Belle Vue Healthcare Limited

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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

This inspection was carried out over three days, each of which was unannounced. This meant the registered provider did not know we would be visiting. We attended out of hours on each day. Two adult social care inspectors and a specialist advisor attended on 21 March 2016; one adult social care inspector, one pharmacist inspector and one specialist advisor attended on 5 April 2016 and three adult social care inspectors and one specialist advisor attended on 18 April 2016.

Bellevue Healthcare Limited is registered to provide care and support to 102 people. At the time of our inspection there were 76 people using the service and 96 staff employed. There were three units at the service which provided care and support to people living with a dementia, people who required nursing care and young adults living with a physical disability.

Bellevue Healthcare Limited had been registered with the commission since 2001. A registered manager was in place until 2014 when the registered manager retired. There had been three managers since then however none applied to become registered manager. At the time of inspection, one of the registered providers told us they were in the process of applying to become a registered manager. 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 service was placed into the serious concerns protocol with the local authority in March 2016. This is way of providing support to a service where there are concerns. The service was placed into this protocol because of an increased number of safeguarding alerts made by health professionals external to the service. The professionals involved in the serious concerns protocol had significant concerns about the registered provider's ability to provide safe care and support to people. An embargo was put in place which meant that admissions into the service were stopped.

The registered providers had not always notified CQC about events which had taken place at the service. This included when DOLs applications had been granted, when the nominated individual and registered manager left their posts and when a person had died. CQC will take action to address these outside of this inspection process.

When a person died, we could not be sure if appropriate action had been taken by the service. We will look at this outside of this inspection process.

Staff did not always know the people they were providing care and support to. Some staff lacked confidence in caring for people with specific needs because they had not received the training and support to do so.

Privacy and dignity was not always maintained. We observed personal care taking place as bedroom doors were not always closed when this was carried out. People's care records were not stored securely. Incontinence pads were displayed in communal bathrooms, in the corridors on trolleys or left on people's bedroom floors.

People were regularly left in bed throughout the day. Staff told us this was because of people's health needs or because it was safer for people. The two registered providers told us that there was no reason why people should be in bed throughout the day unless it was their choice to do so.

Evidence of consent was not available in all of the care records which we looked at. At the start of our inspection not everyone who needed Deprivation of Liberties Safeguards had them in place. Staff displayed very limited knowledge and understanding about the Mental Capacity Act. Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) were not accessible at the start of our inspection.

Care plans were not person-centred and lacked the detail needed to provide care and support to people according to their wishes, needs and preferences. Care plans were not always reviewed within the timescales set by the registered provider and lacked detail. People had the same care plans in place regardless of whether they were needed. Some people did not have the care plans in place which were specific to their individual needs.

Risk assessments contained limited information and did not always match care plans. They were not regularly reviewed. Some people did not have the risk assessments in place which they needed.

We could not be sure if appropriate action had been taken when a person experienced a fall because no additional checks had been carried out to check the person. A safeguarding alert had not been made in light of this.

When people moved into the service we could see that there were gaps in their initial assessment records. The service had not taken action to request this information from the people involved.

We could see people were involved with health professionals however regular health checks were not up to date. There were gaps in the records about visits from health professional and their recommendations.

There was no evidence of people's involvement in their care records. There was no evidence of people's wishes, likes and dislikes. The registered providers confirmed staff wrote peoples care plans without involving them.

Training for end of life care was not up to date. Records relating to people's wishes relating to the end of their lives were not up to date.

Risk assessments and food and fluid balance records were in place but were not fully completed. Some people were not supported to eat when choosing to stay in their own rooms.

Medicines were not managed safely. Some prescribed topical cream prescription labels were not legible and nutritional supplements did not contain people's names.

Infection prevention and control procedures were not always followed. Some areas of the building required cleaning and some items of bathroom furniture were in need of repair or replacement. People's toiletries were found mixed together in communal bathrooms.

Safeguarding alerts had not been made by the service. Staff training in safeguarding was not up to date. Staff displayed very limited knowledge and understanding of what could constitute a safeguarding alert and the procedure which they needed to follow.

Staff told us they had been a significant lack of leadership at the service; however all spoke positively about the two registered providers who were now providing day to day management.

There was a lack of clinical leadership in place to make sure staff were carrying out the duties expected of them. No one was accountable for the service in the absence of the registered providers.

The vision and values for the service were not being followed by the staff in place at the service. Staff told us they had struggled with the number of different managers which had been in place and the number of changes which had been made.

A survey had been carried out in 2015 however no action plan was in place. The two registered providers told us they had responded to key points identified in the survey however there were no records to support this.

There were no quality assurance processes in place. This meant the registered provider had not identified the concerns found during inspection.

The service had taken on a 'Step down bed' contract with a local hospital which had been busier than expected. We found that there was a lack of communication between the registered provider and the local hospital. Information needed about people placed at the service under this contract was not always sought. The service failed to make any safeguarding alerts against the local hospital when they needed to.

Staff did not carry out the duties expected of them. There was no-one in place to support staff to ensure that these duties were carried out. When staff raised potential safeguarding alerts with senior staff they had failed to take action. They had not raised a safeguarding alert or had not shared this information with the two directors.

The CQC had not been notified of any potential safeguarding alerts because the service had failed to make them to the local authority or CQC.

Staff told us there had been a lack of communication at the service because there had been no consistent manager for some time. Some staff told us they had discussed their concerns with the registered provider however felt that they had not been listened to or their concerns had not been resolved.

There were not enough staff in place to provide care and support to people. There were limited systems in place to cover sickness and annual leave.

Supervision, appraisal and training were not up to date. Staff participated in an induction programme and records were in place to support this.

There were systems in place to recruit people which included a disclosure and barring services check and two checked references however nursing PINS were not checked.

Disciplinary procedures were in place however formal records were not. During our inspection staff were taken into the disciplinary process.

Certificates relating to the health and safety of the building were up to date. Maintenance checks were carried out however they were not always at the frequency expected by the registered provider.

Each person had their own room and we could see that these rooms contained people's personal possessions. People had the choice of spending time in their rooms, in communal lounges and in the garden.

A small number of complaints had been made over the last year. We could see that appropriate action had been taken and records were in place to support this.

We found ten breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to person-centred care, consent, care and welfare, safeguarding, quality assurance and staffing. In light of the serious concerns identified at this inspection we are taking enforcement action and will report on this once it is concluded."

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.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Safeguarding alerts had not been raised when needed. Staff displayed poor knowledge of safeguarding procedures.

Medicines were not always managed safely for people and medicine administration records had not been completed correctly. People did not always receive their medicines at the times they needed them and in a safe way. Medicines were not administered and recorded properly.

There were not enough staff to provide care and support to people at the service and ineffective processes to cover staff absence.

Is the service effective?

Inadequate

The service was not effective

Supervision, appraisals and training were not up to date for all staff. Some staff did not appear confident looking after some people with specific health conditions due to a lack of training.

Staff displayed poor knowledge and understanding of capacity and did not always know if people had the ability to make a decision.

Monitoring of nutrition and hydration was not always clear and there were significant gaps in these records.

Is the service caring?

Inadequate

The service was not caring.

Some staff did not appear to know the people they were providing care and support to. People spoke positively about staff.

People were not regularly involved in making decisions about their own care.

The privacy and dignity of people was not always maintained. Some people spent a lot of time in bed throughout the day.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans were not person-centred and lacked the detail needed. Records of care reviews were very limited. Care records were not stored securely.

There was no evidence of people's choices and wishes in care records. Some care records contained contradictory information.

There were limited activities taking place and people told us they did not always get to go outside.

Complaints had been made and dealt with appropriately.

Is the service well-led?

Inadequate

The service was not well-led.

There was a lack of leadership in place. No-one appeared accountable during our out of hour's visits.

There were very few quality assurance processes in place. They did not highlight the concerns we identified during inspection.

The registered providers and staff did not always carry out the duties and responsibilities expected of them.

CQC had not always been notified as required about changes at the service.

Bellevue Healthcare Limited

Detailed findings

Background to this inspection

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

This inspection was carried out over three days, each of which was unannounced and outside of normal working hours. Two adult social care inspectors and a specialist advisor attended on 21 March 2016; one adult social care inspector, one pharmacist inspector and one specialist advisor attended on 5 April 2016 and three adult social care inspectors and one specialist advisor attended on 18 April 2016.

Before the inspection we reviewed all of the information we held about the service, such as notifications we had received from the service and also information received from the local authority who commissioned the service. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescale. We also spoke with the responsible commissioning office from the local authority commissioning team about the service.

Prior to our inspection, the service had been placed into serious concerns protocol with the local authority because of concerns raised by health professionals who had submitted a number of safeguarding alerts. This is a process of offering support to a service to make improvements.

The registered provider was not asked to complete a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During this inspection we spoke with 16 people and four relatives. We also spoke with the two registered providers and 31 staff.

We looked at 19 care records and a variety of supplementary records such as food and fluid balance charts for a further ten people. We looked at the medical administration records (MAR) of 11 people and we looked at the topical creams of 16 people.

We looked at a range of records which related to the day to day running of the service. We looked at staff records which included five recruitment records, the training records of all staff and 57 supervision and appraisal records.

Inadequate

Is the service safe?

Our findings

The service made safeguarding alerts to the local authority when needed. Safeguarding alerts had been raised by visiting health professionals because they had concerns about the ability of the service to keep people safe and to provide appropriate personalised care and support to people. The safeguarding team at the local authority upheld some allegations of abuse. This meant that they had the evidence they needed to determine that abuse had taken place. The number of safeguarding alerts received into the local authority had led to the service being entered into serious concerns protocol with the local authority. This meant that the professionals meeting under this protocol had significant concerns about the services ability to keep people safe.

At the time of our inspection, there were eleven safeguarding alerts open with the local authority for the service. Under the serious concerns protocol, an embargo was in place which meant admissions into the service were stopped. The serious concerns protocol team determined that the registered provider had poor knowledge and understanding of safeguarding.

During our inspection we raised four safeguarding alerts. These alerts were raised because we were concerned that people were in bed throughout the day because staff felt people needed to be, because of their health conditions. There were significant gaps in care records and deprivation of liberties safeguards had expired or were not in place. Of the four safeguarding alerts we made, we noted staff had failed to recognise the signs of abuse.

Staff knowledge of safeguarding, specifically what needed to be reported and the procedures they needed to follow, was poor. We could see that safeguarding training was not up to date for staff. An inspector observed part of the safeguarding training delivered by the registered provider and found that a superficial level of information was given. We found that information was unclear and conflicting at times. For example, the registered provider told staff that if someone refused to have their incontinence pad changed this did not need a safeguarding alert to be raised; however if they were wearing the same incontinence pad three days later then staff were required to make a safeguarding alert.

During our inspection, we spoke with one person who told us that money had gone missing and they had reported it to a member of care staff. We spoke with the registered provider who knew nothing about it. From their investigation we identified that the member of care staff had recorded this allegation in the person's care records and had shared the information with a nurse and team leader. Both of these people had failed to take action to raise a safeguarding alert and inform the registered provider who was on site on the day of the allegation. We asked the registered provider to make a safeguarding alert. They contacted the local authority to ask about how they did this. We saw later that a safeguarding alert had been made and the police had been contacted. The registered provider told us that staff would face disciplinary action because they had failed to follow correct procedure.

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

There were insufficient staff on duty to provide appropriate care and support to people. People and staff told us they felt that there was not enough staff at times. On staff member told us, "We are concerned there is not enough staff on a night." Another staff member told us, "There is not enough staff. It's worse on a weekend. They take staff from this unit and use them to fill another unit which is short. This leaves us short." One person told us, "It's very understaffed really." One staff member told us, "There is a lack of staff here. You find yourself rushing around. It worries me. I don't like to say 'No' to people. People think you will never come back. If we had more staff, people's needs would be met. I like to value time with people. I don't like to rush people. I feel like I can't sit and have a conversation with people." One relative told us, "No there is definitely not enough staff. All the staff are running around. It's worse at mealtimes. Staff are diving all over the place. There are no systems for looking after people."

Staff told us they were busy and couldn't always provide care and support to people when they wanted to. One member of staff told us, "I feel we are neglecting people because we are busy." One staff member told us, "Sometimes we leave people later than we want because we are busy."

Another staff member told us, "We are often short on the young adults unit. It is an extremely busy unit. There is a lot to do. People stay up later. We use ceiling hoists. We need three staff." One staff member told us, "Service user needs have changed. They are now more complex and everything needs documenting." One person told us, "They are short staffed upstairs (elderly unit). We need more staff in here. There no one around." We spoke with a staff member working in the young adults centre about staffing and they told us "If we have our (staff) numbers (on this unit) we have enough staff. If staff are off sick or moved to another unit then we are under pressure."

Each person had a dependency tool in place which was completed each month, however this information was not used to inform staffing levels. No other formal tool was in place to determine staffing levels. We found that no formal procedures were in place to cover staff absence. The service used an agency service for nurses but not for care staff. There were no robust procedures in place to cover staffing levels. One staff member told us, "When people ring in sick, there are no attempts to cover shifts. We all work on minimum staffing levels.

On our first day of inspection at 06:40 we visited the young adults centre and found two care staff and one nurse on duty. Both care staff were assisting one person with personal care and the nurse was dispensing prescribed medicines to another person on the same (upper) floor. This meant the ground floor was left unstaffed and staff told us they would not have been able to respond to any call bells while they were busy.

On the third day of our inspection we identified that one person slept downstairs and 10 people slept upstairs on the dementia unit. One member of night staff stayed with the person who slept downstairs throughout the night. We saw that this person was in the day room with the night staff member. We could not be sure if this person could spend time in their room throughout the day because a member of staff would have needed to stay on the ground floor with them which would have left the dementia unit short staffed.

Although there was a nurse on each unit, we identified that they only dispensed the prescribed medicines of people with nursing needs. One team leader dispensed prescribed medicines to people considered to have 'residential care needs' on all three units. This meant that there would have been a shortage of staff during this time. On the first day of our inspection, staff on duty left the floor to attend planned training. This meant the home was short staffed for the duration of this training. One staff member told us, "We are short staffed today because of training." On the third day of inspection we arrived at the service at 05:40. We observed three staff outside having a break. This meant the home was short staffed during this time.

We looked at three months' worth of staff rotas and identified gaps throughout these records. This meant that we could see that the home had been short staffed on many occasions. Staff told us that 'fully staffed' units were relied on to provide cover to the units which were considered to be short staffed. We found that staff picked up extra shifts when they were able to. However we also found that staff were off sick on many occasions and the registered provider had not taken any action. Many staff told us that staff often phoned in sick at weekends.

We spoke with the registered providers about our concerns with staffing levels and they felt that there were enough staff on duty to care for the number of people using the service. They told us that there was high sickness at the service however disciplinary procedures had not been followed by previous managers. One staff member commented to us about sickness levels and told us they wanted the sickness rates to improve. At the start of a training session we observed the registered provider spoke to staff about sickness levels and the actions they would take if staff repeatedly took sick leave. Following our discussion with the registered providers, 11 staff were involved in the disciplinary process related to sickness. This meant the registered provider was addressing an issue which was affecting the smooth running of the service.

This meant there was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how medicines were handled and found that the arrangements were not always safe.

Most of the people who used this service had their medicines given to them by the staff. We watched a nurse giving people their medicines. They followed safe practices and treated people respectfully. People were given time and the appropriate support needed to take their medicines. One person was self-administering some of their medicines. However a robust risk assessment was not in place to ensure that they were safe to do so.

Records relating to medication were not completed correctly placing people at risk of medication errors. Medicine stocks were not properly recorded when medicines were received into the home or when medicines were carried forward from the previous month. This is necessary so accurate records of medication are available and care workers can monitor when further medication would need to be ordered. For medicines with a choice of dose, the records did not always show how much medicine the person had been given at each dose. For example, eye drops for one person were signed for on the MAR as applied twice daily which was different to the once daily dose prescribed. This meant that it was not possible to tell whether these eye drops were being used correctly.

When we checked a sample of medicines alongside the records for 11 people we found that 12 medicines for six people did not match up. This meant we could not be sure if people were having their medication administered correctly. Three medicines for three people were not available. This means that appropriate arrangements for ordering and obtaining people's prescribed medicines was failing, which increases the risk of harm. For one person the same medicine was not available on three occasions in the last two months.

We looked at records kept on the use of 'when required' medicines. Although there were arrangements for recording this information we found this was not kept up to date and information was missing for some medicines. This information would help ensure people were given their medicines in a safe, consistent and appropriate way. For example, one person was prescribed a medicine that could be used for agitation. There was no documentation in the care plan to guide staff on when it should be used. For another person the prescribed dose had changed but the guidance had not been updated to reflect this.

Medicines were stored securely. Records were kept of room and fridge temperatures to ensure they were safely kept. However, we saw that eye drops for two people, with a short shelf life once opened, did not have a date of opening noted, so could still be in use after the date recommended by the manufacturer. This meant that staff could not be sure this medicine was safe to administer.

Medicines that are liable to misuse, called controlled drugs, were stored appropriately. Additional records were kept of the usage of controlled drugs so as to readily detect any loss.

We looked in the rooms of 19 people on the elderly unit to look at prescribed topical creams. There were no records or body maps in place for these topical creams. This meant that we did not know when, where or how often these prescribed topical creams should be applied. Not all of the prescription labels of these creams were legible and there were no dates of opening on any of the prescribed creams which we looked at. This meant that we did not know if these prescribed topical creams were safe for use. One prescribed topical cream we looked at had a prescription date on the tub which showed the prescribed topical cream was out of date.

We looked at how medicines were monitored and checked by managers to make sure they were being handled properly and that systems were safe. We were told that no audits had been completed in the last three months therefore issues found during our visit had not been identified.

We found that fortified food and drinks were kept in an unlocked room and did not always contain the names of the people they belonged to or a date of prescription. We found two boxes of nutricia calogen extra shots, five boxes of fortisip compact and 10 boxes of calgon shakes which had no name or date on them. There were 27 Enteralock plus syringes with no name and three Terumo syringe with no name.

We observed one person asking a staff member to check them for a rash which the staff member did in the lounge where other people were sitting. No attempt was made to move the person into a private area. The staff member said it was red and they would get a team leader. Later in the day the person asked the staff member to scratch this area for them because it was itchy. The staff member did this in the lounge area and did not wear any gloves. This meant that infection prevention and control procedures were not followed and the dignity of this person was not maintained. We could see that the team leader checked this person and the person told us they had to keep an eye on it. The person told us they had a history of shingles. Staff failed to take action to ensure that rash was checked by the person's general practitioner.

The registered provider had an up to date policy on restraint, however this policy made reference to a different service. The policy gave examples of when restraint could be appropriate to use and staff needed to work within the guidance of the Mental Capacity Act and Deprivation of Liberties Safeguards. The registered provider told us they had worked with staff to understand the definition of restraint, specifically for the use of bed rails, because many of the beds in use at the service had integrated bed rails in place. We did not see risk assessments in place for people with bedrails or consent from people with them in place. The policy stated that best interest decisions needed to be in place for people using bedrails. However during our inspection, we observed people with bed rails in place without any best interest decisions available. We saw that health and safety checks of bedrails were carried out by the maintenance team but not within the timescales set out by the registered provider. However, there was no guidance available for this which meant we could not be sure what checks were being carried out.

Risk assessments were in place, but not for all of the areas relevant to each person. We also found that information contained in them was limited. We looked at two risk assessments relating to pressure sores. We could see they had been completed, but they were undated which meant it was unclear whether they

reflected people's current level of risk. A 'Risk review' was in place for two people which included areas such as sensory perception, activities, mobility and nutrition. We could see this review had been scored, however there was no information about what the scoring meant. This meant that we did not know when staff should be taking action. A care plan for one person was in place because they were unable to use the call bell, however no risk assessment had taken place to determine if the care plan was sufficient.

Risk assessments for one person had not been reviewed every month as required by the registered provider for moving and handling, bed rails and falls. A risk assessment for behaviour had been signed by staff and the person's relative but had not been updated since it was written on 8 March 2015. We saw that two staff were needed to support the person and to provide reassurance, but there was no record of how or when this should be done. The record stated that if the person did not settle, they should be left and allowed time to settle. We found there was insufficient information for staff to be able to provide appropriate care and support to the person when they were distressed. Monthly evaluations stated that there were no changes needed, however we could see from the person's care records that they became agitated on intervention. This had not been picked up during the monthly evaluation.

Turn charts were not regularly completed. In one person's records we could see that two hourly turns to prevent pressure sores from developing had been completed throughout the night but not during the day. We saw the person was in bed throughout the day which meant the risks of developing a pressure sore was increased. A review of one person's care stated that they needed to be checked by staff every two hours because they were unable to use the call bell system. We found that no risk assessment or review of this had taken place. This meant that we did not know if two hours was sufficient and how the person could gain staff attention if they needed help in between these two hourly checks. Two hourly safety checks were carried out for everyone using the service. We found there was sometimes a delay in these checks being completed, for example for one person we identified that their 06:00 check had been recorded at 07:05. This meant that this person had gone unchecked since 04:00. For another person we found that an 08:00 check had been missed. We checked the records at 08:50 and it had not been carried out.

People had personal emergency evacuation plans in place however we identified gaps in these records. The records looked at during inspection were not person-centred. They did not state if people were taking important prescribed medicines such as epilepsy medicines. There were no care needs identified other than whether a hoist was needed.

When we inspected out of hours, we found there was no one accountable for the service. The nurse on each of the three units was responsible for that unit but no one for the service as a whole. This meant that the nurse which we spoke with could not provide details about the total number of people using the service, for example. It also meant no one knew who would take charge during an emergency situation, or if staff had the information they needed to pass onto emergency services.

Accidents and incidents had been recorded. However, actions taken had not always been evidenced. We looked at five recorded falls and could see that one had resulted in a visit to accident and emergency and another had resulted in a head injury. From speaking with staff we could see that appropriate care and support had been given to people. The registered providers told us they looked at this information each month to look for patterns and trends to allow action to be taken.

On the first day of inspection we observed people using wheelchairs in the young adults centre struggling to open doors themselves. We found people were struggling to open doors in the dining room and the garden area on their own. On one occasion we had to intervene because we could see that the person was at risk of harming themselves.

Wheelchair cleaning records were in place. We could see from the records that weekly cleaning of wheelchairs was not being carried out. We looked at records between 1 January 2016 and 5 April 2016 and found they had been cleaned six out of a possible 13 times. We identified that one person's wheelchair had not been cleaned since 25 January 2016.

There was no guidance in place for hoists, which meant that we did not know what checks were being carried out. We could see from the records that weekly checks of hoists had not been carried out. Nurse call bell checks were in place; however they were not carried out each week as required by the registered provider. We found seven weekly checks out of a possible 16 had taken place during 2016. Water temperatures had been checked regularly. The records did not always show what action had been taken when temperatures did not fall within health and safety guidelines.

We saw one mattress check had been carried out in 2016. There was no guidance in place about the frequency or the types of checks that should be carried out. Records showed that some mattresses were worn but did not show if they had been replaced. When we spoke with the registered providers they told us they had been replaced but the records had not been updated. Bed rail checks had been carried out each month, however there was no guidance in place about what checks should be carried out to ensure bed rails were safe for use.

The fire alarm was tested weekly. Three planned fire drills had been carried out in the last 12 months. Records did not include the times of planned fire drills which meant that we did not know if day or night staff had been included.

We looked at how the registered provider ensured the building was kept safe for people to live in and saw staff had access to maintenance sheets to report to the maintenance staff repairs which needed to be carried out.

On each day of our inspection we were able to enter rooms that should have been locked. These included gas and electric cupboards, sluices, the laundry and the paint cupboard. This meant people using the service were a risk of harm.

An upstairs bathroom was not available for use because it was being used to store a cleaning trolley, a wheelchair and two shower chairs despite there being a sign on the door not to store chairs and wheelchairs. People who had bed rails in place had bed rail bumpers to protect them from harm; however these bumpers were stored in bathrooms on floors or on toilets. We could see that some bumpers required cleaning.

We checked to see if the home had practices in place to minimise the risks of cross infection. In the bathroom on the dementia unit we saw two bowls of personal toiletries and a large shopping bag half full of the same. This meant personal toiletries were not routinely stored in people's bedroom to reduce the risk of infections spreading. In the same bathroom we saw piled up unwrapped clean incontinence pads together with underwear for the pads and found people had access to the continence wear of others. A staff member explained to us they were put there for ease of use.

On each day of our inspection, we observed a strong malodour on both floors of the elderly care unit. We also found that some people's rooms required cleaning because some people's bathroom floors were sticky. When we visited one person in their room we saw it was in need of cleaning. The bathroom floor was sticky and the bedroom floor had crumbs of food on it. There was also a full urine bottle on the television cabinet. When we spoke with the registered provider we could see that there had been some difficulty with

staff being allowed into the person's room, however no action had been taken to make an agreement with the person to clean their room. A safeguarding alert had not been raised by the service in relation to this, however this was completed by them following inspection.

In a communal bathroom the bath panel was cracked and coming away from the side of the bath which increased the risk of harm to people. Paint had started to wear away from the housing unit to cover pipes. In another bathroom the light did not work. A shower room contained a shower screen which did not stand up steadily and a rusty shower chair which had left brown marks on the floor. In a communal toilet the 'Pull cord' to alert staff was inaccessible because it had been wrapped around a hand rail and there was no toilet roll. We looked in one sluice and found that the sink area required cleaning. We found bedding, towels, incontinence pads, weighing scales and a stand aid were being stored in the room.

On the first day of inspection we observed a staff member clean a toilet without wearing any gloves. On the third day of our inspection we observed one staff member clean a sluice room wearing gloves but no apron. They confirmed they then were cleaning people's bedrooms.

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

We asked people if they felt safe living at the service. People we spoke with told us they felt safe. One staff member told us, "People are safe. It's the staffing levels which makes people unsafe." One relative told us, "[Service user] is safe here."

We looked at the recruitment records of the five newest staff members. We could see that there was evidence of an application form, interview questions and any gaps in people's employment history had been checked. Each person had a disclosure and barring services check and two checked references. This is a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruiting decisions and also to minimise the risk of unsuitable people from working with children and vulnerable adults. There was no evidence that nursing PINS were checked during the interview process. This is a check to see if nurses are registered with the Nursing and Midwifery Council. The registered provider told us this was something which they did not check, however they would change this practice straight away.

Inadequate

Is the service effective?

Our findings

We looked at the training records for all 91 staff and found required training was not up to date. Fewer than 75% of staff had received training in fire safety and moving and handling. Fewer than 40% of staff had received up to date training in infection prevention and control, health and safety, first aid, safeguarding, equality and diversity, deprivation of liberties safeguards and the Mental Capacity Act, nutrition, behaviours which challenge, epilepsy, diabetes, Autism and Huntington's disease. Staff had not received any training in end of life care, Dementia, stroke, pressure area care, falls and records.

On the second day of inspection, we found that the registered provider had taken some action to address this. Mandatory training sessions lasting three hours each had been put in place. However we were concerned about the volume of training the registered provider had planned to cover in one session. The registered provider planned to cover health and safety, COSHH, equality and diversity, fire safety, food safety, moving and handling, safeguarding and complaints training in one session. We observed a training session. We found staff said they had covered some of the training during the planned session. We were also concerned that a superficial level of information was given to staff during training and there appeared to be a lack of understanding.

We could see that newly employed staff had not undertaken all of the training needed to carry out their role. This meant they had not been supported to carry out their roles appropriately. We also found that staff had been caring for people with Huntington's disease for many years without any training. Training had been provided to a small number of staff during our inspection.

From our observations we could see that some staff lacked confidence in dealing with people with specific needs, such as dementia and behaviours that challenge. We observed some staff standing in doorways rather than interacting with people. When we observed some staff supporting people with behaviours that challenge we found they struggled. We found that there was a lack of guidance available to staff about how to support people. No observations of staff were carried out as part of their work performance which would have enabled the registered provider to determine which staff needed extra support and training. One staff member told us, "Skill levels are horrendous. Some staff shouldn't be here."

We looked at staff supervision and appraisals. Supervision and appraisals are formal methods of support for staff to make sure they are able to carry out the role they are employed to do. This ensures staff have undertaken appropriate training and are supported to achieve workplace goals.

It was difficult to track whether staff received supervision in line with the registered provider's policy because there were gaps in the records and there was no consistent method for filing supervision records. There was evidence of some staff receiving supervision between June 2015 and December 2015, but not for all staff. There were no records in place to show that staff had received supervision between January 2016 and April 2016. We found that supervision records had been pre-populated to cover specific topics and there were gaps within these records. This meant supervision sessions were not person-centred and there was no evidence of the discussions taking place between the supervisor and staff member. There was also

no evidence of staff's ability to carry out their role effectively.

We looked at the appraisal records of all 91 staff and found 62 have received an appraisal in the last year. We found gaps in all of the records looked at, for example we found that appraisals had not always been signed by the staff member or appraiser. Staff had not always completed their appraisals fully, in particular their feedback section. Action plans had not always been completed. This meant that we did not know if appraisals had been completed or agreed by the staff involved. We identified one issue in an appraisal but records did not show what action had been taken to address this. When we spoke with the registered provider, they were able to tell us and informal notes had been made in their diary.

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

We found an open room containing people's dietary supplements. This indicated some people were at risk of losing weight and malnutrition. Kitchen staff told us they would fortify food if people needed it. However we found there was no information given to the kitchen staff about people who needed a fortified diet. We visited one person in their room and found an unopened fortified dessert. There was no information about the time this dessert was offered to the person, when it should be eaten and within what timeframe. One staff member we spoke with told us the person liked to eat this dessert throughout the day however there was no information in the person's care records to support this.

One person had a care plan in place which stated that they needed a high calorie diet with 1500 millilitres of fluids each day. There was no information about the number of calories which needed to be consumed or what foods should be offered. When we looked at the person's fluid balance charts we could see that they did not total up to the recommended amounts needed. We saw that fluid balance charts were in place for everyone using the service whether they were needed or not. Records did not identify a target amount of fluid intake for any person and the total amount for each day was generally not recorded. This meant staff were not able to see from the records to decide if a person's hydration levels were sufficient to meet their needs. There was no guidance about the action staff needed to take if people did not achieve their daily target. Recorded regularly showed that people consumed 200 millilitres each time they were given a drink. During inspection we saw staff recorded when people were given a drink rather than what they had drunk. We also saw that some people had jugs of water in their rooms which were not included in these records. We saw that staff completed one person's fluid balance chart to show that the person had drunk 200ml of tea at 10:50 on 5 April 2016 however the person had not consumed any of it. The drink remained untouched on the table in the person's room and not within their reach.

One person had a care plan in place which stated they should receive 'Normal fluids' however they had a risk assessment in place for dehydration. Neither of these records stated the target volume of fluids. A risk assessment was in place for weight loss for this person also and stated that they should receive two fortified drinks each day. However the person's care plan stated that they had been discontinued and had not been updated in line with the risk assessment.

Some people received their nutritional intake via Percutaneous Endoscopic Gastroscopy (PEG) feeding. This is a way of introducing food and hydration through a tube to people who need it. In one person's records, advice from a dietician showed that the person should receive 1600 millilitres of fluids each day and a PEG feed should be given if the person ate less than half of their meal. We found that fluid balance records did not meet this recommended target of fluid. We spoke with a member of staff who told us the person was eating regularly and this was no longer relevant. This meant the care records had not been updated. We saw that this person was required to have fluids given via their PEG at specific times of the day. We found

that only three records to support this had been completed during 2016. We spoke to one nurse about this and they completed a record in front of us. The record was completed at 14:20 to show that a flush had been given at 10:00 on the same day. We looked at the PEG records for one person and saw there were no records to show weekly PEG balloon checks and only two weekly PEG equipment changes had been carried out in 2016. There were gaps in records to show whether PEG feeds had been given. We could see when PEG feeds had been refused for one person but we did not always know if the person had been given their PEG feed because there were gaps in the records. For another person we could see there were some PEG records in place but not all that were required.

In the care records which we looked at, people's food preferences, likes and dislikes had not been recorded.

We found that some people ate their meals in their own rooms. We observed one person in bed eating with their hands. We saw they were coughing and having difficulty eating. We observed another person almost laid flat with a towel on their chest and their lunch on top. We spoke with the registered providers about this because we were concerned that this increased the risk of choking to people. Staff on duty had not taken action to ensure people were supported to eat safely.

We saw that some people's lunches remained uneaten one hour after it had been given to them. We observed another person asleep with their dessert on the table in front of them. This had been sat on the table for two hours. We visited one person over lunch who was not happy with their meal and observed a member of staff remove the meal from their room. At 3.30pm on the same afternoon we found there was nothing recorded for the person's lunch.

We looked at the weekly weight records of three people and found that they were not completed every week. We also found that weight loss and gain had not been consistently recorded for these three people. One person had not been weighed weekly since 21 February 2016 and records did not show what action had been taken to address this. Another person had refused to be weighed on 14 occasions with their last recorded weight made on 2 August 2015. There was no evidence to suggest that staff had taken action to address this. A care plan for nutrition for this person stated the person required assistance with meals. We found that the MUST was not up to date. Monthly reviews of this care plan in November and December 2015 and January 2016 stated that there had been no weight gain. We questioned the accuracy of this because the person had refused to be weighed since August 2015. No arm circumference checks had been carried out. This is an alternative way of determining if someone had lost or gained weight. For another person we found that a risk assessment for nutrition had been incorrectly scored which meant that information was inaccurate.

A dental care plan showed the action staff needed to take to support one person with their oral hygiene. Records did not show if the person had their teeth brushed three times per day as recommended to increase their oral hygiene. The records showed the dentist recommended that visits be carried out every three months, however from the care records there was no evidence to suggest that this had taken place. The records showed that the person had visited the dentist in September 2014 and July 2015.

We saw one person asleep in bed and could see that the person's toe nails were very long and were catching on the bedding. We spoke with staff who told us a referral to chiropody had been carried out however there was a six-week wait for this. We found that there had been a delay in staff seeking assistance for this person.

We saw people had do not attempt resuscitation (DNAR) certificate in place. We found that DNAR certificates were not kept in people's care records but were kept in the treatment rooms which only nurses

had the keys to. This meant that staff did not know who had a DNAR in place and certificates could not be sought in an emergency situation which meant that people were at risk of being resuscitated against their wishes.

We found that some people had returned from hospital with these certificates in place. The doctors in the hospital had signed these documents and the service had been left to contact relatives to see if they agreed. One staff member spoke to us about a person with a DNAR in place since February 2016 and told us they thought it was not required as the person was well and had a quality of life. We found they had contacted the family in line with DNAR but had yet to explore if the rationale for the DNAR was still appropriate. This meant a person was at risk of not being resuscitated. We saw that another person's DNAR expired 7 March 2016 and no action had been taken to address this. We also found that not all sections within the DNAR certificates looked at were fully completed. This meant that not all required questions had been answered and we could not always see the people who had been involved in this decision making.

Communication systems in the home required further development. We observed a handover period where a nurse handed information to another nurse who then in a separate group meeting handed information over to the care staff. This process did not enable care staff to contribute to discussion about people and exchange information. Nurses had in place nursing notes where they were expected to write information about each person during the day and night. Each unit kept a diary which contained people's appointments; this meant staff were able to make arrangements for suitable transport to get people to appointments. One staff member told us they had to change a person's appointment because the clinic appointment finished after the patient transport service was available.

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

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.

There was no evidence of any MCA which had been completed for people in the care records. There was also no evidence that any best interest decision making had been carried out. This is a decision staff can make when people are unable to make a decision themselves. A staff member told us that one person had started to remove their clothes in communal areas and staff had to assist them to put their clothes back on. There was no evidence to suggest a best interests decision had been made. The staff member we spoke with did not know what we meant by a best interests decision. A care plan for another person stated that they would not always cooperate when staff brushed their teeth. The care plan stated that if the "Person would not cooperate then staff should place toothpaste into the person's mouth because it would naturally clean their teeth." A MCA or best interest decision had not been made by staff to enable them to assess whether this was safe to do and in the best interests of the person. We could see that the person was able to communicate verbally with 'Yes' and 'No' answers. This meant that the person could have potentially been able to make their own decision about this

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

At the start of inspection we could see that not everyone who needed Deprivation of Liberties Safeguards (DOLS) in place had them. We could see that the registered provider was in the process of making these applications. Eight people living on the dementia unit had applications in place however all 11 people on the unit were being prevented from leaving because doors were locked. One staff member on the dementia unit told us "Everyone on here needs a DOLS." We could see that some people on the elderly care and young adults units should have had a DOLs in place however there was nothing in people's care records to support this. This meant that some people were being deprived of their liberty without the appropriate documentation in place.

There were no systems in place to show if DOLS applications had been approved or when they were due to expire which would have enabled the service to take action before they expired.

When we spoke with staff they could not always tell us if people had the capacity to make their own decisions. For example, we asked about one person and a staff member told us the person could make day to day decisions but did not know if they could make more complex decisions. We found that sometimes we were given contradictory information by staff. Staff training in the Mental Capacity Act and DOLS was not up to date and we found staff knowledge in these areas was very limited.

One person had a care plan in place for DOLS dated 29 March 2016 which had been updated each month and stated no changes were needed however the DOLS application in the care records showed that this had expired 27 October 2015. The registered provider told us that a new application had since been made. We heard mixed views from staff about whether this person had capacity to make their own decisions and whether a DOLS was in place. This person also had a care plan in place for cognition which stated that the person needed assistance with decision making because they had occasional difficulties with choices. We saw that staff were preventing this person from leaving the building and a risk assessment was in place for this. A care plan for cognition for one person stated they were unable to maintain their own safety, but we could not see if a DOLs application was in place. There was no information in the records to suggest an application had been made.

One person had a care plan in place for behaviours that challenge. The care plan stated the behaviours that could be displayed but did not say what staff should do to minimise these behaviours or how to minimise the risk of harm to themselves. The record stated "If unable to complete the task leave and return in 30 minutes." This meant that staff would leave the person alone if they did not cooperate and the person did not know if or when staff would return. There was also no risk assessment in place to show if it was safe to leave the person.

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

We could see that people were involved with health and social care professionals. We observed many visits taking place during our inspection and there was evidence in care records to support these visits. People had contact with their general practitioner, district nurse, and social worker. The registered provider told us that struggled to get these health professionals to write in people's care records. They wanted them to do this to make sure that staff had accurate and up to date information.

Hospital passports had been newly introduced at the service. These are records designed to assist hospital

staff when people are admitted. This meant that not everyone had one in place at the time of inspection however we could see that staff were working towards this. As a result, we could see that records which were in place were not yet complete.

Consent forms for a key safe had been signed by people. We could see that one consent form had been signed by the person's mother because they were not able to sign themselves due to their health condition. Records detailed the specific reasons for this and we could see that the person had been able to give verbal consent but not written. Not everyone had consent forms in place for the use of photographs and to share information.

People spoke positively about the food. They told us that it had recently improved. One person told us, "The food's great in here. I've just had stir fry, and a brilliant Sunday dinner yesterday. It's always very good." The registered provider told us they had employed a new chef who was in the process of developing new menus to increase the choices available to people. One person told us, "If I asked for something specific, I would get it."

We spoke with the kitchen staff and found they were working from a list of people with their room numbers on which was hand written the person's type of diet e.g. PEG fed, diabetic. The kitchen showed us a menu and told us they were revising the menu and trying out new meals to see if people liked them.

Each person using the service had their own room. We looked in some people's rooms and found they were personalised. People could spend time in a variety of communal areas inside the service and out in the garden. We could see that people had access to private spaces when they received visitors. Bedrooms and communal areas were available on both floors of the service which could be accessed via a lift.

People told us they enjoyed the décor in place at the service. Window restrictors were in place at the service which minimised the risk of harm to people. There was a lack of dementia friendly signage at the service. We could see that coloured handrails and toilet seats were available in the communal bathroom on the dementia unit but not in other areas of the service where people living with a dementia were being cared for.

Inadequate

Is the service caring?

Our findings

During inspection we spent time with people in communal areas and found people were regularly left without any interaction from staff. We found interaction from staff was limited to times when personal care was given. Staff told us they did not have time to sit with people to chat informally. We found people spent time in their own rooms or in lounges and there was little interaction between people. We found televisions were on but not watched and found that some people spent time sleeping. People told us there was not much to do and staff were busy.

There was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's choices were not always respected. During our inspection, we were concerned at the number of people laying in bed throughout the day, particularly on the elderly unit. There was nothing in people's care plans to say that they preferred or needed to stay in bed because of their health condition. We spoke with the registered providers who confirmed that there was no reason why any person using the service should be in bed throughout the day. On each day of our inspection we had to speak with the registered providers about this because people remained in bed. We found that the registered providers took immediate action and staff got people up however staff failed to continue this action without prompting.

We visited one person who was in bed and they asked if they could get up. We spoke with staff about this and one staff member told us that this person was, "Safer in bed." They told us this was because they would slide down their specialist wheelchair and loosened the straps which meant they were at risk of falling out. We looked at the person's care records and there was no evidence in place to support this. The care records did not state if they person should remain in bed throughout the day and there was no evidence of a reassessment for their specialist wheelchair. We spoke to another staff member about another person we saw in bed throughout the day and they told us that this person needed to be in bed because, "They had suffered from a stroke and had dementia." There was nothing in the person's care records about the time which should be spent in bed and whether they had specialist equipment in place to support them to be out of bed.

People's bedroom doors were open on each day of our inspection. Anyone passing people's rooms could see people sleeping which meant their dignity was compromised. There was no information in people's care records to show that people had chosen to leave their doors open while they were sleeping. On the third day of inspection staff had written a note on people's supplementary records stored outside of their bedroom doors to say that they wanted their doors open. Care plans had not been updated to reflect these choices and there was no evidence to show this is what people had requested.

There was a 'bath list' on display on the elderly unit. This gave information about the day each person was allocated a bath. This information was in public view. One staff member told us, "We've always had a bath list. I would want it, a bath everyday, but we can't bathe everyone every day. This way we know everyone gets bathed twice per week." However we saw there were daily records in place for staff to complete when

personal care had been given which included bathing. We asked the team leader to remove this record. We saw that this bath list was still on display on the third day of our inspection. We spoke with one relative who told us, "Care could be better. I don't agree with having two showers/baths per week." The records showed that people did not have choice about when they bathed. Some people we spoke with also confirmed that they didn't always get a choice. One person told us, "It's not good in here. You can't go out for a walk when you want. They tell you what to do and you can't have a bath when you want to."

Each person who used the service had a body map in place regardless of injury, which was completed every week. We talked to staff about the impact on people's dignity. Staff told us they carried out visual checks when they were providing people with personal care, however not everyone required assistance with personal care. The purpose of these weekly checks when people had not experienced injury was not explained to us.

One person told us, "I needed the toilet yesterday and waited 20 minutes. I was busting. The buzzer was not in my reach. I was sat thinking about the embarrassment of not making it to the toilet." We looked at this person's care plan which stated they must always been in reach of a call bell. We could see that a call bell was available in the lounge where this person had been seated; however staff had not placed the person within reach of it. A staff member told us, "People are left too long. They can be incontinent during this time." One relative told us, "[Person using the service] is incontinent waiting for staff."

We visited one person in their room who was in bed watching television. They were not able to get out without assistance. We found their television remote was on the floor under the bed which meant they could not reach it to turn the television off, as they had to ask us to do. When we checked the remote we found only one battery in place. We asked a staff member to replace the battery which they did. We found that we could not get the remote to work to switch the television off. We found that they was no back on the remote to keep the batteries in place. When we spoke with the staff member they told us that we needed to press the batteries in to enable the remote to work. We could see that the person was not able to do this. The staff member had failed to take appropriate action to ensure the person's needs were met.

We observed one staff member say to another staff member that they would take a person's wheelchair back to their room. The person was sitting in the same area. The staff member did not ask the person whether they could remove their wheelchair. We saw that the person was not able to leave the room because their wheelchair had been taken away from them. We observed another staff member pull a person from behind who was sitting in their wheelchair. The staff member did not offer any interaction to the person or give any indication that they were going to move the person. This meant that the person did not know what was happening to them

People were not always listened to. We sat in the lounge with people and observed one person shout "Are you there love?" to a staff member who had just finished their break. The staff member said "Someone will be there." However it was not loud enough for the person to hear. Another staff member walked past and this person asked again and was told "Two minutes." We observed another person asking for help from staff and were told they needed to wait. We observed that this person waited for twenty minutes before assistance was given.

We made safeguarding alerts because we found that some people's dignity was not maintained. This was not reflective of all staff and we did observe some staff did carry out care and support in a way in that respected people's dignity. We saw staff knocking on people's doors and closing them during personal care. However our judgement was that people were not always treated with dignity or respect.

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

People told us they were happy with the care and support they received from staff, however the number of staff available could sometimes impact on this. One person told us, "The staff are absolutely brilliant. They all are. [Staff member] absolutely shines, but they're all fantastic." Another person told us, "Yes I am well cared for. Generally the standard of care is fine. They attend reasonably quickly if the buzzer is pressed. Anything reasonable they will do for me." A relative told us, "There are friendly staff here." We spoke with two relatives visiting one person and they both told us, "The staff are nice."

We could see that some staff were genuinely concerned about people's well-being. Staff spoke to people using their preferred names. From speaking with them we could see that they enjoyed providing care and support to people. Staff told us, "It's a lovely home, the residents are lovely." And, "I like this unit. I like the residents. I have a laugh with them." And, "I get along with all of the girls, we work as a team. I like to see everyone clean, dry, fed and watered before I go home." One person told us, "The care is spot on. It's brilliant here. Can't say nowt bad about it."

Some people had concerns about the care they received. One person told us, "The staff are quite good. [Staff member] is very abrupt and says 'I've only got one pair of hands. It's her nature and they are not like it all of the time. If I see her, I think 'Dare I shout her?'." We spoke with two relatives together about one person. They told us, "I am concerned, I come at different times of the day. The staff are canny and work hard. I have to ask the staff questions, they don't ask me."

Not all staff appeared confident looking after people, but we did observe some very positive care from staff. We observed staff on the dementia unit listened to people and gave them the time their needed to express themselves. We found staff responded appropriately.

There was information on display at the service about advocacy. This is a process of supporting people to express their views and concern, access information and promote people's rights.

The service provided end of life care and support to people. We identified that training was not up to date and records contained limited information.

Inadequate

Is the service responsive?

Our findings

Care records did always show if people had been involved in making decisions about their own care. This meant we could not see evidence of people's likes, dislikes, wishes and preferences. We also saw little evidence that people had signed care plans to show their consent. When we spoke with people, they told us they had not been involved in developing their care plans. When we looked at care plans we could see that they had been signed by staff but not the person they related to. Not everyone we spoke with knew they had care plans in place. In one person's records, we saw that a relative had signed care plans to say they were happy with the care plans. This relative signed on behalf of the person because they could not consent themselves. However this record referred to a registered manager who had not been in post since 2014.

In a care plan for one person, we saw that they had expressive dysphasia. The care plan stated that staff should encourage the person with a picture board and flash cards. When we spoke with staff they were not aware that these communication methods were in place for this person and we did not observe staff using them during our inspection. We asked to see them but staff on duty could not provide them. The care plan stated that staff could understand the person from their facial expressions but records did not show what facial expressions could be displayed and what they meant. A risk assessment completed 29 March 2016 stated that the picture board and flash cards were in use.

Care records were not securely stored. This meant some people's information was stored in areas where visitors could look at these records. We saw a list of people who had a DNAR certificate in place and two people's prescriptions on a noticeboard at the staff desk in the young adults centre which anyone had access to. Confidential letters for people regarding their deliveries of incontinence products had been left on the staff desk on the elderly care unit.

Care records were not stored away securely throughout the service. Locked cabinets were available on the dementia and elderly care unit but not on the young adults centre. This meant that people's confidential information was not protected.

There were gaps in pre-admission and admission records. Records did not show if people had capacity, what their end of life wishes were or information about people's social history which could be used to develop relationships and inform care planning. This meant that we did not know if staff had obtained the information needed before people moved into the service.

Care plans were titled as 'Problems.' We could see that people generally had the same care plans in place even if they were not needed. Some people needed more specific care plans, which were not always in place. For example, staff told us one person had started to remove their clothes in communal areas however we could not see a care plan in place for this. Another person had a care plan in place for Parkinson's disease however there was no information about this health condition or how it affected the person. A care plan for cognition for another person stated that they were a risk to themselves, but did not say how or why. For this same person, a care plan for anxiety stated that staff needed to talk through any care intervention to reduce anxiety. There was no information about the signs and symptoms of anxiety

which the person could display or distract techniques for staff to use. Monthly evaluations for behaviour had been completed on a care plan for pain. This meant the information provided was not accurate.

Care plans were not personalised which meant they did not contain the information needed to provide care and support according to people's individual wishes. For example, in a care plan for personal care we could see what time the person liked to have a bath but there was no information about the routine in place for this person to get in the bath which is particularly important for people living with Autism. This meant staff unknown to this person did not have any knowledge of this person's routines which could have caused distress. A care plan for hygiene for another person stated that the person was in pain and staff needed to be cautious. There was no information about when and where pain was experienced or what staff needed to do to minimise the person's levels of pain. In a care plan for communication for another person stated, the record stated "Needs time when having periods of confusion." We were unsure what this meant. There was no information about when confusion was experienced and what staff needed to do to communicate with the person when they were experiencing confusion. A care plan was in place for a person living with Parkinson's Disease. The care plan made reference to 'freezing episodes' but no information about this was provided. We could also see that communication could vary but the plan did not show how to communicate with this person when communication was limited. Care records stated that this person had 'attacks' when their relative left. The records did not explain what this meant or what action had been taken by staff. When we spoke with the person's relative they had not been informed about this. We could see that this happened quite often however care plans had not been updated and support not offered when the person's relative left. We identified that this person became distressed when their relative left.

We found that the information contained in risk assessments and care plans did not always match, for example a risk assessment for using the hoist stated that staff needed to be aware that the person could be experiencing pain in their legs; but there was no mention of this in the person's care plan. One person's care records stated they had occasional incontinence and were regularly incontinent. Care plan reviews stated that the person remained incontinent. This meant that we did not know whether this person was occasionally or regularly incontinent.

Care records to manage behaviours that challenge contained examples of behaviours which could be displayed but did not say what distraction and de-escalation techniques should be used. There was no information to show what steps should be followed when PRN medicines were being considered. ABC records are observation tools which allow information to be recorded about particular behaviours which allows staff to provide appropriate care and support. These had been completed by staff however there was no evidence that these had been analysed to try to identify patterns and trends which could have been used to determine any changes in the care and support needed.

Monthly care plan reviews were carried out inconsistently. We saw some care plans for some people had been reviewed each month, however we also saw that for some people there were gaps in when reviews were carried out. For example, for one person a care plan for Parkinson's disease had been reviewed in July 2015 but not again until November 2015. It had then been reviewed each month until January 2016, where no further reviews had taken place. In all care plans looked at there was little evidence of any evaluation. This was because staff had not provided any information in the review. In one person's review we found that changes had not been reflected in the review, for example, we found that the level of observation for this person had changed and no comment was made about this in the evaluation. We also found that the level of observation had not been changed in the person's risk assessment.

Each person had a 'This is me' record which gave information about the person's likes and dislikes, routine and things staff needed to know. We looked at one person's records and could see it had been completed

by a relative on 28 October 2013. We found that some areas of the record were incomplete and we found that some information was now out of date. The record stated that the person had no problems with their mobility but observing the person we could see that their mobility was limited. The same record for another person stated they had a PEG in situ however from speaking with staff we could see that this was no longer the case. Where the record asked about things which could 'worry or upset me' we could see that "Staff members to work this out' had been recorded. This meant that staff did not have the information they needed to support this person when they were worried or upset.

We found the information contained within people's care records could be contradictory. One person's care records made reference to two different room numbers. We could see that staff had not updated the person's records when they had moved rooms. Another person was on two hourly observation checks by staff, however we could see that they were also on one hourly observation checks and 15 minute observation checks. A risk assessment for using the call bell stated that the person was on two hourly checks. A care plan for DOLs was in place for one person to help them to remain safe. However a care plan for cognition for this person stated that they only experienced occasional difficulty with making choices but were not aware of risks to themselves. This care plan also stated that this person should have the call bell available to them at all times and they understood how to use it, however a risk assessment stated that they forgot to use this.

Progress and evaluation records completed by nurses stated that one person was regularly settled each day for records looked at from 1 March to 5 April 2016 however the person's care plan stated they were agitated during any care intervention and we could see that that there was care plan in place for behaviours that challenge.

Records were not always contemporaneous. A two hourly observation chart was dated 28 March 2016 on one side of the record and 4 April 2016 on the other side.

Daily records were generally completed three times per day as required. The information provided was minimal. For example in record dated 4 April 2016 for one person, each of the three entries stated that the person had been settled. In another person's record dated 5 April 2016 the record for the day stated "[Person using the service] is fine." No other information relating to either person's care needs had been included.

Daily records also included a checklist of personal care provided by staff. We found significant gaps in these records. For example, in a record dated 04 April 2016 we could see one person had been assisted with a 'general wash.' Assistance with a bath, hair, nails, mouth care, hearing aid, glasses, bowels, dentures and shaving had not been recorded.

A daily bowel movement chart for one person showed that seven bowel movements had been recorded between 1 January and 5 April 2016. We could see that this person had a stoma bag in place. The same record for another person was in place and recorded nine bowel movements between the same dates.

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

At the time of our inspection there were two full time activities co-ordinators employed at the service to provide activities each day. An activities timetable was in place which listed three activities each day. These activities were group based and were aimed at everyone using the service. We found the activities on offer were not suitable for everyone using the service. For example, we could see that Scrabble was aimed at

people living with a dementia. We observed activities and found people were not always actively engaged in them, for example, one staff member was reading a book to a group of people.

Although there were activities staff in place at the service, we found there were limited activities at the service. We observed that people spent time in the own rooms or in the lounges watch television or sleeping. Care staff told us they were too busy providing care and rarely had the time to carry out activities with people. People told us they did not always get to go outside. One person told us, "Staff don't take me out and I like to go outside."

One person we spoke with told us they did not join in activities because they found them, "Boring." They said they had tried a number of different activities but had not enjoyed them. Another person said that they did not join in the activities as they found them, 'Boring'. They said that they had been before but did not enjoy it. Another person told us, "Activities. It's just like sitting in a room like this lounge asking questions or playing bingo. There's not a lot to do. I've only been a few times. I sit in there, I might as well sit in here."

The registered provider told us that individual activities were offered, however there were no records to support this. People told us they did not get to go outside into the local community. We saw that people who were independent with their mobility could go to the local shops themselves.

There was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a communal garden at the service and the registered provider told us that they had raised flower beds and gardening equipment however they were no gardening activities scheduled. The registered provider told us that this would be utilised in the summer time.

We spoke with the registered provider about activities and they told us they had been disappointed with activities, especially those which linked in with special occasions during the year. For example, they told us they had been very little decorations put up in the home over Christmas period and there had been no Easter based activities provided by staff. The registered providers told us they had been so disappointed, they had gone shopping and purchased an Easter egg for each person using the service. They told us the provision of activities provided at the service was being reviewed and discussions were taking place with staff to improve the quality of activities for people.

We found a complaints procedure was on display in communal areas at the service. This meant people and visitors had the information they needed. There was also an easy to read version of the complaints procedure in place for people who needed it. An up to date complaints policy was in place. We could see that only one complaint had been received during the last year and records showed that procedure had been followed. The investigation and outcome had been recorded; this meant that we could see that appropriate action had been taken.

When we spoke with two relatives visiting one person they told us, "We've no complaints to make about the home."

Inadequate

Is the service well-led?

Our findings

The registered providers had failed to notify the CQC that the nominated individual had left the service in April 2015 despite being a requirement to do so. Since November 2014 there had been three different managers in place at the service, none of whom had applied to become registered manager. This meant the service had failed to inform CQC when changes had occurred at the service despite being required to do so.

This was a breach of regulation 15 of the Care Quality Commission (Registration) Regulations 2009. We will take action outside of this inspection to address this.

The registered providers were not aware that they needed to notify the commission about incidents at the service such as safeguarding alerts, police attendance, deaths of people or when application for DOLs had been granted. The registered providers had failed to notify CQC in a timely manner when an incident occurred at the service. A death of a person occurred 08 March 2016, a safeguarding alert had not been raised and CQC were not informed until 29 April 2016. There were 17 DOLs applications which had been granted in 2015 which the commission were not informed about.

There was a breach of regulation 18(1) of the Care Quality Commission (Registration) Regulations 2009. We will take action outside of this inspection to address this.

There were limited quality assurance measures in place. This meant the service had failed to identify the concerns which we had during this inspection.

There were no records in place to show that the registered providers had carried out quality assurance checks of the service prior to them taking over the day to day management of the service. This meant that the registered providers had not carried out appropriate monitoring to ensure the quality of the service. At the time of our inspection there were no audits in place for areas such as medicines, care records, record keeping, infection prevention and control, pressure area care or falls. Following inspection the registered provider told us new audits had been put in place.

Formal records for meetings for people using the service were not in place. This meant we did not know how many meetings for people had been held over the last year.

This meant there was a breach of Regulation 17 of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was correctly registered with the CQC. However we found that the service user bands for the service were not up to date. The registered provider had added the 'older people' service user band to their registration during their initial application. During our inspection, we could see that the service was providing care and support to people who did not reflect this service user band. The registered provider had failed to add the appropriate service user bands.

We asked staff about the service. We heard mixed reviews from staff about the staff team. Some staff thought that not everyone worked together as a team and some staff wouldn't carry out specific duties. One staff member told us, "The night staff work together as a team. They will help out if they are not busy. Other staff told us they enjoyed working at the service. They told us, "The residents, I love them. They are absolutely class." And "It's good here. Only thing is we need more staff." And "We get to care for someone." The registered provider told us that "Some staff were very good and were committed to providing good care and the newly opened dementia unit had been successful."

One staff member told us, "This was a lovely home. I've worked here a long time. We used to have a waiting list but no longer. Standards have slipped. Not slipped, but spiralled." One staff member told us, "I've worked here a long time. At the moment it's a lot of work and a lot of pressure. I have considered leaving."

Staff told us they had been a lack of leadership in place and they had struggled with the number of managers which had been in place because each had brought their own changes with them. One staff member described this as an, "Upheaval." Another staff member told us, "We need an approachable manager. Someone we could go to in confidence and confidence that it would be dealt with. The staff team needs to be improved and the management needs to stop messing staff about." Another staff member told us, "This place would be improved if we got rid of the lazy staff."

Staff told us they had struggled with the number of different managers in place because each brought in their own ways of working which had included many changes to records which had left them confused. One staff member told us, "[The registered provider] keeps us informed of everything. The other two (previous) managers didn't. [Registered provider] is alright. I can talk to them and find them OK." One relative told us, "I've met [The registered provider] and he's very nice." One person told us "[The manager is good. He speaks to everyone and says 'Good morning. He goes up to everyone."

During our inspection there was no visible management in place. There was no one visibly leading staff in each of the clinical areas. There was a nurse in charge of each unit. People and staff spoke highly of the registered providers and we could see that they were at the service most days. People who used the service and staff spoke positively about the registered provider, in particular the director who was applying to become registered manager. People told us that this manager walked around the service every day and spoke to people individually. People told us they really valued this. One staff member told us, "Since [Registered provider] has been doing the manager role, they visit us on a morning. They give good feedback."

We found that the culture of the home needed to be improved. The registered provider told us they had recognised they needed to do this when we spoke with them. They told us they felt that this was key in driving the changes needed at the service.

We found a mixed staff team in place at the service. Some staff were motivated and committed to their role at the service, however others were not. Staff did not always seek guidance or further explanation about the care and support people needed; or did not take action to ensure that care needs were met. For example, staff were not responsive when people refused to be weighed. Staff did not work as team to ensure care records were fully completed.

At the time of this inspection, the service did not have any established links with the community however the registered provider told us this was in their long term plans and they would be involving activities staff. They planned to participate in the National Care Home Day and planned to organise events which would bring the community into the service.

There were records in place to show that regular staff meetings had been carried out and a wide range of topics had been covered. We saw that staff had been required to read and sign the minutes to confirm they had been understood.

An annual survey had been carried out in 2015 and a summary of results was available for inspection. The registered provider told us that any issues raised had been addressed but no action plan had been put in place.

We found that the champion's roles at the service had been taken away by a previous manager and had recently been re-established by the registered providers. There were champions in place for nutrition, health and safety, dignity and infection prevention and control however there was no guidance about what the role entailed or records in place to show what action the champions had taken to improve the standards of care at the service. Our inspection identified breaches of care in each of these areas.

The service had a 'Step down' bed contract in place with a local hospital and had not taken action to ensure that all information needed, was obtained prior to people moving into the service. We found there were gaps in care records. One staff member told us, "Relatives didn't understand why people were moved to our service from a local hospital and in a handover from them they didn't tell us that [person using the service] was nearing the end of their life. From speaking with the registered providers we could see that people arrived at the service without prescribed medicines or without the people's relatives having been informed. We could see that the registered providers took action to ensure people had their prescribed medicines as soon as possible however they failed to make any safeguarding alerts against the local hospital.

Some people spoken with during inspection told us they felt able to raise any concerns with staff or the management team. However we heard mixed reviews from staff. Some told us they felt able to raise concerns and others not. There was also a lack of confidence because some staff had not felt listened to when they had raised concerns. However one person told us, "I'm frightened of the repercussions in here."

The registered providers had kept staff updated about concerns with the service and the serious concerns protocol that was in place with the local authority. However we found that staff did not understand the seriousness of the concerns. Staff did not consider that they were responsible for the service going into serious concerns protocol and an embargo being placed upon the home. They did not understand that they were concerns about the service because they were failing to keep people safe, had not raised safeguarding alerts when needed and had failed to carry out the duties expected of them in providing appropriate care and support to people in line with the registered providers policies and procedures.

This meant that staff had not carried out the duties expected of them. Procedures were not in place to check that staff had carried out the duties expected of them. There was a lack of staff understanding about what was expected of them, especially in relation to safeguarding. The service had not supported staff when they failed to be accountable for their decisions or had not adhered to the registered providers policies and procedures.

After our inspection we sent a letter to the service because we had significant concerns. This letter outlined each of our concerns and the breaches within the Health and social care Act 2008 (Regulated Activities) Regulations 2014. We asked the service to tell us what action they were planning to take to address each of our concerns. The registered providers expressed their disappointment about the service which they have owned for 20 years and what has now become of the service because it had always had a good reputation. In response the registered providers demonstrated that they had already started to make changes. A clinical lead had been appointed and work to improve records had started. We could see that an external

pharmacist had been involved with the service and supervision and appraisals had increased. The registered providers recognised that the culture of the service needed to change however this would take some time.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care was not person-centred.

The enforcement action we took:
We cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's dignity was not maintained.

The enforcement action we took:
We cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent There was no evidence of any Mental Capacity Assessments or best interest decision making.

The enforcement action we took:
We cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not managed appropriately. Infection prevention and control measures were not carried out appropriately. There were gaps in food and fluid charts and PEG records. There were gaps in DNAR records. Risk assessments did not

contain the information needed and were not always in place for people's specific needs. Some people did not see health professionals are regularly as needed.

The enforcement action we took:

We cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding alerts had not been raised when needed. DOLS had not been put in place when needed. Behaviours which can challenge had not always been managed appropriately.

The enforcement action we took:

We cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance There were significant gaps in all records looked at. There were very few quality assurance processes in place. These had not highlighted any of the concerns which we had.

The enforcement action we took:

We cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient staff on duty to provide safe care and support to people. Staff supervision, appraisal and training were not up to date.

The enforcement action we took:

We cancelled the provider's registration.