M J Flynn

Parkfield House Care Home

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?	Requires improvement
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

This inspection took place on 17 and 19 November and 2 December 2015 and was unannounced. At the last inspection on 18 February 2014 we found the home was meeting the regulations.

Parkfield House Care Home provides nursing and personal care for up to 24 older people, some of who are living with dementia. There were 23 people using the service when we visited. Accommodation is provided over two floors. There are nine single rooms and eight shared rooms. There is a large conservatory and lounge areas on the ground floor and a small sitting area on the first floor.

The home does not have a registered manager. The registered manager left in 2014 and a new manager was appointed who was not registered with the Commission. This manager was absent when we carried out the inspection and has since resigned. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found people were not kept safe in the home. Staffing levels were insufficient to meet people's needs. For example, during our inspection there were occasions when we had to find staff to help people and keep them safe. Although staffing was increased following the first day of our inspection this was only due to the feedback

Summary of findings

we provided. Risks to people were not managed well. For example, we found on three occasions people had gone missing from the home due to lapses in security and a lack of staff supervision. Safeguarding incidents were not always recognised, dealt with or reported appropriately.

Staff recruitment processes were not robust as full checks were not carried out to ensure staff's suitability to work in care services. There was no evidence to show new staff had completed an induction. The training matrix showed many staff had not received up-to-date training in the providers identified mandatory subjects such as moving and handling, fire safety and safeguarding.

Maintenance works were not always identified or addressed promptly until we brought them to the provider's attention. There were strong malodours in two bedrooms, although these had been addressed on the third day of our visit.

We found systems in place to manage medicines were not always safe which meant people were not always receiving their medicines when they needed them. Care records were not up-to-date or person-centred and lacked detail about the support people required which placed people at risk of receiving unsafe or inappropriate care.

People were not offered a choice of meals although this had improved by the third day of our inspection as a new cook had started. People's nutritional needs and weight were not monitored or reviewed to make sure they were receiving sufficient to eat and drink.

Staff lacked understanding and knowledge of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Two people had DoLS authorisations, yet conditions applied to one of the authorisations had not been implemented.

We observed some kind, caring and sensitive interactions between staff and people who used the service. However, we found examples which showed people's privacy and dignity was not always respected and there was no provision to meet people's cultural preferences. Some activities were provided which we saw people enjoyed, yet there was no structured activity programme and people's interests and hobbies had not been determined.

There was a lack of consistent and visible leadership which, coupled with poor communication systems, led to disorganised service provision. Quality assurance systems failed to identify or address risk to people's health, safety and wellbeing or secure improvements in the service.

Following the second day of our inspection we contacted the provider to inform them of our concerns and requested action plans to show how these would be addressed. The action plans were provided and our visit on the third day showed some improvements had been made. We liaised with commissioners from the Local Authority and Clinical Commissioning Group, as well as the safeguarding team.

Overall, we found significant shortfalls in the care and service provided to people. We identified eleven breaches in regulations – regulation 18 (staffing), regulation 19 (recruitment), regulation 12 (safe care and treatment), regulation 15 (premises), regulation 13 (safeguarding), regulation 11 (consent), regulation 14 (nutrition), regulation 9 (person-centred care), regulation 10 (dignity and respect), regulation 16 (complaints) and regulation 17 (good governance). The Care Quality Commission is considering the appropriate regulatory response to resolve the problems we found.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

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

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

Summary of findings

inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

Summary of findings

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.

There were insufficient care staff deployed during the day and night shifts to ensure people's needs were met and they were kept safe. Staff recruitment processes did not ensure staff were suitable to work.

Medicines management was not always safe and effective, which meant people did not always receive their medicines as prescribed.

Risks to people's health, safety and welfare were not properly assessed and mitigated. Safeguarding incidents were not always recognised or reported.

Systems in place to keep the premises clean, secure and well maintained were not effective.

Is the service effective?

Inadequate

The service was not effective.

People's weight and nutritional and hydration needs were not monitored effectively, which placed people at risk of not receiving sufficient quantities of food and drink to maintain their health.

Staff lacked knowledge and skills to meet people's needs. Training was overdue or had not taken place for many staff and there was no evidence of an effective induction for new staff.

Staff lacked understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Conditions applied to a DoLs authorisation were not being followed.

People had access to healthcare services, however a lack of communication between staff meant advice and information was not always passed on.

Is the service caring?

Requires improvement

The service was not consistently caring.

We saw some caring and kind interactions between people and staff. However, there was a lack of respect for people's privacy and dignity.

People's views were not sought or acted upon.

Is the service responsive?

Inadequate

The service was not responsive.

Care was not planned or delivered to meet people's individual needs.

Summary of findings

Although some activities were taking place, there was no structured programme and people's interests and hobbies were not taken into consideration

Complaints were not dealt with in accordance with the home's complaints policy.

Is the service well-led?

Inadequate 

The service was not well led.

There was no registered manager. We found a lack of leadership, poor communication and ineffective quality assurance systems meant people did not receive the care and support they required.

Parkfield House Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 17 and 19 November and 2 December 2015 and was unannounced. Two inspectors attended on all three days.

Before the inspection we reviewed the information we held about the home. This included looking at information we had received about the service and statutory notifications we had received from the home. We also contacted the local authority commissioners and the safeguarding team.

We usually send the provider a Provider Information Return (PIR) before the inspection. 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. We did not send a PIR on this occasion as the inspection was planned at short notice.

We spoke with ten people who were using the service, five relatives, three nurses, six care staff, a laundry assistant, the cook, the care quality manager, the support manager and the registered provider.

We looked at ten people's care records, six staff files, medicine records and the training matrix as well as records relating to the management of the service. We looked round the building and saw people's bedrooms, bathrooms and communal areas.

Inadequate

Is the service safe?

Our findings

Our observations showed there were insufficient staff on duty to keep people safe and meet their needs. On the first day of our inspection there was one nurse and four care staff on duty. The nurse had come from one of the provider's other homes, one of the care staff was an agency worker and another of the care staff was new in post, which meant these staff had limited knowledge of people's needs. We saw staff were not directed or deployed to keep people safe. For example, the two experienced care staff took their lunch break together leaving the new care assistant and agency worker to manage the area. During this time we saw these staff assisted a person to transfer using unsafe moving and handling techniques. When we spoke with these staff they were not aware of how to move the person safely, had not received the appropriate training, had not looked at the person's care plan or been informed of this person's needs. When we looked at the person's care plan it did not set out this information.

Throughout the day there were several instances where we had to intervene and alert staff to situations where people required attention and support because no staff were around. For example, we saw one person spilt a cup of tea on their knee and was shouting that their leg was hurting. The inspector had to press the buzzer in the lounge to alert staff as no staff were present. We saw another person whose care plan stated they should be checked by staff every 15 minutes to make sure they were safe yet we observed there were periods of up to 45 minutes when no staff checked on this person.

The care quality manager told us the usual staffing levels were one nurse and three care staff during the day and one nurse and one care assistant at night. They said they were intending to increase the staffing levels the following day, yet when we asked why they had not done so already they said they felt there were no immediate risks to people and the increases were to provide additional activities. The care quality manager said staffing levels were determined by people's dependencies, however they acknowledged there were no records to evidence this or to show how the levels had been calculated.

On the second and third days of our inspection the staffing levels had been increased by one care assistant on all shifts. We saw this meant staff were available and more attentive to people's needs. However, we noted concerns had been raised about staffing levels in staff meetings in August 2015 yet no action had been taken to address this until our inspection on 17 September 2015. This was a breach of the Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found inconsistencies in the approach to recruitment which placed people at risk of harm from staff who had not been thoroughly vetted to determine their suitability to work safely in the service. We found there was no evidence to show criminal record checks from disclosure and barring service (DBS) had been obtained for three of the five staff members we checked. The full recruitment file for one recently appointed staff member could not be produced. A copy of their DBS check was faxed over from the provider's sister home, however we were still unable to confirm that complete checks had been made to ensure this person was safe to work as their application form and complete references could not be provided. There were discrepancies in other staff's references. For example, one staff member had a reference which was undated and had no name on and the other two staff members had no references from their last employer. On the third day of the inspection we checked the recruitment file for the manager. Although there was an application form and references these related to the manager's initial employment as a nurse in the home in 2002. There was no evidence to show a DBS check had been completed and no evidence to show when the person had been appointed as manager or the processes completed to determine their fitness for this position. This was a breach of the Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found risks to people were not managed safely or appropriately. For example, the care records for one person who was living with dementia showed they were at risk of falling and required a low bed and a crash mat at the side of their bed. When we looked in this person's room we found the bed was in a low position but there was no crash mat and there were bed rails in place. An unsigned and undated risk assessment showed bed rails were not suitable for this person yet they had still been put in place. Records showed this person had been found on the floor next to their bed on three occasions on 28 October, 5 and 8 November 2015, yet no action had been taken to investigate these incidents or to review the use of the bed rails, which placed the person at risk of harm or injury. Two people had deprivation of liberty safeguards (DoLS)

Is the service safe?

authorisations in place to keep them safe through constant staff supervision and locks on doors to prevent them from leaving the premises alone. We found both these people had managed to leave the home unsupervised when doors had been left open. Fortunately neither person came to any harm, although the police were involved in one incident. However, care plans and risk assessments had not been reviewed or updated to show what action had been taken to keep each person safe. Neither had these incidents been reported to the local authority safeguarding team or notified to the Commission. This was a breach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The training matrix showed 11 out of 20 staff had not received any safeguarding training and the remaining eight staff had not completed annual refresher training. Staff we spoke with had a lack of understanding and knowledge of safeguarding and what constituted abuse. This was also evident from the records we reviewed which showed a number of incidents and accidents which were clearly safeguarding matters but had not been referred to the local authority safeguarding team or notified to the Commission. We found there had been a failure to safeguard people from the behaviour of people who lacked capacity and were unaware of the impact of their actions which resulted in people being abused. One person told us they did not like another person and when we asked them why they said, "He likes the ladies, has touched me and I don't like it, tries to do it with other ladies, he's a big chap so it's a bit scary." Records showed there had been other incidents where this person had inappropriately touched females yet there was no evidence to show how people were being protected from further incidents occurring. In another instance a person was found to have unexplained bruising to their lower legs, although it was recorded that the person had been seen by their GP who was not concerned, there had been no investigation to establish how the bruising had occurred. Following the first day of our inspection we made referrals to the safeguarding team as we considered people were at risk. By the third day of our inspection, the provider had taken action to reduce and monitor the risks to people in response to the feedback we had given. This was a breach of the Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although medicines were stored safely and securely, we found systems and processes in place to manage medicines were not always safe or effective. We saw where medicines had to be given at a specific time, instructions were not always being followed. For example, a medicine prescribed to be given 30 minutes before food, had been given after the person had finished their breakfast. The nurse, who was from one of the provider's other homes, said where they usually worked these medicines were given out by the night staff to make sure people received them before their meal. We found gaps on the medicine administration record (MAR) charts where staff had not signed to show that the medicine had been given. For example, we saw one person was prescribed a nutritional supplement to be given three times a day. There was only one signature on the MAR to show this had been given over a nine day period. There was no reason recorded to show why the supplements had not been given and the nurse could offer no explanation.

Another person was prescribed an anti-coagulant (a medicine which thins the blood) with the dose alternating between 2.5mgs one day and 2mgs the following day. The person was prescribed 1mg and 0.5mg tablets. The MAR had no signatures to show that the 0.5mg tablet had been given. When we asked the nurse they said they thought staff had been breaking the 1mg tablets in half to make the 2.5mgs dose. When we checked the stock levels of both quantities of tablets against the levels recorded on the MAR they were incorrect, which meant we could not establish if the medication had been administered as prescribed.

We saw a lack of robust protocols and ineffective management where people were prescribed medicines to be taken 'as required'. For example, where people were prescribed pain killers to be given 'as required' there were not clear protocols or information to guide staff about how to identify when people were in pain. We also saw two examples where people were prescribed medicines to help reduce their agitation. There were not clear protocols in place to provide staff with guidance around when to give this medicine and what other measures should be tried to reduce agitation prior to giving the medicine. Staff were also not always recording the time and number of tablets given when people had taken their 'as required' medicine.

The processes for ordering medicines were ineffective as there were occasions when the service ran out of the medicines people required. For example, for one person records showed they had run out of a cream and their medicine prescribed to reduce their agitation. We checked

the stock levels and found this medicine was still out of stock for this person. On the 2 December we checked their MAR and saw this medicine had been given on 1 and 2 December 2015. The provider had made a note on this person's medicines records that they were "awaiting stock" of this medicine, however this was not dated so we were unable to establish when this had been identified. It was not clear how this person had been given this medicine whilst it was out of stock. The support manager contacted this person's GP and established this medicine had not been ordered since 18 August 2015. This showed there was a lack of communication between the provider and nursing staff to ensure the medicine was ordered and obtained.

We were not able to establish if topical medicines, creams and lotions were being administered as prescribed due to the lack of protocols and information about how, where and when these medicines should be applied. For example, we saw one person was prescribed an antiviral cream. There were two MARs for this cream one stated the cream was to be applied three times a day and the other five times a day to 'the affected area'. We asked the nurse where this cream should be applied and they did not know and told us they had not been able to find the cream when giving out the medicines. The support manager checked the person's room but could not find the cream or any records to show where the cream should be applied or how often. This was a breach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We toured the premises with the support manager and found the home was not adequately maintained. On the first two days of our inspection the temperature in the conservatory was 19 degrees centigrade and we heard people who were sitting in this area commenting that it was cold. The conservatory roof was also leaking when it rained heavily. When we reported this to the care quality manager they took action to move people out of the conservatory. However, we observed several occasions when three different people accessed the conservatory area without staff's knowledge. Inspectors had to take action to ensure these people did not slip on the area where the floor was wet from the leak. By the third day the room temperature had increased. The care quality manager told us the radiators had been full of air which was why the room had not been warm. Although most areas of the home were clean and odour free we found two bedrooms had a strong urine odour. When we returned on the third day the flooring in one of these rooms had been replaced and new flooring had been ordered for the other room. We found an unguarded radiator in one bedroom where the surface temperature was very hot when touched. A guard had been fitted when we returned on the third day. We found shared rooms, which were occupied by two people, where there were no screens to maintain people's privacy and dignity. These were in place on the third day of our visit. Records we reviewed showed two people, who were vulnerable and at risk, had been able to leave the building without staff's knowledge as doors had not been secured properly. By the third day security checks had been put in place to ensure all doors were locked and new locking devices for the doors had been ordered. Although the issues we raised were addressed we were concerned that this was due to our intervention rather than as a result of the home's routine maintenance checks. This was a breach of the Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty 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.

Two people had DoLS authorisations in place, yet when we asked the nurse in charge on the first day of the inspection they were not aware of these. There were two conditions applied to the authorisation for one person but there was no evidence to show either of the conditions were being met. Our discussions with staff showed a limited knowledge and understanding of the MCA and DoLS. This was a breach of the Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found there were gaps in staff's knowledge and skills. Our observations and discussions with staff indicated that most staff would have benefitted from additional training particularly with regards to dignity, dementia, safeguarding, MCA and moving and handling. There was no evidence of an effective and comprehensive induction for the three new care staff whose recruitment files we reviewed and the senior managers were unable to provide us with this evidence. We spoke with one newly recruited staff member who told us they had received no induction or training since they started employment two months previously. The training matrix showed staff had not received training updates and in some instances there were no training dates recorded. This included training in practical moving and handling, fire training, food hygiene, safeguarding and MCA and DoLS. This was a breach of the Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had concerns about how staff monitored people's weight and ensured their nutritional intake was sufficient. For example, one person's care records showed they had lost 3kgs prior to their admission to the home, their care plan noted they had lost weight and had a poor appetite. We saw food charts had been completed for three days, but these were undated and on two days no food intake was recorded after lunch. There were fluid charts covering eight days, one chart was blank, one had only one entry which showed sips of fluid had been taken and the others showed a daily fluid intake which varied from 100mls to 700mls. There was no target fluid intake and no staff signatures to show the information had been monitored or reviewed. Another person's records showed they had lost 9kgs between June and September 2015 and their care plan dated 26 August 2015 stated their food intake was to be monitored via a food chart. Only one food chart was available which was for the week beginning 2 November 2015 and there was only one day's worth of food recorded. Both these people had diabetes yet there was no information in their care plans about how this was managed. We found people were not always receiving their nutritional supplements as prescribed. For example, one person was prescribed a nutritional supplement to be given three times a day but the medicine administration record showed they had not received this for over two weeks.

We observed the lunchtime meal on the first day of the inspection. The meal was served in the conservatory and people were brought to the table at 12.15pm. Two people mentioned it was cold in the room and after waiting for 30 minutes people started to ask each other where their lunch was. Staff brought in the meals at 12.50pm. Meals arrived already plated and were brought from the kitchen uncovered. Nobody was given a choice or told what the meal was, the staff member put the plate in front of the person saying, "Here you are" before going back to the kitchen to bring in more meals. No one was offered a drink or seconds and everyone received the same meal – chicken, mashed potato, cauliflower, sprouts and gravy. We saw an agency care staff member sat and assisted one person with their meal for 20 minutes. The agency staff member did not engage with the person at all but sat silently spooning food into the person's mouth. We saw another staff member spoke with the person occasionally as they were clearing other people's plates away. One person told us, "You get what food you are given, if you

Inadequate

Is the service effective?

don't like the food that's on offer then it's tough luck, you don't get another choice." On the second and third day, improvements had been made and we saw people were offered choices and drinks and staff engaged more with people.

On the first day of the inspection we spoke with the cook who told us there was usually one main meal at lunchtime and a vegetarian option. The cook told us if people did not like the meal it would be difficult to make them something else as all the meat was supplied frozen in bulk. The cook said people were not asked what they wanted to eat as this would mean they would have to cook too many different things. We asked the cook what was for tea and they said, "Whatever's in the freezer." This was a breach of the Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.On the third day of our inspection a new cook had started in post and the support manager told us the menus were being revised with the involvement of people who lived in the home.

People's care records showed they had access to healthcare services and we saw records of visits from GPs, the mental health team, the optician and chiropodist. Although the service engaged with health professionals we found it was not always clear from the records appropriate action had been taken to follow their advice. For example, on the third day of the inspection we found there was no record of the outcome of a GP visit to one person. The nurse confirmed the visit had taken place and told us what the GP advised but acknowledged they had not documented this information.

Requires improvement

Is the service caring?

Our findings

One person said, “Staff are very nice, they keep an eye on you.” Another person said, “I am happy living here, I have made lots of friends.” A further person said, “Some staff are ok, other staff can be rude.”

A relative told us they were happy with the care their family member received. They said they could visit whenever they wanted and described the staff as “very nice”. Another relative said, “I am always made to feel very welcome whenever I visit. They make me a meal so I can eat with [my relative] which is nice.”

On the first day of our inspection we found although some staff took time to engage with people and were warm and caring, other staff were less responsive to people’s needs interacting only when carrying out care tasks. We found improvements on the second and third day of our inspection as we saw staff spent more time with people and were more attentive to their needs. For example, we saw one staff member comforting a person who was distressed. They were patient and calm and listened to what the person was saying and reassured them. We saw another staff member accompanied a person as they were walking around the home and gently guided them so they remained safe.

However, we observed a lack of training and direction impacted on how staff responded in certain situations. For example, one person’s care plan said to dress them in warm clothes as they felt the cold. We heard this person saying they were cold and staff brought them a blanket to wrap around themselves, but this meant when the person stood up the blanket was trailing on the floor. This person was at risk of falling. We asked staff if the person had warmer clothing they could put on and they brought the person another jumper but no one had thought to do this until we intervened. On another occasion when we were in a communal area we saw a person stand up and pull down their trousers, although staff responded quickly and assisted the person to pull their trousers back up they did not ask the person if they wanted to go to the toilet or explore why the person may have acted in this way but sat the person back down and left them.

We found people’s privacy and dignity was not always maintained. For example, we saw there were no screening curtains in three bedrooms where people were sharing a room, which meant people had no privacy when dressing and undressing or when they were receiving personal care. This showed a lack of respect for people and undermined their dignity. We saw one en-suite facility had a door which led out into a corridor. There was no lock on the door which meant access could be gained to the en-suite from the corridor compromising people’s privacy and dignity. Two bedrooms had windows which looked into the conservatory. We saw blinds at these windows did not close fully which meant people in the conservatory could see into the rooms. Also when these bedroom windows were open conversations taking place in the bedrooms could be overheard in the conservatory. By the third day of our inspection these issues had been addressed, however the provider had failed to identify and address these issues until we brought them to their attention. This was a breach of the Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found no evidence to show that people were involved in making decisions or planning their care. Although there were consent forms in some people’s care files these were blank and a document entitled ‘This is me’ which explored people preferences and wishes had not been completed.

Inadequate

Is the service responsive?

Our findings

People's care was not planned and delivered to meet their individual needs. Care records we reviewed contained minimal information and did not reflect people's current needs or detail the support they required from staff. For example, care records for one person showed there had been three incidents in October 2015 which related to falls and safety, yet their falls risk assessment had not been reviewed since September 2015 and the safety care plan was dated March 2015 and provided little detail about how to keep the person safe. For another person we found contradictory information about their care needs. For example, the sleep care plan written in November 2015 said to make sure bed rails were in place when the person was in bed to keep them safe, yet an undated risk assessment showed it was not safe for bed rails to be used. A mobility care plan dated 22 October 2015 stated the person was able to stand with two staff and weight bear, yet a safety care plan dated 22 October 2015 stated the person 'will not weight bear so hoist for own safety'. There was no detail in the moving and handling assessment, which was undated, about the type of equipment to be used with this person.

People's cultural needs were not considered or respected. For example, one person, whose nationality was not British, told us they liked food from their country of origin. When we asked them if this was provided they said no but told us their relative brought in food for them.

We found staff were not always aware of people's needs or the support they required. For example, the staff we saw assisting a person to transfer using unsafe moving and handling techniques were not aware of how to move the person safely. Our discussion with these staff showed they had not been informed of this person's needs. When we looked at the care records for this person there was no information about how this person should be moved safely or the equipment required. On the third day of our inspection we found an agency care worker had been assigned to provide one to one support to one person. We spoke with the agency worker who said they had not been told anything about the person and had just been told they "liked to walk around" and to "keep them calm". We saw every time the person stood up the agency worker tried to sit them back down and the person was becoming agitated. Shortly after our conversation with the agency worker a permanent care staff member was allocated to provide this support. We saw this person spent the rest of the day walking around the home with the support of this staff member, they were calm and their body language showed us they were relaxed.

We found there was a lack of information in people's care records about their interests and hobbies and no plans to show how people's social needs were being met. Where there was information recorded about people's interests there was no evidence to show this was utilised by staff. For example, one person's records showed they liked cricket and to look at a newspaper, yet we saw this person sat for long periods of time at a table with nothing to do apart from look out of the window. We asked staff if the home had a newspaper people could look at and we were told no. There was no planned programme of activities and no activity co-ordinator and activities were carried out by the care staff This was a breach of the Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed some activities taking place during our visits. On the first day we found staff interactions with people focussed mainly on care tasks although a musical entertainer visited the home and we saw people singing and enjoying the music. On the second and third days we found staff were more responsive to people's needs and took opportunities to spend quality time with people. For example, we saw staff playing dominoes with two people and another staff member accompanied one person chatting with them as they walked together around the home.

A complaints procedure was displayed in the lounge. We looked at the complaints file and saw two complaints recorded. For one of the complaints there was evidence to show the action taken and the provider's response to the complainant. For the other complaint there was a record of the concerns raised which stated the complaint had been passed to the provider. There was no record of any response to the complainant. We saw evidence of other complaints in the care records we reviewed, which were not included in the complaints file. For example, a relative had reported a missing item of property and although there was a record to show this had been discussed with senior managers and the provider there was no evidence of a formal response to the complainant. The home's complaints policy stated 'all complaints are responded to

Inadequate

Is the service responsive?

in writing by the home', yet our evidence showed this was not happening. This was a breach of the Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

The home had no registered manager. The care quality manager told us the registered manager left in 2014. A new manager was appointed in 2015, although we could not ascertain from the recruitment records or discussions with the senior managers exactly when this person had started as the manager. The manager was absent on all three days of the inspection and following the inspection we were informed they had resigned. Following the first day of the inspection the provider, the care quality manager and support manager took over the management of the home.

We found the lack of strong and consistent leadership underpinned many of the failings we have identified in this report. Poor communication systems and the lack of co-ordinated team work meant managers and those in charge of the home were not always aware of what was happening. For example, the nurses in charge of the home were not clear about how many people were using the service or the staff who were on duty. On the third day the nurse in charge told us there were 19 people, when there were actually 23. They said there were five care staff on duty when there were six. One of the care staff who was an agency worker had arrived late and told us they had not received a handover. The nurse in charge on the first day of the inspection was not aware that two of the people had DoLS authorisations in place.

When we were reviewing one person's medicines we found they had not being taking their prescribed nutritional supplement and when we asked the nurse why they told us the person did not like the banana flavour they were prescribed and refused to take it. Although the person was known to be nutritionally at risk and had refused the supplement for over two weeks no one had followed this up with the person's GP or considered obtaining different flavoured supplements. The support manager said they would arrange for this to happen. Yet later in the day a care staff member showed us different flavoured supplements prescribed for this person in a cupboard downstairs. The care staff member told us the person loved having the strawberry flavoured supplement as they said it was like milkshake. This example demonstrates the lack of communication between staff and how that impacts on the care being delivered to people.

On the third day of our inspection we found evidence which showed some people had lost weight yet there was no clinical oversight to ensure weight loss was acted upon or reported to the appropriate professionals. For example, we saw one person had lost over 2kgs in the last three months. Their care plan dated October 2015 stated if they lost weight to inform the GP. There nutritional assessment had not been updated since August 2015 when their body mass index (BMI) was already low. We saw the GP had visited on 2 December 2015 and we asked the nurse if they had informed them of this person's weight loss. The nurse said they had not as they were not aware the person had lost weight.

On the second day of our inspection we found systems in place to manage and record people's money were not being followed. The nurse initially told us they did not look after anyone's money, but when asked again told us they kept two people's money. When we checked the safe with the nurse we found money for five people, one of whom was no longer living at the home. Records were not up-to-date and balances for two people were incorrect. Following this visit the provider told us a full audit had been completed of people's money and balances were now correct.

There were quality assurance systems in place but none of these were effective in securing service improvements. For example, we saw a room check list completed in October 2015 identified missing screen curtains and we found the same issue at our inspection. We saw care and support audits had been completed in April, June and October 2015 and all three audits identified issues yet there were no action plans or evidence to show that these issues had been followed up. A health and safety audit completed in July 2015 had not been fully completed and although issues had been identified in relation to fire drills and monitoring of water temperatures, no actions were recorded. Although regular room checks and health and safety audits were completed they had not picked up the environmental issues we identified in this report. The conservatory roof was leaking in several places on both days of our visit. The conservatory is used as a dining room. There were problems with the heating in this room and it was cold on both days when we visited. The room thermometer showed the temperature was 19 degrees centigrade. On the first day of our inspection the service users had to be moved out of the conservatory because of the cold and the leaking roof.

Inadequate

Is the service well-led?

We found accidents and incident reports were not being reviewed or monitored by managers. We saw two accident audits dated April and July 2015, both identified that next of kin were not always being informed and forms were not being completed correctly. Yet there was no evidence to show what action had been taken to address these issues. There were no systems in place to identify trends or themes or consider lessons learnt to prevent similar accidents occurring. When we reviewed the accident and incident forms we found they were poorly completed and there was often no evidence to show what action had been taken. For example, an accident report for one person dated 28 October 2015 stated '? fall from bed – small skin tear to right forearm', there was no other information and nothing to show the next of kin or GP had been informed. This person had bed rails but there had been no investigation to establish how the accident occurred or if the bed rails were up when the person fell.

We saw weekly and monthly medicine audits completed by the manager. The monthly medicine audit in September 2015 had identified no issues and the weekly audit in October 2015 had identified two issues regarding the recording of fridge temperatures and reasons why medicines had not been given. There was no evidence of any follow up and none of the issues we identified at our inspection had been picked up in either audit.

There were no systems in place to check nurses had valid registration with their professional body. On the third day of our inspection the care quality manager showed us an audit they had completed on 25 November 2015 of staff recruitment files. This identified that for four nurses there was no confirmation of their personal identification number (PIN) showing their registration with the Nursing and Midwifery Council. We asked the care quality manager if the nurses PINs had been checked since the audit to make sure their registration was valid and they told us an administrator was following this up. We established from the care quality manager that these nurses were working in the service and advised them to check the nurses registration details online, which they did immediately and all the nurses were found to have valid registration. However, the care quality manager was unaware of the online checking service until we brought this to their attention.

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

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements 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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not protected from abuse and improper treatment as systems and processes were not established and operated effectively to investigate any allegation or evidence of abuse. Regulation 13 (2) & (3).

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 Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed and had not received appropriate support, training, professional development to enable them to carry out the duties they were employed to perform. Regulation 18 (1) (2) (a).

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 The care and treatment of service users was not appropriate and did not meet their needs or reflect their preferences. Regulation 9 (1) (a) (b) (c) (3) (b) (I)

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 Systems and processes were not established or operated effectively to assess, monitor and improve the quality of the services provided or to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. Regulation 17 (1) (2) (a) (b)

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints An accessible system was not established or operated for identifying, receiving, recording, handling and responding to complaints. Regulation 16 (1) (2)

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 Service users were not provided with care and treatment in a safe way in relation to assessing the risks to the health and safety of service users of receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks and in relation to the proper and safe management of medicines. Regulation 12 (1) (2) (a) (b) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment All premises used by the service provider were not clean, secure or properly maintained. Regulation 15 (1) (a) (b) (e).

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 Service users were not treated with dignity and respect and their privacy was not ensured. Regulation 10 (1) (2) (a) (b)

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs Service users' nutritional and hydration needs, were not being assessed and reviewed to ensure they were being met. Regulation 14 (1) (4) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Recruitment procedures were not established and operated effectively to ensure that persons employed were of good character and have the qualifications, competence, skills and experience which are necessary for the work to be performed by them. Regulation 19 (1) (a) (b) (2) (a)

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 The registered person had not ensured that they had obtained the consent of the relevant person to care and treatment, and where the service user was 16 or over and was unable to give such consent because they lacked capacity to do so, had not acted in accordance with the Mental Capacity Act 2005. Regulation 11 (1) (2)(3)