Lotus Care 2 Limited

Abbas Combe Nursing 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

We carried out this inspection on 10 and 16 February 2015. This was an unannounced inspection.

Abbas Combe Nursing Home is a detached property set within its own grounds. It provides nursing care for up to 24 older people, including people who may be living with dementia or have a range of physical health problems. At the time of our inspection there were 11 people receiving care.

The service did not have a registered manager, although the provider had recently made an appointment of a manager who would be starting in April 2015. 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.

People were not protected against the risks of receiving care that was inappropriate or unsafe. Care plans were reviewed but were not updated or changed to reflect the changing health and social needs of people. Although

Summary of findings

staff had received training in safeguarding they did not feel confident to report abuse. The provider had reported same safeguarding concerns to West Sussex County Council but had not notified us of these concerns.

People's risk assessments identified areas where the person may be at risk of harm. However there was no care plan or guidance for staff on how to support an individual to manage their behaviour. People's freedom was restricted as all but one person did not move out of their rooms on the two days of our inspection. People had told us they wanted to spend time in the lounge and with other people.

On the first day of our inspection there were insufficient numbers of suitable staff to keep people safe and meet their needs. Two of the three staff were agency staff and one shift had not been covered. There were no domestic staff which meant care staff were also responsible for the cleaning and laundry which took time away from staff giving care to people.

Medicines were not managed safely. There were gaps in medication administration records and medicines no longer in use were still in the medicines trolley. Controlled medicines no longer required had not been returned to the pharmacy and there was not an effective medicines audit in place to monitor stock.

People were not protected by the prevention and control of infection. Cleaning records were incomplete and only some of the cleaning tasks were being carried out by care staff. A control of infection audit had not been carried out. Areas of the home were dirty and we saw stained sheets, carpets and furniture.

People were not receiving effective care due to the care plans not relaying up to date information. With a high number of agency care staff being used, care was not being delivered consistently by staff who knew and understood the care needs of people in the home.

Consent to care was not always sought when staff delivered care. Care plans and risk assessments were not signed by all people or their relatives. Staff were aware of the Mental Capacity Act (MCA) 2005 and we saw people had been assessed as to their capacity to make decisions.

The Care Quality commission is required by law to to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). The group manager informed us that there were no people who required DoLS authorisations and that no requests had been made for people who this legislation may apply to due to them not having capacity to make decisions.

Not all people were supported to eat and drink enough to maintain a balanced diet. We were made aware of two instances where people had lost significant amounts of weight. In these cases people's weights were not monitored consistently and there was a delay in seeking medical advice and to monitor food and drink intakes.

People's health needs were not always managed effectively. People were able to access regular healthcare visits from GPs and nurses. However there were instances where medical treatments were required and people suffered delays in receiving them.

Permanent staff were committed and caring and spoke respectfully about the people they cared for. The agency staff were thoughtful but lacked knowledge and understanding of the people they were supporting. People were not encouraged to express their views and they felt they may not be listened to if they did express their views. People's privacy was not respected at all times in that on some occasions doors to people's rooms were not closed when staff delivered care. Not all people's end of life care plan had been completed even though we were made aware of some people whose conditions were seen as approaching end of life.

People did not always receive personalised care that was responsive to their needs. Assessments of people's needs were often out of date and care plans did not reflect what their likes, dislikes and preferences were. The provider had systems in place for complaints and concerns to be heard. This was not effective as concerns about lack of activities had not been addressed.

Systems to assess and monitor the quality of the service were not effective. Leadership in the home was not visible due to the loss of the registered manager, registered nurses and experienced care staff. Staff did not feel they were supported and systems to supervise and induct new staff were ineffective.

During this inspection we found several breaches of the Health and Social Care Act 2008 (Regulated Activities)

Summary of findings

Regulations 2010 which correspond to breaches of the 2014 fundamental standards. You can see what action we have told the provider to take at the back of the full version of the report.

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 was not always sufficient staff on duty who had the skills, knowledge and experience to understand people's needs and support them safely. Care plans did not contain sufficient and up to date information for temporary staff to deliver safe care.

Risks were not managed appropriately. Where risk had been identified there was not a care plan or guidance for staff on how to manage that risk.

Medicines were not recorded or disposed of safely. There was a lack of an effective medicines audit.

People were not protected from the risk of infection. The home was visibly dirty and in need of re-decoration. Records of cleaning were not completed and staff were unable to complete all cleaning tasks.

Is the service effective?

Inadequate

The service was not effective.

Induction for new staff had not been completed fully and new staff did not have the right knowledge to meet their needs. Due to the large staff turnover there was a reliance on agency staff who did not have knowledge of people they were supporting.

Consent to care was not always asked for. Whilst some people had been assessed for their capacity to make decisions there was no application of DoLS where people were restricted to their rooms.

Some people's nutritional needs were not monitored and medical advice was not sought in good time. People had access to health care but some medical needs were overlooked.

Is the service caring?

Requires Improvement

The service was not caring.

There was a task led approach to care due to a lack of staff. This meant people's individual needs were not being accounted for.

People's privacy and dignity was respected although relatives told us they were unhappy that on occasions doors were left open when people were being given care.

People and their relatives were not involved in decisions about the planning of their care.

Summary of findings

Is the service responsive?

Inadequate 

The service was not responsive.

Care plans were not updated or amended to reflect changes to people's health and social care needs.

Feedback from people, their relatives and healthcare professionals had not been sought consistently. When feedback had been received this had not been acted on and used to improve the service.

People were not supported to pursue their interests and hobbies. Due to the length of time people spent in their rooms they were at risk of becoming socially isolated.

Is the service well-led?

Inadequate 

The service was not well led.

There was no registered manager at the service and people were unclear as to who was in charge.

Quality monitoring systems were not consistently maintained. They were ineffective and failed to address concerns they had found.

Staff did not feel supported by the management in the home. Meetings to address concerns and listen to suggestions to improve the service were held infrequently.

There was not a clear and open culture to put people at the centre of the service. People and their relatives did not feel involved in decisions made about the quality of the service.

Abbas Combe Nursing 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 10 and 16 February 2015 and was unannounced. The inspection team consisted of an inspector and a specialist advisor who was an experienced nurse.

We spoke with the provider and group manager. We met the newly appointed manager, although they had not taken up post at the time of our inspection. We spoke with six members of staff and two agency staff. Six people who used the service spoke with us and we spoke with three relatives. We spoke with two healthcare professionals and one social care professional.

We looked at care records for seven people. We looked at medicine records for seven people and records the service used to manage the administration, storage and safety of medicines. We looked at six staff member's recruitment and support files. We looked at policies and procedures the provider used and records of how they monitored different aspects of the service. We observed staff interactions with people whilst carrying out their duties such as supporting people in their rooms. We observed how people were supported during their lunch time meal.

This inspection was carried out in response to concerns raised to CQC about a high turnover of staff, medicine errors and poor care practices. We looked at previous inspection reports and other notifications we had received. A notification is information about important events which the provider is required to tell us about by law, such as expected and unexpected deaths.

We last inspected Abbas Combe Nursing Home on 27 August 2014 where no concerns were identified.

Inadequate

Is the service safe?

Our findings

People told us they did not feel safe at Abbas Combe. One person said, “I do not always feel safe here and I cannot tell you why.” Another person said, “I suppose I am safe but I never leave my room.” One person said, “Most of the staff have left, I just don’t know who the people are who care for me.” One relative told us, “I had to ask staff to give mouth care to my nan. I also had to take my nan to the hospital to have a suture removed two months after it should have been taken out.” Another relative told us, “this place is awful, I should have moved [person’s name] a month ago but she is now so frail a move might harm her. She used to say she felt like she was in prison.”

There had been a high turnover of staff since August 2014 which meant that out of a staff team of nearly 26 only 6 staff were still working in the home at the time of our inspection. This had led to the provider having to rely on temporary agency staff. On the first day of our inspection three staff were on duty, two of them being from an agency. A fourth member of staff was due to be on duty but did not come in. The agencies were unable to provide cover for this shift. People were left without support for longer periods of time as while the nurse was administering medicines, two staff were engaged in supporting one person, meaning call bells were not answered in good time. A member of staff told us, “Some of the agency staff are good but others do not know the people or how they like to be supported. I then have to leave who I am supporting to give advice to agency staff.”

The provider was recruiting domestic staff and no cleaners were on duty, so care staff were expected to carry out cleaning as well as care duties. A new member of domestic staff had started on that day but was receiving their induction training. Due to insufficient numbers of staff people were at risk of not receiving appropriate and safe care or levels of observation and support their needs required. Staff did not have sufficient time to meet the needs of people and care was delivered to people in their rooms. People were isolated and only saw staff when they were giving care.

New staff had received an induction before starting to work with people in the home. This consisted of an introduction to the home, training in infection control, basic first aid, administration of medicines and safeguarding. Four staff were all new starters who had little experience in care.

There were only two staff who had been working in the home for more than two years. Due to the low number of permanent experienced staff available, this meant that there were occasions where experienced members of staff were not on duty. On the first day of our inspection the lead nurse was from an Agency and was working their third shift at the home. They told us, “the home is over reliant on agency staff, which leaves people feeling vulnerable as there is no consistency for residents or staff and the passing on of information is inconsistent.” There were two care staff on duty one of them being from an agency. This placed people at an increased risk of poor or inappropriate care because staff did not have the knowledge to support them.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The group manager for the provider told us they had reduced the number of staff to meet the reduction in the number of people who lived in the home. Although they did not use a dependency tool to identify staff they required they stated this was to provide levels of staff to meet the support needs of people. They were recruiting to a number of positions due to the high turnover of staff. They had approached two agencies to provide domestic staff but had not engaged them as they did not have appropriate Disclosure and Barring Services (DBS) checks. These checks were used to make sure that staff were suitable to work with people who needed care and support. All new staff appointed were able to start once appropriate DBS checks and references were received. New staff completed an induction to the home on their first day, however, there were no records of further induction programmes for staff who had started prior to December 2014.

Staff received training in safeguarding and protecting people from abuse. One member of staff said, “I wanted to report a safeguarding concern to the provider but was unsure how they would respond. When I did they listened to me and took appropriate action." Other staff also did not feel confident in management’s response if they reported safeguarding concerns. The provider’s safeguarding policy was based on ‘No Secrets’, which is a government publication that sets out a code of practice for the protection of vulnerable adults. Information available to people, their relatives and staff gave advice about how to

Is the service safe?

report concerns to the West Sussex County Council safeguarding team. An agency member of staff told us, "If I had any concerns about safeguarding, I would report it to the lead nurse on duty."

The provider had recently been involved in a safeguarding concern that had been investigated by the local safeguarding team. They had taken appropriate action to protect people within the home and staff had been dismissed following their investigation. The provider was notifying the Nursing and Midwifery Council (NMC) and the Disclosure and Barring Service (DBS) of the dismissal of staff. Whilst the provider had responded to this incident there had been another safeguarding concern which had not been notified to the Care Quality Commission as required. We were made aware of this incident by West Sussex safeguarding team.

People's medicines were not always recorded as prescribed. We found there were blank boxes on medication administration records (MAR) for three people, where staff had not signed to show medicines had been given. The lead nurse confirmed the medicines had been given but had not been signed for. These had occurred on more than one occasion for one person in their MAR for January 2015 and February 2015. Some medicines in the medicine trolley and cabinet were no longer in use. There were also controlled medicines in the controlled medicines cabinet that were no longer required. These should have been returned to the pharmacy for safe disposal at the time they ceased to be required or prescribed for people. There were also medicines in the trolley and cabinets for people who no longer lived in the home. As agency nurses were regularly administering medicines this could have led to a mistake in administration and put people at risk of harm.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Cleaning tasks and laundry were being carried out by care staff and the maintenance person who worked two days a week. Visitors told us the home was dirty and repairs had not been carried out. We confirmed this when we walked around the home. Walls, ceilings and some carpets were dirty. There was a strong smell of urine in the corridor outside two rooms. We heard the provider ask two members of staff to clean the carpet. Staff did not know how to use the carpet cleaner and had not received training in its use. A visitor told us the soap dispenser in their relative's room had been reported as not working for at least four weeks. Another visitor told us they had tried cleaning their relative's walls but had found they could not remove the dirt. They gave us a list of problems they had reported which we noticed had not been fixed a week after they had reported them to the management team. A chair in one person's room was ripped and other chairs in communal areas were in need of repair. A hoist used for one person had areas of rust on the legs. Some sheets on people's beds were stained, thin and in some cases had rips. A visitor told us they had brought towels in for their relative and had seen these being used for other people in the home. There was a risk of cross infection due to the poor levels of cleanliness within the home.

One person required a compressed oxygen machine. This was receiving regular maintenance on the morning of 10 February. When the cover was removed it was noted the filter was clogged with dust and had not been regularly cleaned. There was no cleaning log for the machine available. This placed the person at risk of receiving insufficient oxygen and the potential of a respiratory infection.

The Department of Health has published the Health and Social Care Act 2008 Code of Practice on the Prevention and Control of Infections and Related Guidance. This sets out the basic steps that are required to ensure the essential criteria for compliance with the cleanliness and infection control requirements within a nursing or care home. Under Criteria 1, the provider did not have an individual designated as the lead for infection control in place. There had not been an Infection Control lead in place for over a month. There were no systems of audit in place to ensure key policies and practices were implemented appropriately. Some risk assessments associated to personal care and laundry had not been carried out. Under criteria 2 there were breaches within cleanliness and maintenance of the property and equipment as outlined.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

There was a review of accidents and incidents in the home which had been carried out by the provider. One person had been found on the floor of their room three times in the space of two weeks. There were no changes made to

Inadequate

Is the service safe?

the person's care plan or risk assessment as a result of this. There was a note in the daily records which highlighted the need for staff to be more observant. A notification we had received from the registered manager made us aware that one person had recently suffered a fractured bone due to an incident when using the hoist. There was no record of this incident in the accident book and no referral to review the moving and handling guidance for people. This showed records were not consistent and that the provider had failed to respond to concerns, incidents and accidents that had placed people at risk of harm.

The risk assessments we looked at were being reviewed by the lead nurse at the time of our inspection. Whilst some had been reviewed there were no recommended changes identified or feedback from the person, their representatives or professionals. Two of the risk assessments we saw had been written over two years ago. We also found that in some people's care records a care plan had identified a particular risk but there was no risk assessment for this. For example one person had been identified as at risk of malnutrition. There was no risk assessment to identify ways to monitor and support this person around their eating. People were not receiving support to minimise known risks and ensure their needs were met safely.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.y here>

Inadequate

Is the service effective?

Our findings

People told us the staff worked hard. One person said, "The staff are nice people." Another person said, "Staff look after me well enough. They bought me a special bed which is comfortable." A relative said, "There just aren't enough staff around. They always seem to be rushing from one room to another." Another relative said, "The staff do their best but they never seem to stay long. Agency staff just do not know [person's name]."

Staff told us they did not have much supervision and three staff told us they had not been given supervision since they started three months prior to our inspection. Staff records showed staff had received two or three supervisions a year. The provider's policy stated they should have four supervisions a year. None of the staff had received an annual appraisal in the last two years. The last staff meeting minutes were dated 14 October 2014. This showed communication between the management and staff was not consistent or recorded in a formal setting. This meant staff practices were not assessed or discussed with them to give feedback on how they were performing.

Staff induction occurred for new starters when they commenced working in the home. This consisted of a familiarisation with the people, the home and essential health and safety information. Records did not show new starters had carried out further essential training as part of their induction programme. We were told this was something that was on the registered manager's computer which could not be accessed. This would identify how long staff should work alongside experienced staff and an assessment of their competency to deliver care to people on their own. New staff told us they had not received any training apart from the initial induction. Therefore the provider could not be sure that new staff were appropriately skilled and knowledgeable. This placed people and staff at risk because care was being given by staff without sufficient skills and knowledge.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Consent to care and treatment was not always sought. A relative told us, "I have seen staff just walk into the room and carry out care without talking to [person's name]. They don't tell her what they are going to do or ask her for permission to carry out care." We saw a member of staff going into a room to carry out a wash. Conversation was minimal and we did not hear the member of staff ask for the person's assistance or consent to the care given. They did tell the person what they were going to do. Care plans were not signed to show that people or (where appropriate) their representatives had agreed with or consented to the plan of care. A relative told us, "I have not been asked to give consent on behalf of mum, as she cannot do this for herself." This did not protect people's rights to make decisions about their own lives and about the care that was offered to them.

CQC is required by law to monitor compliance with the Deprivation of Liberty Safeguards (DoLS) requirements of the Mental Capacity Act 2005 (MCA). These safeguards protect the rights of people using services by ensuring that if there are restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. The group manager told us they did not have any people who required DoLS authorisations and had not submitted any other requests. Where people have been judged to not have capacity to make decisions authorisation should be sought on any restrictions to their liberty that have been put in place for their protection or in the best interests of their safety. Where people were spending most of their days in their rooms and in their beds this was a restriction on their liberty. The provider was failing to make applications for DoLS authorisations.

The MCA sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected. Records showed that not all staff had received training on MCA and DoLS. Only two staff were able to tell us about their understanding of MCA and DoLS. Basic mental capacity assessments had been made and records were maintained within people's care files. Five people had been assessed as lacking capacity to make decisions. Some of these decisions would have been about where they lived, aspects of their treatment or medical intervention. These people's care records did not contain any notes from best interests meetings about decisions made on medical interventions. These are meetings where decisions are made on behalf of people who do not have capacity to make decisions. They should involve the

Is the service effective?

person's representative, an advocate, staff and professionals who know the individual well. This ensures that any decisions made would be in the best interests of the person.

One person's assessment of Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) had highlighted they did not have the capacity at this time to make this decision and the GP's decision had been made after consultation with the person's relative. This had been carried out on 03 September 2013 but had not been reviewed since then. The person's condition may have changed over that period of time and a review would have made note of those changes. The person may have had fluctuating capacity and may now have wished to be resuscitated.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

One person told us, "the food is good but it could be hotter." A relative told us, "My relative has lost a lot of weight over the month. They had not been eating or drinking much and it took some time to find out they had an infection. No one seemed too concerned and I had to ask the manager to monitor how much food they had."

People were offered nutritious and healthy food. The chef told us they always used fresh ingredients and had a sufficient budget for the meals they prepared. They were aware of the dietary needs of people and were aware of individual likes and dislikes of people. There was a rolling menu of foods and each main meal had an alternative if people requested. Where people did not want the menu choice, a meal could be prepared of what they wanted if available. People made their choices from the menu the day before. Nurses gave people food supplements where people were not eating sufficiently. People were given drinks and snacks throughout the day by staff and fluids were available by the bedside for those people who remained in bed.

Where people had known physical conditions, which required monitoring, we found records were incomplete and not consistently kept up to date. For example one person's weight records showed they had lost 19 kg between September 2014 and January 2015. Records of weight had not been completed in October, November and December 2014. It was not clear if this weight loss had been due to ill health or as a result of a controlled diet plan. Care plans for this person did not contain any information or guidance for staff in monitoring food and fluid intakes for this person. This placed them at risk of harm caused by them not receiving effective nutritional support and monitoring.

People were supported to have access to other healthcare services such as GPs, dieticians and nurses. Records around people's health care needs were not completed consistently or appropriately. Two visiting nurses told us they had been unable to complete an assessment of a person's needs as the records were incomplete and inconsistent. They were unable to gather enough information from staff and the records did not reflect what the person's health needs were. Monitoring and observation charts had also not been comp;leted consistently. One person required a weekly blood level check for their diabetes. There were gaps of more than two weeks in some parts of the record and the last check had been undertaken on 01 February 2015. One person's health condition required regular monitoring and observation of their temperature, pulse and respiration. The records showed these had not been done in October and November and there were gaps in December and January's records where this had not been recorded. A relative told us they had to take the relative to the doctor's to have sutures removed two weeks after they should have been removed. People were not supported to maintain good health because there were omissions in their necessary health checks and they did not always receive timely health care. This placed people at risk of poor health and well-being.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Requires Improvement

Is the service caring?

Our findings

One person said, “the staff are alright, I suppose.” Another person said, “Staff look after me well enough but they never have enough time to talk to me.” A relative told us. “Some of the staff are caring enough and others, I was glad to see them leave.” Another relative said, “They just don’t seem to have enough staff. The agency staff try their hardest and can be quite caring. But it’s not the same as permanent staff who know my Gran well and she knows them.”

Mealtimes were not a pleasurable social experience for people. The dining room would not have been able to accommodate all people if the home was full. Only one person sat in the dining room for their meals. All the other people had their meals in their rooms. We knew some people were unable to leave their beds but there was no medical reason why other people could not leave their rooms. A member of staff told us they had a Valentine’s meal where people sat in the dining room which was enjoyed by all. A person told us they had enjoyed this and wished they could eat meals more often in the dining room.

Staff told us the lounge on the ground floor was not used as it was 'shabby, dirty and smelly'. People spent all of their time in their rooms where staff and visitors were the only people they saw. Staff told us people left their rooms when there was a social occasion such as Christmas, Easter or other events. There were no recreational or occupational activities planned for people and most people had televisions or radios in their rooms which provided background entertainment for them. This put them at risk of becoming socially isolated and could have a detrimental effect on their well-being as they could not engage in conversations or social relationships with their peers.

Staff spoke to people in a warm, friendly and respectful way. They knocked on people’s doors and waited for a response before entering. We saw some people’s doors were open and they were lying in their beds. People were able to say if they wished for this to happen. Where people did not have capacity this should be considered a best interest decision. Although staff were friendly they were task focused and did not appear to spend time with people engaging in conversations with them. Some people said staff were too busy and they did not like to bother them.

We saw in people’s files a document to record people’s end of life wishes. In all of the files we looked at only two had been completed and the others had nothing written in them. Staff would have been unable to identify how people wished to be cared for towards the end of their life. They would also not be aware of their wishes following their death. We had been made aware of two people who had been placed on end of life care and their plans had not been completed. This did not ensure that people were supported at the end of their life.

People told us they did not feel involved in decisions about their care. One person told us they only spent time in their room since suffering a stroke. They said, “I would like to spend some time with other people here and I have told the staff this.” The care plan for the person said they needed to reduce their social isolation. There were no records of times when this person had been able to socially interact with other people and care records showed they had left their room once in the last month for the Valentine dinner.

Inadequate

Is the service responsive?

Our findings

People and their relatives told us they had not been involved in the planning of their care. One person told us, "I don't know what is in my care plan. I have asked to spend time out of my room but this does not happen." Another person said, "Staff look after me well but don't listen to me when I tell them what I want." A relative told us, "I told the manager and staff that I was worried about my relative losing a lot of weight. They didn't seem to do much about it and I demanded she saw a doctor. They diagnosed an infection but this illness has left her very frail." Another relative said, "My gran spends too much time in her room, there are never any activities or entertainment for her to enjoy and motivate her to move about the home."

Some care records were personalised and outlined people's care needs. The care records did not show how people had been involved in deciding what their care plans contained. Consent forms to authorise personal care, treatment, sharing information and photographs had been signed by individuals or their representatives. However none of the care plans or risk assessments had evidence to demonstrate how these had been discussed with them.

Whilst care plans had been reviewed annually there was no record of any changes in people's needs or to the care plans. For example one person's care plans had been originally written in 2011. These had been reviewed every year but no amendments had been made in that time. We had seen from care records where people's health care needs had changed but this was not reflected in people's care records. There were no records of discussions with people about any changes they wanted to make to their care plans. A relative had told us of a change they had requested to a care plan about continence they had reported in November 2014 and this had not still been altered in February 2015.

People were not offered mental stimulation or given opportunities to pursue their interests and hobbies. One person said, "I would like to go to the lounge but there is no one else there and nothing to do." A relative said, "I worry that [person's name] spends too much time in their room and they have become socially isolated. It would be nice if they could have a sing-song or play games with other people." Staff told us there were no organised activities apart from seasonal events at Christmas, Easter and other special occasions. One person told us they had enjoyed a recent Valentine's dinner which eight people had attended in the dining room. They said, "If only we could do that more often it was nice to talk to other people." Staff and relatives told us that people spent most of their time in their rooms watching TV, listening to the radio or reading.

This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2010. which corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Where temporary staff did not know people well they relied on people's care plans to provide them with information about the individual. Care plans did not contain accurate up to date information to enable temporary staff to support people appropriately. People's care plans and risk assessments had been reviewed but there were no alterations or changes recorded in those records for over a year. Where an assessed need had been recorded, care plans were not detailed on how to appropriately support the person. For example one person's risk assessment stated they had a history of aggressive behaviour. There were no care plans or guidance for staff to follow that described the behaviour and ways in which to support the person to manage this. This meant temporary staff were unaware of ways to identify when the person's behaviours escalated. They were also unaware of techniques to distract and calm the person.

A relative said, "I had to ask staff to carry out mouth care for my wife. I also had to remind them about changing continence pads." The person's care plans stated they were unable to manage these activities for themselves and needed staff to carry out these activities three times a day. The care records did not show when these tasks had been carried out. Therefore the provider was unable to evidence how people were protected from the risk of unsafe or unsuitable care and treatment.

One person's assessment identified they were known to be aggressive due to their dementia. There was no care plan in place to guide staff on supporting the person to manage their aggression. There were no guidelines for staff explaining how this presented or signs the person showed when they were becoming anxious. Staff were unaware of how to respond to support this person. This placed the person, other people and staff at risk of harm. There was no evidence to show whether the person had been referred to a mental health specialist.

Inadequate

Is the service responsive?

Staff kept individual daily records for people which detailed information about people's health and welfare. In one person's care records these were not placed in the appropriate section and were filed in other areas of the care record. Important information may not have been seen by staff and they would have been unable to respond to any concerns noted.

This was a breach of Regulation 9 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

One person told us they were not happy at the home but they did not want to make a complaint because they believed it would not make a difference. A relative told us they had raised concerns about their relative's care and maintenance issues in their room. They said "I have not been told about the care concern as the manager has left. The maintenance work has also not been done." The provider had a complaints policy and maintained a record of all complaints received. The last complaint dated 14 September 2014 was concerning laundry where items of clothing for one person had gone missing or were damaged. The response was to issue an apology to the relative and to talk to care staff about ensuring laundry was done properly. There were no records of other complaints received.

Inadequate

Is the service well-led?

Our findings

People told us they were not happy with the management of the service. "One person said, "I liked the manager, where have they gone?" Another person said, "I don't know who is in charge or who any of the staff are now." A relative told us, "There is something wrong with this place. Why have all the staff left? Why are there only 11 people living here?" Another relative said, "I keep telling the staff things are not right but the management don't make changes."

There was not a registered manager in position at the time of our inspection. The previous registered manager had been dismissed a week before our inspection following an investigation by the provider. Four of the registered nurses had left the service within a four month period and the majority of experienced care and domestic staff had also left during this period. The impact of this was the provider had relied on agency nurses and care staff to provide cover whilst recruitment for the vacant positions was underway. For people this meant they were receiving care from a number of new carers who did not know them or have the necessary knowledge of the people to deliver care effectively.

The provider told us how they were trying to recruit and appoint new staff and shared with us advertisements and responses they had received. Part of their strategy for staffing at this time was the use of two agencies in particular and requests for a number of staff who had experience of working in the home. This could add some consistency to care. Due to the high turnover of staff people were supported by a number of new staff who had been recently recruited and did not know people or their needs sufficiently well enough to meet their needs effectively. With only one permanent nurse in post and no manager there was a risk that new staff would not receive an appropriate induction and support when they started. Although the provider had moved quickly to appoint a new manager they were not due to take up their position until April 2015.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The culture and ethos of the service was unclear to relatives and staff. Relatives told us they were concerned about the future for the service due to the impact of high staff turnover and the number of people who had died or left the service in the last six months. One relative said, "The home and furnishings are tired and the whole place needs a makeover." One member of staff said, "It's not a good place to work at the moment and I am only staying as I feel loyal to the residents. If I left I feel I would be letting them down."

Whilst the provider explained their philosophy to be person centred and involving people in their care, we found little to support this. Care given to people was task focused and staff did not have time to engage people in conversations as they had to carry out a wide range of activities such as cleaning and laundry. People and their relatives told us they were not involved in planning their care and had little opportunity to talk about their concerns as they felt they would not be listened to.

Systems to monitor the quality of the service were not effective and had failed to identify issues highlighted during the inspection. For example, the last audit undertaken by the provider in November 2014 had stated, 'Inspection of premises – clean state, no unpleasant odours, a few cobwebs noticeable.' The current condition of the walls and carpets did not match this description. The audit did identify that cleaning records were not complete but did not highlight actions necessary to remedy this. They identified the MAR sheets upstairs had been completed with gaps where medicines had not been administered. Whilst they had checked the MAR sheets they had not undertaken an audit of medicines in the cabinet and trolley. The audit identified health and safety checks were in place but were not up to date. Again there was no record of the action required to remedy this situation.

The provider last sent out a quality survey to relatives in September 2013. Another survey had not been undertaken since this date. Comments made in that survey were about the lack of entertainment and activities that were available to people. This was still a concern of relatives at the time of this inspection. The provider used a comment card system within the home where people could write comments and suggestions about the service received. The last card was from August 2013 about arranging a day out. Whilst systems had been available for people and their relatives to make comments they had not been used recently and there had been little response to the comments that had been made to improve the service for people.

Inadequate

Is the service well-led?

This was a breach of Regulation 10 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act (Regulated Activities) 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

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 2008 (Regulated Activities) Regulations 2010 Management of medicines **The registered person did not protect people from the risks associated with the unsafe use and management of medicines. Medicines were not administered or recorded safely.**

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 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **People's dignity, privacy and independence were not supported. People were not involved in making decisions about their care. People did not have appropriate opportunities, encouragement and support to promote their autonomy, independence and community involvement. Regulation 17 (1) (a) (b) and (2) (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 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **The registered person had not taken appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced persons employed to carry out the regulated activity.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff

This section is primarily information for the provider

Action we have told the provider to take

Staff were not appropriately supported to enable them to deliver care and treatment safely and to an appropriate standard. Regulation 23 (1) (a)

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 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The registered person had not taken proper steps to ensure each service user is protected against the risks of receiving care or treatment that was inappropriate or unsafe. Regulation 9 (1) (a) (b) (i) and (ii)**

The enforcement action we took:
We have issued a Warning Notice which requires the registered person to become compliant with Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014 by 23 May 2015

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 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **The registered person did not have effective systems in place to regularly assess and manage risks relating to the health, welfare and safety of people. Regulation 10 (1) (a) and (b)**

The enforcement action we took:
We have issued a Warning Notice which requires the registered person to become compliant with Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 by 23 May 2015

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 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **The registered person did not have appropriate systems in place to protect people from the risk of infection by not maintaining appropriate standards of cleanliness and hygiene in relation to premises and equipment. Regulation 12 (1) (a) (b) (c) (2) (a) (c) (i) and (ii)**

The enforcement action we took:
We have issued a Warning Notice which requires the registered person to become compliant with Regulation 12 HSCA 2008 (Regulated Activities) regulations 2014 by 23 May 2015