Sun Care Homes Limited

Victoria Cottage Residential Home

Inspection report

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14 January 2016

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected the service on 13, 14 and 19 January 2016. The inspection was unannounced. Victoria Cottage Residential Home is owned and managed by Sun Care Homes Limited. It is registered to provide accommodation for up to 18 older people. On the day of our inspection 15 people were using the service.

The service did not have a registered acting manager in place at the time of our inspection. A registered acting 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 from the risk of harm due to ineffective systems and the environment they lived in. Risks in relation to people's daily life were not being assessed or planned for. Staffing levels left people at risk of being supported in an unsafe way. Medicines were not managed safely and people could not be assured they would receive their medicines as prescribed.

People were supported by staff who did not have the knowledge and skills to provide safe and appropriate care and support. People were supported to make decisions if they had the capacity to do so. However people who did not have the capacity to make certain decisions were not protected by the Mental Capacity Act 2005. People had restrictions placed upon them without the required authorisation to do so and care was not planned to ensure it was delivered in the least restrictive way. People were not supported appropriately with their ongoing healthcare.

People were supported by staff who did not have guidance on people's current needs and how they should be supported. Staff were caring towards people but were working in an environment which restricted them from providing care which was tailored around the individuals they were supporting. People were not given the opportunity to have stimulation or follow their hobbies and interests.

There was a lack of appropriate governance and risk management framework and this resulted in us finding multiple breaches in regulation and negative outcomes for people who used the service. People were not involved in giving their views on how the service was run and there was a lack of systems in place to monitor and improve the quality of the service provided.

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

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People may not be protected from abuse because the provider had not ensured there were systems in place to protect people from the risk. People were exposed to risks unnecessarily because ways on minimising these were not identified.

People did not always receive their medicines as prescribed and medicines were not managed safely. People lived in an environment that was not safe and was unhygienic.

There were not enough staff to provide care and support to people when they needed it.

Is the service effective?

Inadequate

The service was not effective.

People were supported by staff who were not provided with enough training to enable them to support people safely.

People made decisions in relation to their care and support but where they needed support to make decisions they were not protected under the Mental Capacity Act 2005. People received support which was not assessed and planned for to ensure it was delivered in the least restrictive way.

People were not always supported to maintain their nutrition and their ongoing health care needs were not responded to appropriately.

Is the service caring?

Inadequate

The service was not caring.

People lived in a service where staff were caring but were given limited information on how people preferred to be cared for.

Staff supported people in a rushed way and did not have time to respond to their emotional needs.

People's dignity was compromised because of the environment and the systems in place.

Is the service responsive?

Inadequate

The service was not responsive.

People's care and support was not planned in a way that showed their needs and how these should be met. People were not involved in the planning of their care and were not provided with the opportunity to live a fulfilling life and to follow their hobbies and interests.

People's concerns may not be recognised and acted upon due to a lack of systems in place to ensure these were recorded and responded to appropriately.

Is the service well-led?

Inadequate

The service was not well led.

There was a lack of an appropriate governance and risk management framework and this resulted in negative outcomes for people who used the service.

People were not involved in giving their views on how the service was run and there were a lack of systems in place to monitor and improve the quality of the service provided.

Victoria Cottage Residential 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.

We inspected the service on 13, 14 and 19 January 2016. The inspection was unannounced. The inspection team consisted of two inspectors.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and assessing whether statutory notifications had been received. A notification is information about important events which the provider is required to send us by law.

During the visit we spoke with six people who used the service and carried out observations in the service. We spoke with the relatives of three people and two visiting health professionals.

We spoke with five members of support staff, the cook, the acting manager and the area manager. We looked at the care records of six people who used the service, medicines records, staff training records, as well as a range of records relating to the running of the service.

Inadequate

Is the service safe?

Our findings

People could not rely that any risks to their safety would be recognised and appropriate action taken to keep them safe. There had been a recent safeguarding investigation undertaken by the local authority about the care management of one person who used the service. The investigation had found the person's needs were not being suitably met and they posed a risk to themselves and others in this placement. The findings of the investigation were that there was a lack of staff available to respond to the person's needs when they tried to leave the building, and the environment posed a risk to the person. Staff on duty had been directed to attend to the person if they became agitated causing a risk to their and other people's safety, which left other people without any staff support. When we visited we found that action had not been taken to address the concerns raised in the safeguarding investigation.

We looked at this person's care records and saw they needed support from staff due to unpredictable outbursts of behaviour which staff may find challenging to deal with. Staff told us there had been incidents of aggression toward staff and other people who used the service from this person. One person told us, "I don't feel safe when [person] is like that." One member of staff told us, "[Person] has been very volatile." Staff told us this person needed to have extra supervision due to their unpredictable behaviour. We found the person was left unobserved for some periods during the afternoon. We observed the person in the lounge removing other people's possessions from in front of them and people were telling the person not to do this. We saw this created a tense atmosphere as the person retaliated against the people who told them not to remove their belongings. This created a risk that the person could harm other people who used the service. The provider had not referred the concerns, or incidents that had taken place as a safeguarding concern.

The three staff we spoke with had an understanding of how to raise concerns if they felt someone was being abused. However, people were at risk as nine of the staff employed had not had any training on how to recognise and act on any form of abuse. The acting manager said they did not have a copy of the local authority safeguarding policy, and the provider's policy contained incorrect and outdated information and did not provide staff with the guidance needed to raise a concern about someone's safety. This meant that staff did not have access to the correct information to follow if they needed to raise a concern about anyone's safety.

We looked at the personal allowances of four people who had their allowances held in the office by the acting manager. We found the systems used did not protect people from the risk of financial abuse. For example one person had a consent form in their care plan to give permission for the acting manager to manage their personal finances. The consent form had been signed by the acting manager and there was no evidence the decision had been discussed with the person or their family. We saw the acting manager was not always getting a second member of staff to witness the transactions on the person's records and receipts were not always gained for money spent.

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

People were not kept safe from the risk of harm from the environment they lived in. The majority of corridors were narrow and difficult for two people to pass each other, particularly if anyone was using a walking aid or wheelchair. A wider area of corridor which acted as a 'passing point' had various items stored or left there making this more difficult for people to pass each other safely. We observed people were regularly put into a position where they could be injured. There was insufficient care taken to prevent people from collisions with furniture or other people. Where someone was moved in a wheelchair they were manoeuvred past obstacles and other people. At one point we saw a person's wheelchair was tipped onto two wheels to avoid another person when helping them to the dining table. A person who used the service said, "I do get bashed into doorways especially first thing in the morning, but I've never been hurt."

We found several toilets seats were broken and these toilets were frequently used by people. There were also two bathrooms which we saw were used as storage areas and although staff told us these were unused, they had not been locked. This meant people may not know they were not to be used and people would be placed at risk of falling due to the clutter in the bathrooms.

People who had fallen or had an accident could not be assured that action would be taken to reduce the risk of this happening again. We found records made of incidents, such as when someone had fallen, did not always tally with other records kept. We found different records had been made of the same incident and the section to review these had not been completed. This meant there was not accurate information about the incidents people had been involved in. The acting manager said they had not undertaken any analysis of these records to see if there was anything that could be done to prevent an incident occurring in the future.

Practices to prevent the formation of the legionella bacteria were not being followed. We asked the acting manager if there was a system in place to run any water outlets which had not been used and clean unused shower heads where stagnant water may be present. The acting manager told us the handyperson did this weekly. We asked to see the records showing this was done but the records we were shown did not include running unused water outlets or cleaning unused shower heads to prevent the formation of legionella bacteria. A legionella risk assessment completed by an external company in August 2015 had identified some works were needed to the water storage sytem to prevent the risk of infection. At the time of our inspection some of this work had still not been carried out. For example the water tanks had not been cleaned and disinfected, in line with the report. This placed people at risk as legionella bacteria could develop in these areas.

We saw risk assessments had not been updated to show the level of risk people may face and how this could be minimised. For example one person had been assessed to be at the top of the high risk band for their tissue viability. Any increase would have meant they would be assessed to be a very high risk. This assessment had not been updated for eleven months which meant any increased risk in the person's tissue viability would not be recognised so that plans could be put in place to prevent them from forming a pressure ulcer. A staff member told us that one person who had been sat in a wheelchair should not have been because this was not good for their skin integrity. We saw the person was sat in their wheelchair at the breakfast table when we arrived and had still been sat in this an hour later.

People were placed at risk of the spread of infection from living in an environment which was dirty and unhygienic. Prior to our inspection we were told that the NHS Clinical Commissioning Group (CCG) infection control nurse had visited the service twice and had concerns about the cleanliness and hygiene of the service. The infection control nurse had made recommendations for the provider to make improvements and to protect people from the risk of the spread of infection. We looked the recommendations made by the infection control nurse in July and December 2015 and found they had not all been addressed at the time of our visits.

One of the recommendations was that the service reviewed the number of cleaning hours and days available as cleaning staff should be available seven days a week, to ensure standards of cleanliness improved, as a matter of urgency. We found there was still only one cleaner employed by the service and they worked 24 hours per week over four days. We found the cleaner had a good knowledge of infection control procedures and how to prevent the spread of infection. However on the three days the cleaner was not working, it was left to care staff to keep the service clean and hygienic, as well as provide care and support to people who used the service and do the laundry. Not all of these staff had been trained in how to minimise the risk of the spread of infection and we observed one member of staff who did not follow basic infection control procedures.

We carried out a tour of all bedrooms, communal areas including bathrooms and toilets and the laundry. We found the service was not clean in some areas and there were risks to people from the spread of infection. We saw the laundry area was very small and there was no room for clean and soiled laundry to be kept separately. We saw a clean duvet was on the floor, which was dirty, and was leaning against dirty mop buckets, which were used to clean toilets and other areas of the service. Clothing awaiting laundering was stored on a dirty floor near the washing machine. This process of laundering placed people who used the service at risk of the spread of infection

We saw the carpet in the lounge area was dirty and stained and several chairs had food debris down the side of the cushions. One pressure ulcer prevention cushion was stained with what looked like faecal matter. We found two bedroom carpets which were heavily stained and dirty and both bedrooms had offensive odours. We found toilets and a raised toilet seat to have a build-up of faeces and urine stains underneath.

People were not always given their medicines and when staff gave the medicines they didn't always follow safe practice. We saw some people were left with a pot of tablets to take unobserved at lunchtime. We asked the acting manager about this who said they should have been observed. This posed a risk to people's health if the person did not take their medicines or another person took the medicines by mistake.

We found the medicines systems were not safe and there was a risk people would not be given their medicines as prescribed. For example, one person had been prescribed a medicine to be given for two to three days but we found the person had been given 13 doses of this medicine and we had to ask the acting manager to address this.

We saw that staff signed people's Medication Administration Record (MAR) to state the medicines had been taken prior to actually administering them. We saw although staff had signed the MAR for two people on one occasion, the medicines had not been given and were still in the medicines trolley. Medicines which were hand written by staff onto the MAR were not being signed and the entries were not being checked by a second member of staff to ensure the entry was accurate. This gave the potential for the entry to be incorrect and people being given the wrong medicines. We saw that staff who were administering medicines were not having their competency assessed, to ensure they knew how to safely manage medicines.

There was a lack of audits being undertaken to ensure medicines systems were safe and we found a number of concerns about the way medicines were managed. Medicines were not always signed into the service so that checks could be made on whether they were being administered as prescribed. Staff were not completing stock checks of medicines to ensure they had been given when they should.

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

People's needs were not met, or not met in good time, because there were insufficient staff employed to provide the number of staff required each shift. We observed that people were left sat at the dining table for long periods of time after they had finished their breakfast and lunch. One person told us, "Can you please take me to my room? I have been waiting an age." We observed people waiting at the dining room table for their evening meal for 50 minutes and one person had fallen to sleep.

The provider had assessed there should be three staff on duty throughout the day. However we saw from the staff rota that there were regular occasions when there were only two staff on duty. During the afternoon on day one of our inspection there were only two staff on duty, the acting manager and a recently employed member of staff who had not yet completed their induction. We observed people had to wait for assistance from staff and a person who needed a higher level of supervision was not given this.

Staff told us there were eight people who needed two staff to support them with personal care and that if the two staff were upstairs supporting a person, this left the remaining 14 people without any staff to support them. Staff told us that as well as supporting people they were responsible for completing the laundry, doing cleaning tasks and in the afternoon they also had to complete kitchen duties and serve the evening meal.

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

The provider had a recruitment process to determine if new staff were suitable to work with people who used a care service. We looked at two staff recruitment files and found the checks had not been robustly followed. We saw one staff member had not had a second reference obtained and application forms had not been completed with sufficient detail. For example they did not include the full dates of the applicant's previous employment. Checks had been carried out by the Disclosure and Barring Service (DBS) who provide information about an individual's suitability to work with people to assist employers in making safer recruitment decisions.

Inadequate

Is the service effective?

Our findings

People received care and support from staff who did not all have the skills and qualifications to support them safely. The acting manager told us there were a number of staff who were behind with their training. The staff training matrix showed that a lot of staff had not completed the training they needed to ensure they were skilled in supporting people safely. There were shortfalls in some staff not completing training in fire safety, falls prevention, diet and nutrition and first aid. On the first day we visited we saw there were two staff on duty in the afternoon. One of these staff was new and had not yet completed moving and handling training and the second member of staff told us their moving and handling training was also out of date. This placed people at risk of harm as eight people needed two staff to support them with transfers and neither of these staff had the skills or knowledge to do this safely.

There was one recently appointed staff member who had started an induction. We saw the record of this which showed the staff member had not completed a number of key areas, including moving and handling training so they could help people with their mobility. We saw the staff member was one of two staff on duty and would be required to assist the other staff member where two staff were required to support someone with their mobility. The acting manager told us they had signed up for the care certificate but they didnt know how to access this. This meant staff did not have the opportunity for this training. The care certificate is a recently introduced nationally recognised qualification designed to provide health and social care staff with the knowledge and skills they need to provide safe, effective care.

People were supported by staff who were not having their working practice or training needs assessed. The acting manager told us they had not had the time to provide staff with supervision about their work where they could have discussed their practice and identified any training needs. Staff confirmed this to be the case and told us they were not receiving any formal supervision. Our observations showed that staff did not have the skills and knowledge to follow safe moving and handling and infection control practices.

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

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

However, people were not always protected under the MCA. In the care records of one person we saw there was conflicting information about the person's capacity to make decisions. One record showed that the person could communicate consent but in another record staff had recorded that the person had 'Little insight into health and would not be able to make an informed decision.' We saw staff had recorded that the person was unable to manage their own medicines or personal spending money, however a MCA assessment had not been carried out to determine capacity and to ensure decisions were made in the person's best interests. This person had an assessment in place which had determined they did not have the capacity to make decisions about their care at the end of their life; however this had not been reviewed since 2013.

Another person who lived with a dementia related illness had a consent form in their care plan which detailed decisions such as allowing staff to administer medicines, manage personal spending money and for medical attention. This had been signed by the acting manager on behalf of the person but assessments had not been completed to assess the person's capacity to make these decisions for themselves and to ensure the decisions were made in their best interests.

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

People were not protected from the risk of being supported in the least restrictive way. The acting manager had made an application to the local authority for a DoLS, eight months prior to our visit, for one person, who regularly tried to leave the service and was prevented from doing so. However despite this person breaking the glass in the door on one occasion in their attempt to leave the service, the acting manager had not contacted the local authority to chase why the application had not yet been assessed.

The manager told us there had not been any DoLS applications made for other people who used the service. During day one of our visits we overheard a person who was being supported by staff to get up and dressed. We heard this person resisting the support staff were giving and were shouting, "No, no stop it." but staff continued to support the person. We spoke with the staff after they had finished supporting this person and they understood that the support they were giving was in the person's best interests. However, the person's care plan did not contain any guidance for staff on what to do if the person resisted personal care and how to deliver this in the least restrictive way. A MCA assessment had not been undertaken to assess the person's capacity to make this decision and a DoLS had not been applied for to grant the authorisation to continue with personal care if the person resisted. We found this was also the case for a second person who used the service. Staff reported and we saw from records that the person resisted personal care but that staff continued to support the person without guidance and the authority to deliver this care in the least restrictive way.

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

People were not always supported with their ongoing healthcare. We observed one person looked poorly and kept holding their head in their hands. We spoke with the person and they told us, "I have not been well lately." Records showed the person had been poorly for 14 days but there was no evidence the person had seen their GP or that staff had informed the GP the person was poorly, with the exception of reporting an unrelated health issue. Two days before the person started to feel poorly they had been prescribed some new medicines and staff had not recognised that the person may be experiencing side effects from the medicine and there was no record of staff having discussed this with the person's GP. Staff we spoke with said they had not considered that the new medicine may be causing any side effects and as far as they were

aware the GP had not been consulted.

Another person had a medical need and their care plan stated they managed this themselves. However this had changed and staff were now managing this but the care plan had not been updated to reflect this and there was no guidance informing staff how they should manage this medical need. We spoke with staff and they told us they asked the person to show them how to care for the medical need, however they had not received any training in how to do this safely and this posed a risk to the person.

A visiting GP told us things were not always well organised and described their experience with the service as, "Hit and miss." They said there was not always the same information passed to healthcare professionals by different staff and they thought communication was an issue of concern.

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

People we spoke with told us they felt they were supported to make decisions about how they spent their time. One person told us, "It's not regimental." We observed some instances where staff asked people for their consent such as, "Is it OK if I sit with you?"

Although people's nutrition had been assessed and guidance given to staff where risks were identified, the risk assessments for some people had not been reviewed for up to four months and so their current nutritional risks were not known. One person had been cared for in bed for the whole of 2015 and staff had recorded on their weight chart, 'unable to weigh as bedridden.' Staff had not used a recognised method of determining the person's body mass index (BMI) by using other measurements and so this person's nutritional risk had not been known by staff who were supporting them.

We saw that staff had noted that a person, who was already a low weight, had lost 4KG and staff had started to record what the person was eating so they could monitor their nutritional intake. However we saw there were frequent gaps in the recordings so it would be difficult for staff to determine what the person's nutritional intake was. There was no evidence in the person's care records that staff had discussed this weight loss with the person's GP so that a referral to a dietician could be considered. We saw from the person's care plan that they needed prompting and encouragement to eat. However we observed this person and they were not given any prompting. The person left the majority of their meal and when staff removed the plate they did not offer an alternative or explore if there was something else the person may fancy eating.

People told us they were supported to eat and drink enough. One person told us, "The food is very good." Another person said, "I get plenty to eat and I enjoy what I am given." The acting manager told us anyone who was not eating well had their food and fluid intake recorded to enable staff to monitor their nutritional intake. The acting manager also told us that if a person was on a weight chart they would be weighed weekly so that staff could keep a closer eye on their weight. However we saw that six people were on food charts and none of these six people had been weighed weekly. This meant people were being placed at risk of weight loss due to a lack of monitoring.

Inadequate

Is the service caring?

Our findings

People experienced care that was not provided in an individualised and compassionate way due to the amount of staff available and the dependency of people who used the service. We observed staff supporting people and we saw staff were kind and caring. However, due to the amount of work they had to undertake, staff were often rushed and did not have the time to spend talking with people and giving reassurance when it was needed. We saw one person was distressed and crying and staff kept stopping what they were doing to spend a short amount of time with this person but they were busy supporting other people and did not give the person the time they needed to reassure them.

We observed another person being assisted with their mobility. We saw this was not done with the care we would expect and was rushed. There was a lack of explanation to the person whilst they were being assisted to inform them of what was happening. We saw other people being wheeled backwards in wheelchairs which did not have footplates fitted and this resulted in people's feet dragging on the floor. This is a disrespectful way of supporting people and could cause people to be disorientated. We also saw two people were asked to move out of wheelchairs they were sat in at the table because the chairs were needed to help move other people.

One person told us they had asked staff to return some items to a store for them as they were unable to do this themselves and didn't have any relatives to do it for them. The person told us they didn't think this had been done and they were frustrated by this. We saw these items had been left in a bag on the floor behind the corridor door and the acting manager said they thought the items had been returned to the store for the person. We asked that the items be returned as soon as possible.

People were supported by staff who did not have information available to inform them what was important to people. A person who used the service said, "The staff are flexible, some staff think quicker about what I need (than others). Staff we spoke with had some knowledge about the people they were supporting but we found records which would give staff information about people's lives and what was important to them were not in place. There were life history documents in people's care plans but these had not been completed and were left blank.

People were not supported to be involved in planning how their care was delivered. People we spoke with told us they had not been involved in developing their care plans. The acting manager told us there was not a system for people to be involved in discussing and reviewing the care and support they received.

One person who used the service had been supported by their social worker to access an advocate. However we saw there was no information in the service informing other people how they could access an advocate and the acting manager confirmed there was not any information available. Advocates are trained professionals who support, enable and empower people to speak up.

People's dignity was not always respected. Staff had a good knowledge of how to respect people's privacy and dignity and we saw staff were respectful to people. However staffing levels and the systems in place had

an impact on people's dignity.

We saw some people were wearing creased clothing and one staff member told us, "We don't really have the time to do the laundry; we just fit it in when we can."

The laundry area was small and did not give staff the room they needed to treat people's clothing in a respectful manner. We saw freshly laundered clothes had been left on the corridor floor outside the laundry, waiting to be taken back to people's rooms. The carpet on which the clothing had been left was dirty and stained. We also saw some clean towels had been folded up and left on a closed toilet seat, due to a lack of space to place the towels

People and relatives we spoke with generally commented positively on the staff and told us they were kind and caring. One person who used the service said, "Staff are very helpful." A relative told us, "I feel the staff really do care."

We observed people were given some choices about what they ate and how they spent their time. One person told us they preferred to spend their time in their bedroom and confirmed they were supported to do this. We heard staff offering choices to people such as, "Would you like salt and pepper" and "Would you like to sit here." We saw there was a choice of meal available for people and one person told us, "If I don't like what is for lunch they (staff) will get me something else." We observed one person requested something different for their evening meal and the acting manager ensured this was fetched from the local shop and given to the person. This was important as the person was nutritionally at risk.

Inadequate

Is the service responsive?

Our findings

People did not have their needs responded to in a way they preferred. A person sat at the dining table when they had finished their breakfast told us, "I will probably be stuck here (at the dining table) for a bit until they come and move me. I would like to be there (in the lounge area)." The person said they would not ask to move, but would wait until staff came to move them. The person waited for over an hour before they were moved.

People were not supported to be involved in planning how their care and support would be delivered and their relatives were not always given information to enable them to be involved. One relative said their relation's health had deteriorated over recent days and they had been told they needed to see a doctor. However the relative did not know whether their relation had seen one as they had not been told.

People were at risk of their needs not being met due to poor planning of their care. People's care plans did not describe people's current needs and how these should be met. We found a number of examples where people's needs were not recorded or there was no description as to how their needs should be met. One person had detail in their daily notes that a healthcare professional had said they needed to complete some regular exercises. There was not a care plan for these and no information about what the exercises were. We asked the person if they did the exercises and they said they did sometimes. They said, "Some staff do the exercises with me and other staff don't do them." The acting manager did not know the person was meant to be doing the exercises. They asked the other staff on duty who also did not know about these.

People's care was not kept under review and updated with any changes in their health and wellbeing. We found information provided by health care professionals had not been recorded in people's care plans. For example. In the daily records of two people there were recommendations from visiting health professionals for staff to follow to minimise the risk of these two people developing a pressure ulcer. This information had not been transferred into the two care plans and staff were unaware of the steps they should be taking to minimise the risk, such as supporting both people to change their position during the day and night. Records showed the recommendations from the health professionals were not being followed and staff we spoke with were unaware of the recommendations. This meant people were being placed at risk of developing a pressure ulcer.

The acting manager told us they knew we would find some of the care plans were not up to date, however they admitted to being shocked when we found one that had not been reviewed for almost a year. The acting manager then checked all the care plans and found none had been recently reviewed as they had expected.

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

People could not rely on their complaints being acted upon and resolved. One person told us their relatives had raised a complaint. They said this had resulted in a change to the way they received care and support

but they did not know about the outcome of the complaint. A relative told us they had recently made a complaint to one of the staff about the condition their relative's room had been in. The acting manager was unaware of one of these complaints and neither of the complaints had been recorded to show they had been responded to and resolved appropriately.

A complaints procedure was not displayed in the service to ensure people knew who to complain to and what to expect when they made a complaint. The acting manager told us this had been put into a new frame and was waiting for the handyperson to hang this up.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not provided with sufficient opportunities to engage in social activities or to follow their hobbies and interests. A person who used the service said, "There is not a lot to do, I don't have anything to do." Another person said, "We never speak about activities. Sometimes they get games out."

Records kept to show what activities each person took part in showed people had few opportunities to take part in social activities and follow their interests. We also noted the records showed there was little variety of the activities provided for people to take part in.

There was a lack of forward thinking on how to plan and involve people in activities. We saw some people spent the duration of our visit with no activity or stimulation provided. One person was walking around for some time until they were given a box of crayons and paper. They then spent a period of time occupied with drawing which they enjoyed. The person was then asked if they would like to help lay the tables for tea. They started to do this but then stopped doing so when they did not receive any support and encouragement to continue.

Inadequate

Is the service well-led?

Our findings

There was a lack of evidence that the service was being designed to meet the needs and preferences of th people that used it. There was a lack of appropriate governance and risk management framework and this resulted in us finding multiple breaches in regulation and negative outcomes for people who used the service. There were no effective systems in place to develop and improve the service, based on the needs of the people who used it, their families and staff.

There was an acting manager in post but they had not yet applied to register with us. A condition of the registration is that there should be a registered manager in post. We discussed this with the provider and will monitor this. The provider had failed to notify the CQC of significant events such as the deaths of people who used the service. Providers have a legal obligation to notify us of such incidents.

The registered provider's lack of effective systems in place to monitor the quality and safety of the service had led to people being placed at risk of harm and receiving care and support that was not safe.

The acting manager told us a representative of the provider usually visited the service weekly and that the provider visited the service monthly and prepared a report of their visit. We saw the most recent visit form completed on 20 December 2015. The provider had recorded that 14 care plans had been reviewed by the 'registered manager.' This was factually inaccurate as the acting manager was not registered and told us they had not reviewed the care plans and we found this to be the case, despite service user's needs changing in relation to nutrition, mobility and health care needs. The provider had also recorded that the statement of purpose for the service was up to date but this was not, for example the previous manager who was no longer employed in the service was still listed as the current manager.

There was a lack of effective auditing systems in place for identifying and improving the quality of the service and this had led to people receiving care which was inconsistent and had not met their needs. The audits had not picked up issues that are identified in this report in areas such as the risks relating to an unclean and poorly maintained environment, a lack of effective care planning, poor practice resulting from inadequate levels of staff deployed in the service and people not having their needs met. This showed the systems in place were ineffective in identifying where improvements were needed. Had effective systems been in place these issues which placed people at risk of harm could have been identified and acted on prior to us visiting.

The acting manager told us they knew the service would not achieve a good rating from the inspection as there were improvements needed. They said they had been involved in a meeting with the provider and the area manager the previous day where a number of decisions had been made to make improvements to the service following the unsatisfactory infection control audit. However the initial infection control audit had identified a large number of shortfalls in July 2015, some six months prior to the provider deciding that improvements needed to be made. During these six months the provider had left people who used the service at risk of the spread of infection and living in an unclean and unsafe environment.

There was a lack of a culture for encouraging suggestions and ideas on how to improve the service. People had few opportunities to contribute to making improvements or changes to the service. People we spoke with told us they could approach the acting manager if they wanted to discuss anything. One person said, "She (the acting manager) is lovely."

However some people were unsure who the acting manager was and people could not be assured their views would be acted on. One person told us they had raised concerns about the radiator being broken in their bedroom but this had not been addressed.

The acting manager told us there had been a meeting held for people who used the service three months previously, however there was no evidence of this meeting being held. The acting manager could not find any minutes to show that the meeting had taken place, what had been discussed and if any suggestions had been made or acted on. The last client satisfaction survey sent to people who used the service and their relatives had been two years ago. This meant people were not being given the opportunity to give their views on how the service was run and make suggestions for improvements.

Staff told us they did not have the opportunity to attend regular meetings where they could give their opinions of how the service could improve. The acting manager said there had been two staff meetings held since they had been in post. They could not find any minutes for the first meeting and the minutes for the second meeting consisted of feedback to staff on the unsatisfactory infection control audit that had taken place. The minutes did not include any suggestions from staff on how to make improvements. The acting manager said they could not think of any issues that had been raised by staff to change or improve the service.

People did not live in a service that had effective leadership or was managed in a way that kept them, safe and ensured their wellbeing. The acting manager said there was more work needed to help staff make changes in the way they worked and to develop them as an effective team. They said they felt staff could think ahead more and things could run more smoothly. However during periods of observation we saw that there was a lack of leadership for staff and little organisation about how staff could work more effectively at busy times, such as mealtimes. There were no systems in place to support staff to work more efficiently and one person who used the service told us, "There is no leadership here; the staff just do what they want."

The acting manager was regularly used as a care worker due to care staff shortages and so their ability to bring about change and improvement was limited. The acting manager said they did not feel they had the time to fulfil their responsibilities due to working shifts to cover staff vacancies and felt they were struggling to get on top of things. They said they had spoken about this to the area manager. The acting manager told us it was difficult to be a visible presence in the home due to the office being located separate from the main building as they could not see and hear what was going on in the rest of the service.

People could not rely on the management systems identifying where improvements were needed to ensure their safety, wellbeing and comfort. The acting manager told us they knew there were many areas of the home that were not meeting the standards they expected but they could not, "Do it all at once." They also said they could not get things done quickly enough. The acting manager said there were a number of issues with the paperwork that needed to be improved. The acting manager said they had not carried out any spot checks to see how the service was running when they were not there.

The provider had not put in place effective systems to support the acting manager and to monitor the quality of the service. There were visits undertaken by an area manager but these were not effective in identifying and bringing about improvements. For example, some people had their personal spending

monies managed by the acting manager. The acting manager was not ensuring transactions made on behalf of people were witnessed by another member of staff to safeguard people from the risk of financial abuse. The area manager had carried out an audit of people's personal spending monies and this had not identified the shortfalls in witness signatures.

We saw that record keeping in the service was often incomplete and not fit for purpose. We saw there was a cleaning folder for day and night time staff to use. These had not been completed since 28 November 2015 to show what cleaning had been done. There were cleaning schedules in bedrooms which were not being routinely completed. There were gaps in records such as people's food and fluid intake and checks undertaken to ensure people were safe during the night had not been completed in several months. We also saw the accident book was not being correctly completed and complaints were not being recorded.

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