scalds from hot water, hot radiators and pipework. The registered manager used their view that the service provided was a rehabilitation service as a reason not to carry out certain environmental checks. This meant a failure to ensure the service being provided for people was safe.

Poor quality monitoring and governance systems had been identified as a concern in the inspection report for the providers other registered service. However, they had failed to use the feedback provided to adapt governance systems to be more robust at Connemara Lodge. The absence of effective monitoring or auditing meant opportunities to improve were missed and risks of potential harm were not being mitigated as far as possible.

Records of audits showed these did not take place regularly. On the first day of our inspection we found audits relating to all areas of the operation of the service had not taken place since December 2017. These audits had not identified the issues we found on our inspection and where areas for improvement had been highlighted it was not clear whether any action had been taken to resolve these.

There was no effective oversight of medicines audits, the most recent of which had been carried out between the two days of our inspection by the floor manager. This had failed to identify any of the concerns we found regarding the management of medicines and people therefore continued to be at risk of not receiving their medicines as prescribed.

Cleaning schedules were not robust and records of what tasks had been completed were unreliable as it was clear many of these had not been carried out as stated due to the poor hygiene standards found on the first day of inspection. When first presented with this evidence the registered manager blamed staff for this shortfall and failed to acknowledge it was their responsibility as registered manager to have oversight that these tasks were being completed, and to take appropriate action when they had not been.

The poor oversight and lack of leadership had resulted in a lack of structure and direction for the staff team. Staff were unclear on their roles and responsibilities and had not been provided with appropriate training or guidance to enable them to effectively carry out their role. Staff were not recognising or managing risks accordingly. Staff did not have access to up to date and relevant risk assessments and care plans to allow them to provide safe and effective care.

The conduct and demeanour of the registered manager whilst carrying out their role did not promote a positive culture in the service. Prior to our inspection we received negative feedback from family member's regarding the way in which the registered manager spoke to their staff and people living at the service. We observed they constantly used inappropriate language about and to staff about problems found at the service. When one person approached us requesting to speak with us privately the registered manager's manner towards them was parental and accusatory in tone, demanding to know why they had wet hair. The person later explained to us they had just had a shower. The registered managers conduct could be viewed as intimidating to others and prevent people from whistle blowing or raising concerns and complaints.

The lack of governance, oversight and knowledge of the needs of the client group in line with best practice and poor understanding of their responsibilities under the Health and Social care Act, 2008 meant the registered manager failed to demonstrate they had the knowledge and skills to safely provide a service to vulnerable people. They had not researched best practice guidance in rehabilitation care for people with mental health difficulties or liaised appropriately with external organisations about what type of support they should be offering. They demonstrated a lack of knowledge in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards which had led to restrictive practices being used within the service without appropriate assessment or consultation with people and others involved in their care.

They had failed to fully address the concerns about the environment with the landlord for fear of being evicted. They had not used legislation designed to protect tenants in order to ensure the landlord made the updates required to make the environment safe. This has meant people continued to live in a home, which failed to meet their needs and promote mental wellbeing and recovery.

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

There had been some conflict with residents living within the community who had raised safeguarding alerts to the local authority due to people living at the home becoming distressed and behaving in a way that caused concern. The registered manager had attempted to build relationships with the local community and had invited those living nearby to a meeting to dispel negative stereotypes about the service and answer any questions people may have. The event had been advertised via a sign outside stating, "Don't talk about us behind our backs, come and talk to us." No one from the community had taken them up on the offer, possibly because such a statement could be seen as confrontational and not welcoming. Whilst the registered manager demonstrated good intentions with regard to involving the community, they needed to adapt their approach in order to achieve the positive relationships they were aiming for.