Caring Homes Healthcare Group Limited

Southlands Place

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**

Summary of findings

Overall summary

This inspection took place on 4, 5 and 11 June 2018. The first day was unannounced. Southlands Place is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Southlands Place is registered to provide nursing, care and accommodation to 71 people. There were 44 people living in the service when we visited. People cared for were mainly older people who were living with a range of care needs, including arthritis, diabetes and heart conditions. Some people were living with dementia, some of these people could show behaviours which may challenge others. Most people needed some support with their personal care, eating, drinking or mobility.

Accommodation was provided over three floors of a purpose-built building. There were multiple communal areas throughout the building, and accessible gardens. The service was situated in a quiet residential street in Bexhill-on-Sea.

The service was last inspected on 9, 17 and 18 October 2017. The service was rated as inadequate at that inspection and we identified five breaches in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to person centred care, consent to care, safety, safeguarding people from abuse and good governance. As a result of the 'inadequate' rating, Southlands Place was placed into 'Special Measures.'

Following that inspection, we met with the provider and also followed our enforcement procedures. We added a formal condition to the provider's certificate of registration that they must draw up an action plan and submit it to us every month to show what they would do and by when to improve all five key questions to at least good. The provider sent us a monthly action plan as required. After the last inspection, we also continued to receive a range of comments from both people and external professionals about service provision, which we took into account when planning this inspection.

Separate to this inspection, CQC are also reviewing a serious incident for a person in accordance with Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, this review related to the previous inspection.

At this inspection we found the provider had not made the necessary improvements and the service remained rated as inadequate over all. The provider had not ensured they had met any of the five breaches identified at the last inspection and additionally two further breaches in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified.

This service has had no registered manager for over one year. Since October 2017 there have been three management changes, including a newly appointed manager who had started their post on the same day as our first day of inspection. This manager told us it was their intention to make an application to register with

the Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider is Caring Homes Healthcare Group Limited, a national provider of care.

At this inspection we continued to find a wide a range of areas which needed action to ensure the safety and well being of people. People's safety was not ensured in areas such as medicines management, infection risk, wound care, diabetes and prevention of pressure damage. The service also continued not to consistently follow national guidelines to reduce such risks. Additionally, at this inspection we found the provider had not ensured all relevant actions had been taken in relation to fire safety.

The provider's systems for monitoring continued not to identify a range of areas in need of improvement, so necessary actions to address issues were not taken before the inspection. This included a wide range of areas relating to safety, care and treatment of people, staff support and the management of the service. The provider continued not to identify that some records had not been made, others were not accurate or completed in a timely fashion.

Although issues relating to staffing levels had been raised at the past two inspections, the provider continued not to use robust systems to ensure they could assess if current staffing levels were sufficient and suitable to meet the needs of people living in the service.

Some people continued not to always receive the care they needed in relation to areas such as dementia care, oral care and with their communication needs. Some people's care plans continued to be unclear, so did not ensure all staff knew how to provide people with the care they needed. As at the last inspection, some staff did not follow people's care plans when providing care. People continued not to be consistently involved in developing their own care plans.

The service continued not to follow the requirements of the Mental Capacity Act (2005) by ensuring all relevant people had an assessment of their mental capacity. There continued to be a lack of documentation in relation to best interest decisions for some people.

Procedures for safeguarding people continued to be ineffective. This was because timely referrals had not always been made to the Local Authority to ensure risk of abuse was appropriately considered. A range of staff had not completed training in how to safeguard people from risk of abuse.

Staff continued not to have received training in a range of relevant areas to meet the needs of people living in the service. This included training in people's specific care and treatment needs such as catheter care and wound care. The provider had also not taken action to ensure all staff were trained in mandatory areas such as how to safeguard people from risk of abuse, fire safety and health and safety. They had also not identified that many staff had not received regular supervision to ensure they were appropriately supported in their roles.

The provider continued not to ensure people were supported to raise complaints and issues of concern. Where some people raised complaints and concerns, the provider was not consistently following its own complaints procedure. Some people's complaints were not documented in accordance with the provider's policies.

The service continued not to ensure all people received a caring approach from staff. This was because not

all staff treated people with empathy and respect. Other staff were kind and supported people, encouraging their independence and helping them make choices.

We received mixed comments from people about both meals and activities provision. Some people said both meals and activities could do with improvement and others said activities provision met their needs and that they enjoyed their meals. People could choose to sit in different dining rooms and there were a variety of lounges provided, where people could also participate in a range of activities. The service was purpose-built as a care home and the environment met people's needs. It was maintained at high standards of cleanliness. New staff were recruited in a safe way, following the provider's policies.

The overall rating for this service remains 'Inadequate' and the service remains in 'special measures'. We are considering our enforcement powers in response to the continued breaches and inadequate rating and will publish any action we take when this is concluded

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's safety from risk was not always ensured.

The arrangements for the management of medicines were not always safe.

Where people may have been at risk of abuse or neglect, relevant referrals to the Local Authority continued not to be made to safeguard people.

Although people raised issues about staffing levels, this had not been robustly audited by the provider to identify areas for action. There were not always sufficient numbers of staff deployed in line with people's support needs.

There were safe systems for recruitment of staff.

Is the service effective?

Inadequate

The service was not effective.

The requirements of the MCA and Deprivation of Liberty Safeguards (DoLS) were not always being followed.

Staff were not trained in relevant areas to effectively meet people's needs. Some staff were not supported in their role by effective systems for supervision.

Some people did not always receive appropriate support to have the diet and fluids they needed.

The home environment met people's needs.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated respectfully. People's privacy and dignity was not always protected.

Other staff showed a caring, empathetic approach to people.

People's confidential information was kept private

Is the service responsive?

Inadequate

The service was not responsive.

People's care plans did not always clearly set out how they needed to be cared for. Some staff did not follow people's care plans.

People were not always involved in developing their own care plans.

The provider's own systems for addressing people's concerns and complaints were not being followed.

Is the service well-led?

Inadequate

The service was not well-led.

The service lacked appropriate governance and risk management frameworks, which resulted in poor outcomes for people who used the service.

Prior to the newly appointed manager, there had been a continued lack of managerial oversight of the service as a whole. There was a reactive rather than proactive approach by the provider, which meant that people did not receive a consistent, safe and appropriate service.

There was no shared understanding of the service's vision and values and a culture of task-centred instead of person-centred care was embedded.

Southlands Place

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 comprehensive inspection took place on 4, 5 and 11 June 2018. The first day of the inspection was unannounced. The inspection was undertaken by five inspectors, one of whom was a pharmacist inspector, and an expert by experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. Before our inspection we reviewed the information we held about the service, including the previous inspection report. Because this inspection was arranged to follow-up on the issues identified at the previous inspection and the provider had been sending us regular action plans, we did not request a provider information return (PIR) before this inspection.

We had been contacted by a range of people before this inspection including people's relatives, the Local Authority, the Clinical Commissioning Group (CCG) and staff at the service. As part of the inspection, we reviewed this information as well other information about the service. We looked at safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. After the inspection, the area manager gave us further information and we considered this as part of the inspection.

We met with 21 people and five visitors. As some people had difficulties in verbal communication, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed people's care and treatment, including lunchtime, support with medicines and with activities. We spoke with four external professionals, both before and after the inspection. We inspected the premises of the home, including the laundry, bathrooms and some people's bedrooms. We spoke with 14 of the care workers, some of whom were agency care workers, six registered nurses, some of whom were agency registered nurses, two activities workers, the receptionist, the administrator, three domestic workers, two chefs, the maintenance worker, the new manager, the peripatetic manager and an area manager.

We 'pathway tracked' 12 of the people living at the service. This is when we look at people's care documentation in depth, obtain their views on how they found living at the home and make observations of the support they were given. It is an important part of our inspection, as it allows us to capture more detailed information about a sample of people receiving care.

During the inspection we reviewed records. These included four staff recruitment records, the service's training and supervision records, medicines records, risk assessments, accident and incident records, quality audits and policies and procedures.

Inadequate

Is the service safe?

Our findings

At our last inspection in October 2017 we rated this key question as inadequate and we identified two breaches in Regulations. This was because people's safety from risk was not always ensured and some areas relating to medicines had not been identified. We had also found where people may have been at risk of abuse, relevant referrals to the Local Authority were not always made. People had also raised concerns about staffing levels at the last two inspections; we found this issue had not been audited by the provider to identify the extent of any issue. Separate to this inspection, CQC are also reviewing a serious incident for a person in accordance with Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found a range of actions had not been taken to address issues raised at the last inspection. We also found some other areas where attention was needed to ensure the safety of people.

As at the last inspection, the service was not ensuring risk of infection to people was reduced when they used catheters. The National Institute for Health and Care Excellence (NICE) set out guidelines on the use of such equipment. These guidelines identify there is a risk of infection for people unless safe procedures are followed, this includes ensuring people's hygiene needs are met in relation to the catheter. We met with three people who used catheters. For one person, their care plan did not include the type of catheter in use and had no instructions about how staff were to keep the area hygienically clean. We asked staff about personal care for this person in relation to cleaning this area. One registered nurse told us it was usually the care workers who did this, one care worker told us they did not know and they thought it was generally the registered nurses. Only one of the other two people had references to personal hygiene in their catheter care plan. The instructions in this person's care plan did not follow NICE guidelines in relation to cleanliness around their catheter site.

Catheter leg drainage bags need to be changed every five to seven days, as set out in manufacturers' instructions, to reduce infection risk. We asked staff about the changing of people's catheter leg drainage bags. One registered nurse told us that care workers changed catheter leg drainage bags. One care worker told us only senior care workers changed catheter leg bags. One senior care worker told us catheter drainage bags were changed at weekends. We looked at two people's records about changes of catheter leg drainage bags. One person's record showed their catheter leg bag was not being changed in accordance with manufacturer's guidelines in that the record showed it had been changed daily for four days, then two days later, after that eight days later, and then four days later. Following that, no records were completed for the following 13 days to show any catheter leg drainage bag change during that period. Another person had two separate records about change of their catheter leg drainage bags which documented different information and therefore was unclear which records were accurate. The provider continued to not ensure people who used catheters were protected from the risk of infection.

At the last inspection, we identified the service was not following NICE guidelines in relation to the prevention of pressure damage. NICE guidelines state that because pressure wounds once developed, can be very painful, take an extended period to heal and may present a risk of infection, the emphasis must

always be on their prevention. The service continued not to comply with these NICE guidelines at this inspection.

At this inspection, the area manager told us about one person who had developed a pressure wound and one care worker told us about a different person who had a pressure wound. We met with three people who were assessed as being at high risk of pressure damage. All three of them had been provided with air mattresses. In accordance with NICE guidelines, air mattresses should be set at the correct setting for the person's weight, otherwise they can increase the risk of pressure damage for the person. One person's air mattress was set at 20kgs above their actual weight. We asked staff why this was, one member of staff told us they understood there was a reason for this but they did not know what it was. No reasons were documented in the person's care plan. The two other people had different types of air mattresses where mattress settings were not listed clearly on the equipment. We were told one of these two people had sustained a pressure wound. We asked a range of staff how they knew that the air mattresses continued to be at the correct settings for the two people's weights. None of them knew. We asked for the manufacturer's instructions. They could not be located. Neither of these people had instructions in their care plans about what settings the mattresses needed to be kept at for them.

NICE guidelines state people who are cared for using equipment like air mattresses, still need to be supported to change their position regularly to reduce their risk of pressure damage. We asked staff how often they supported one of the people to change their position. This was because there was no information about this matter in their care plan. Staff gave us differing replies. On one of the days of our inspection, the person's record documented they had not been supported to change their position for over 10 hours. For another of the people, their care plan documented that due to their risk of pressure damage, they were to sit for no more than four hours a day. Their relative told us this did not always happen. We saw the person sat in their chair for more than four hours on one of the days of the inspection. This matter was also documented in their movement position chart, but had not been identified by staff and relevant action taken to ensure their safety. The provider continued to not ensure people who were assessed as being at risk of pressure damage had safe systems in place to reduce their risk.

At the last inspection, the service was not consistently ensuring all people were given their medicines in a safe way. At this inspection, we found the management of medicines continued to be unsafe.

One person was prescribed a bag of liquid medicine for their catheter. It was prescribed to be used 'as directed' and there was a bag of the prescribed medicine in their room. There were no instructions in their records about when it was to be used, why or how often. We asked a registered nurse about this and they said they had not received any instructions about when to use this medicine for the person. The person's records showed they had a history of urine infections, so if the medicine was not being used correctly, this could have placed them at additional risk.

Medicines waste was not always stored safely according to the service's policy. Some medicines waste was in a bag on the floor and the bag had spilt open. We also found that staff food was stored in one of the medicines fridges. NICE guidelines state only medicines should be stored in a designated medicines fridge

Staff were continuing to store medicines belonging to people no longer living at the service. Staff had removed name labels from some unused medicines; for example, creams and mouthwash. Although we did not see that these were being used on other people, they had not been disposed of appropriately.

Peoples' medicines were arranged in sections in the cupboards labelled with their name. However, we found personal items other than medicines were stored within the sections and not always under the

correct name. This included dentures belonging to one person stored with another person's medicines.

The service carried out monthly medicines audits. However, we saw that in March and April 2018 staff had not audited the process for people to self-administer their medicines. The audit section documented that no one in the service was 'self-medicating.' During our inspection we saw that people were administering their own medicines. Although staff had carried out some risk assessments, to ensure people were safe to administer their own medicines, these did not always include all medicines that they were self-medicating. Also, the medicines were not always stored securely according to the service's policy. This meant that other people could access medicines not belonging to them.

Some people were administered pain relief via a medicines patch. These were applied and changed every seven days. Although registered nurses recorded the date and position where people's patches were placed, no further checks were recorded in between applications to ensure patches remained in place and that pain relief remained effective.

The service had also not identified other areas of risk for people and ensured action was taken to reduce their risk. We looked at accident records. While audits were performed, they did not ensure risk to people was identified and action taken to reduce future risks. Records showed 10 falls were documented in February 2018, and 10 in March. Records showed these falls did not relate to only one person, or one floor of the service. All were documented as being unwitnessed. These reports had not been analysed to assess risk factors such as staffing levels, whether they were more frequent on any of the floors of the service or why falls tended to be unwitnessed. Records had also not been used to support people in reducing their risk.

We saw two people had mats in their room to alert staff if they got up and moved around without support. One of these people had no information in their care plan about the use of the mat. One care worker did not know why this mat was in the person's room, another care worker told us they understood the person tended to be restless at night, so the mat had been put in their room, so night staff could be alerted if they got out of bed. The person had no assessment of factors which might reduce their risk of falls. Another person had a complex medical condition which could affect their risk of falling. Accident records showed although they had experienced falls during the past six months, there had been no review of their care plan when they fell, to identify factors for the person and to consider ways of reducing their risk of falling.

The provider had not ensured all systems for fire safety were in place. We asked to review people's personal emergency evacuation plans (PEEPs). We found the information was not accurate in that the PEEPs had not been up-dated when changes had occurred for people, so would not be accurate to advise emergency services in the event of a fire. Following the inspection, the new manager has assured us this matter had been dealt with, but it had not been identified by the provider's own systems to ensure people's fire safety until we raised it during our inspection. Records of fire drills for April and May 2018 both indicated matters which needed action to ensure people's safety in the event of a fire. These matters had not been followed up and resolved after each fire drill, or by the time of the inspection, to ensure people and staff would be safe in the event of a fire.

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

At the last inspection we found the provider had not made timely referrals to the local authority in accordance with their policies to ensure people who received care were protected and kept free from risk of abuse or neglect. Despite this finding of this last inspection, the training records given to us showed 33% of staff had either not completed induction training in safeguarding or safeguarding renewal training. This

included a registered nurse who could be in charge of the service for a shift. This meant we could not be assured all staff had an understanding of their responsibilities in relation to safeguarding people.

This inspection also showed the service continued not to make referrals to the local authority when appropriate, in accordance with their procedures. At this inspection we reviewed records relating to one person who was documented as having sustained an accident, who then became seriously unwell during the day of the incident and needed an emergency admission to hospital during that afternoon. There was no evidence that staff or the provider had identified this matter at the time of the event, or considered making a referral to the local authority at the time of the incident, under current safeguarding procedures. The fact that the matter had not been identified as an issue by the provider until our inspection, four months after the matter occurred, shows systems continued not to be in place to ensure timely referrals were made where relevant to the local authority.

After the inspection, a person's relative contacted us to raise safeguarding concerns about their relative. This was because although they felt they had informed the provider about what had happened, they did not feel the provider had acted appropriately to safeguard their relative. We made a referral to the Local Authority to ensure action was taken to safeguard the person.

This is a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2015.

At the last two inspections, people had raised issues of concern with us about staffing levels at the service and we asked the provider to review this matter under Regulation 17 in relation to good governance. At this inspection, comments from people included, "Not enough staff on this floor" and, "I don't think there's sufficient staff to care for people." This was also echoed by people's relatives. One person's relative told us, "No not enough staff." People told us about the effect on them of having not enough staff. One person told us, "I'll ring the bell and nothing happens," another, "They say I shouldn't walk on my own but there's not enough staff for that" and another, "I feel the staff could talk to me more, but they don't have time." This was echoed by people's relatives. One person's relative told us, "The registered nurse on duty never has time to talk." Staff also echoed these comments. One care worker told us, "We are a good team today but we're still all running around like crazy" and a registered nurse told us, "There are not enough staff for the complexity of the residents." These comments were not echoed by everyone. One person told us, "Staffing levels all right" and another said there were enough staff to, "Spend time with me."

People told us they sometimes had to wait for care to be provided. One person told us, "Sometimes you want the toilet and wait and they don't come." We observed occasions when people had to wait long periods for assistance with their care. One person said they wanted to get up. The care worker who came to them told them they would have to wait until another care worker was available to support them because they needed two staff to support them. We saw they were still in bed 40 minutes later. Another person wanted to go to the toilet. Care workers were unable to support them because this person also needed two staff, and one of the staff was on their break and another one was helping another person who needed assistance, so they had to wait until the care worker returned from their break.

Because we continued to receive comments about staffing levels, we asked the provider how they assessed they had enough staff to meet people's needs. They showed us the dependency tool they used. They told us figures for each floor were collated to provide an overall number of staff. Staff were then allocated to different floors on a shift by shift basis. We looked at the dependency tool and found, unlike the last inspection, it was not being accurately completed. This was because although an overall figure was identified for each person, some of the forms did not include any detail of how the overall dependency

figure had been arrived at. This meant the accuracy of the tool could not be audited for each person. At both this and the previous inspection people commented on the length of time it could take for staff to answer call bells. At the last inspection we asked for the audits of response times to call bells, but were told they were not audited. At this inspection, the service continued not to audit response times when people used call bells. The provider was also not considering other factors when assessing if they had enough staff on duty. At night there were seven staff on duty across the service; two registered nurses and five care workers. We were told this meant the registered nurse allocated to the second floor needed to leave that floor at night on occasion to perform their clinical role. This meant one care worker was left to support the 12 people on that floor. One of these 12 people had a history of falling at night. This had not been included in any assessment of whether staffing levels in the service were suitable or met people's needs.

The is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Despite safety concerns we identified, people told us they felt safe in the service. One person told us, "Yes I'm very safe, everything is provided" and another, "I would go to a nurse if I felt unsafe." The emergency bell was activated during the morning of one of the inspection days. We saw there was a very prompt response to it by staff.

People said they received their medicines in a safe way. One person told us, "Medication is regular as clockwork" and another, "Yes, we all get our medications on time." We observed medicines being administered. Registered nurses had a good rapport with people and were caring in their approach. Registered nurses completed medicines administration records (MARs), signing for each medicine after it was given. Running balances were also recorded, to ensure people did not run out of their medicines.

The service was clean throughout. One person told us, "It's definitely clean here." We observed cleaners were diligent in their work, carefully cleaning difficult to reach areas such as room corners and under dining tables. Equipment such as bath hoists were all clean on their under surfaces. The laundry was clean, with no dust or debris visible behind any of the machines.

New staff were safely recruited, this included registered nurses. We looked at records of four staff who had recently been employed. These showed prospective staff were assessed for their suitability. All staff files included key documents such as a full employment history, at least two references and a Disclosure and Barring Service (DBS) check. These checks identify if prospective staff had a criminal record or were barred from working with children or adults. This ensured only suitable people worked at the service.

Inadequate

Is the service effective?

Our findings

At our last inspection in October 2017 we rated this key question as requires improvement and we identified two breaches in Regulations. This was because the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were not always being followed. Improvements were also needed in relation to meeting people's healthcare needs and relevant staff had not been trained in meeting these.

At this inspection, we found actions had not been taken to address the issues raised at the last inspection and we also found some other areas where attention was needed, to ensure the effectiveness of care provision for people.

The 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We found service continued not to work within the principles of the MCA.

We met with a person who told us they did not like having a catheter. There was no evidence on their file to show if they had consented to the use of this catheter. One care worker told us the person had also recently began to show issues with walking about in a restless and unsafe way during the night. We saw a recent letter on the person's file from their consultant physician in which their consultant had written about changes in the person's memory. Despite this, the service had not ensured a mental capacity assessment or best interests decision had been made about the person needing to use a catheter or the use of other equipment which had been provided to ensure their safety at night.

We met with another person who was living with dementia. The person was frail and had limited verbal communication. They had no mental capacity assessment on file and no best interests decision about why they were cared for in bed all of the time. When we discussed these matters with the area manager, they told us the provider was introducing new documentation which would support staff in developing mental capacity assessments for people. We looked at the documentation for a person who had been assessed using the new documentary system; the part of their file relating to mental capacity had not been completed.

We asked staff who had Lasting Power of Attorney (LPA) for the two people we had reviewed in relation to the MCA. A LPA is a legal process that allows people to appoint someone to make financial or health and social care decisions on their behalf. Staff said they did not know. There were also no records on the people's files. We discussed this with the service's administrator. We found that while some people had parts of documentation about LPAs, others did not. The new manager has informed us that this has now been addressed. However, although the matter had been raised with the service by two different people's relatives, they had not taken action until we identified the matter during this inspection.

This is a continued breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As at the last inspection, we identified issues relating to the service not effectively supporting people with their healthcare needs. This included supporting people who had wounds and people who were living with diabetes.

The service used wound booklets. The provider expected that each wound should have a booklet and clear directions for staff to follow. The booklet included that photographs should be taken to monitor wound progression and healing. Staff were not following the service's procedures. Where people sustained skin tears, staff did not always complete a body map or wound booklet. One person had fallen three days before the inspection and sustained a skin tear to one of their hands and both arms. No wound care booklet had been commenced, no photographs had been taken and there was no written evidence of what actions were taken to ensure the person received effective care. This is of particular concern for frail older people because, due to changes in skin integrity with age, even small wounds may deteriorate without close monitoring and treatment.

We looked at the records of one person who had a wound and discussed the person's care and treatment with a registered nurse. The person's records were unclear. The person had been seen by the tissue viability nurse (TVN) and a specific treatment prescribed by them for their wound. The person's care plan booklet had not been updated to evidence this. We discussed this with the registered nurse who was unclear about what dressings were being used. We asked them what the last dressing on the wound had been, but the registered nurse could not tell us because they had not performed the dressing, but assumed it had been the previous dressing, not the one prescribed by the TVN. They said they understood the person had not liked the dressing prescribed by the TVN. This was not documented in the person's records and there was also no evidence this had been referred back to the TVN, if it was the case, to ensure the on-going dressing of the wound was appropriate and safe.

We looked at the records of a person who was an insulin dependent diabetic. As at the last inspection, their monitoring chart continued to document that their upper and lower blood sugar levels be maintained within levels which were outside guidelines from both NICE and Diabetes UK. The CQC were aware from correspondence that the service had been given advice about correct blood sugar levels by the local clinical commissioners (CCG). The person now had a care plan, but it documented different upper blood sugar levels from what was documented on their monitoring record and these levels were also well above recommended levels as advised by NICE. The person's care plan gave guidance on actions to be taken if their blood sugar levels were raised. However, the person's daily records did not clarify if their care plan had been followed when they showed raised blood sugar levels. A registered nurse told us they understood staff had contacted the person's GP for advice, but the person's medicines records did not show any information about the carrying out of the reported verbal instructions from this GP. We spoke with a different registered nurse about this but they were not able to give us any more information.

We were told the person usually performed their own insulin injections but registered nurses sometimes supported them with this, as happened on one of the inspection days. Repeated use of the same injection site can cause tissue damage, which may also affect the uptake of insulin. NICE and Diabetes UK advise a regime is put in place to ensure injection sites are rotated. We asked the registered nurse who gave the person their insulin if there was a system to rotate the sites of the insulin injections, but they did not know. There were no records of this in the person's file.

We looked at the records of a person whose diabetes was not controlled by insulin. They had no guidance in

their care plan about what blood sugar levels they needed to be maintained within, the frequency of any blood testing regime or what staff were to do it the person fell outside these anticipated blood sugar levels.

The service was also not ensuring people's healthcare needs were met for other healthcare conditions. One person received all their nutrition by a tube feeding system called a percutaneous endoscopic gastrostomy (PEG). The provider's policies followed national guidelines by outlining the tube needed to be rotated every day to ensure its safe functioning, so the tube did not become embedded. We looked at the person's care plan. There were no instructions about this in their care plan. The person also had no records to show their PEG tube was being regularly rotated. We asked a registered nurse about rotating the tube. They said they did it when they were on duty but did not know if any other staff did it. We asked the registered nurse about records of rotating the tube, they said none were made. Following the inspection, the provider sent us an undated form relating to rotating the tube. This did not show the service were following their own guidelines about frequency of rotation of the tube.

This is a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection, we identified areas which needed addressing in relation to staff training and support. We discussed training with staff and reviewed records. Although the service provided care and treatment to a person who used a PEG, none of the staff we spoke with told us they had recently been trained in how to support people who had PEGs, including care of the PEG insertion site. There were no records to show staff had been trained in the area or their competencies checked.

The service provided care and treatment to people who used catheters, were at risk of pressure damage, had wounds and were living with diabetes. We asked staff about training in these areas. We received mixed messages with some staff saying they had been trained and others saying they had not. Several of the staff we spoke with were not aware of NICE guidance on areas such as catheter care, diabetic care or pressure area care. We looked at training records for registered nurses in such areas. Records showed no registered nurses or care workers were currently trained in tissue viability or pressure area care, although this was raised at the last inspection. Issues had also been identified in relation to wound care at the last inspection. Of the 12 registered nurses currently employed in the service, there were records to show three of them had been trained in wound management since the last inspection. Although the service had cared for a person who had a specific type of catheter since 2017, the provider's records showed five of the registered nurses continued to await training in the area. Issues had been raised about supporting people who were living with diabetes at the last inspection, but the provider's records showed none of the care workers had been trained in the area.

We asked people if they thought staff were both trained and supported to meet their needs. We received mixed replies. One person told us they felt staff were, "Not confident with what they are doing," another said they felt staff needed to improve when they helped them to move about. However, another person described staff understanding of how to support them as, "Fine."

We talked with staff about their training and support, and again received mixed replies. One care worker told us they felt some of the other staff were not properly trained, when we asked two care workers for people's Personal Emergency Evacuation Plans (PEEPs), they did not know what these plans were. Some care workers showed limited knowledge of supporting people who were living with dementia. All of the care workers we spoke with told us they had not received supervision recently. Other staff were more positive. One care worker told us their training gave them all, "I needed to know", a newly employed member of staff told us, "Training is being arranged." All the domestic workers we spoke with told us they received regular

supervision.

We looked at the provider's training records. We saw about 17% staff had not completed fire safety training, 25% had not completed the provider's training on dementia care, and 34% had not received the provider's training in the Mental Capacity Act and Deprivation of Liberties safeguards. We looked on the file of four agency staff and saw two of them had no evidence they had been inducted into their role at the service to ensure they could safely and consistently care for people.

We looked at records of supervision, these showed about 80% of care workers and about half of the registered nurses had not recently been supported by supervision. We asked registered nurses if they received clinical supervision, so their competency to perform their role was assessed. They said this had not taken place because there had been no nurse clinical lead in post until recently.

We discussed staff training and supervision with the peripatetic manager. They said the member of staff who led on training and staff support had left their post since the last inspection and a new member of staff had now come into post and they would be leading in the area. The provider had not taken action earlier to identify deficits in staff training, monitoring and support so as to ensure people received effective support from staff, who were fully trained and competent to perform their roles.

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

We reviewed systems for meals and supporting people with their nutrition and hydration. People gave us a range of comments about the meals. One person described meals as, "Dull," another person said, "A bit more variety would be nice, more fresh fruit would also be good" and another, "Drinks can be haphazard in frequency." Other people made more positive comments. One person told us, "The food is usually pretty fair, you get a choice and a menu," another, "The food is alright on the whole," and another, "Food is excellent for the type of place, ample to eat, plenty to drink."

We met with a person who had a history of urine infections. Their care plan documented they were to drink 1500mls a day. We asked staff how they assessed if the person was drinking that amount. Staff told us they did not use a monitoring system such as a fluid chart to assess how much the person was drinking. We met with another person whose care plan stated they were to drink 750mls in one part and 1500mls in another part of their plan. They also did not have a fluid intake monitoring system. Both these people were living with dementia and were not able to recall the amount of fluids they had drunk.

We asked staff about how they supported people who were living with diabetes with their meals. Staff told us one of the people particularly like to eat yogurts. We looked at the yogurts given to them and saw they had14.9 grams of sugar in them. The chef told us low sugar yogurts were not provided and they also did not provide people with low sugar custards, hot puddings or cake. There are a wide range of alternatives to high sugar meals, which can also be prepared from scratch, so they are pleasing for people who are living with diabetes to eat and also to support them in healthy diets. The service was not doing this.

We looked at records of people's likes and dislikes. These were contradictory, for example one person's records documented on one page that they did not like yogurt but on another page, that they did. Another person's records documented their preferred drink was tea in one place and coffee in another. As the service used agency staff at times, such information would be confusing for agency workers unfamiliar with what people's actual preferred choices for food and drink were.

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

We observed people being supported with eating and drinking throughout the home, including people who chose to eat in their rooms. Dining rooms were bright and airy, tables were spread with cloths and napkins were provided. People could sit together or on their own as they chose. People were offered a choice of different soft drinks at mealtimes. People appeared to enjoy eating their meals in the dining rooms and were able to eat at a leisurely pace, if that was what they preferred. The chef made them self available to receive people's comments at mealtimes. Where people ate in their rooms, meals were nicely presented on trays, with hot meals being provided with a cover. We could see steam rising from plates when covers were removed, so they had remained hot.

Where people needed help with eating and drinking, staff sat with them, encouraging them and engaging them in conversation. We saw one person was given pureed meals. The pureed meal was presented well with moulds being used so the meal had the appearance of the type of food on the menu, such as sliced meat and vegetables. Staff confirmed that the moulds were always used. One person had difficulties with swallowing. They had a care plan from the speech and language therapist (SALT) about how they were to be supported with eating and drinking. We saw staff consistently followed this plan when supporting the person.

People said staff promptly called in support from their GPs or other professionals when they needed it. One person told us, "Yes a Dr would be arranged," another, "I am waiting on an eye test now" and another, "We see a nurse and a Dr would be arranged." During the inspection, we observed the registered nurse contacting a person's GP surgery, reminding them of the importance of the person being promptly reviewed. Staff told us their relationship with the local GP practices were good and they knew how to seek support from other professionals like the SALT team or TVN.

Southlands Place was purpose-built as a care home with nursing. It provided accommodation for people over three floors, with a choice of different sitting and recreational areas. All parts of the building were wheelchair accessible, including the garden. All toilets and bathrooms were suitable for wheelchair users. The décor of the home was well maintained, giving a pleasing appearance. People commented favourably on the building. One person said they liked the way, "I can have a few of my own things in my room" and a person's relative told us they had chosen this home particularly because of the spacious room their relative was able to have.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in October 2017 we rated this key question as requires improvement. This was because some staff did not ensure people's privacy and dignity or respond to them as individuals. At this inspection, we continued to find some areas where people felt they were not consistently supported in a caring way.

We received mixed comments from people when we asked them if the staff were caring and consulted with them about care. One person told us, "The staff don't come and talk to me at all," another, "No one talks to me except other residents," and another, "Sometimes I feel they don't treat me with respect and dignity, they don't always knock on the door, they rush in and out and sometimes don't say anything." One person's relative told us they felt the staff did not know people as individuals, particularly the agency staff.

We saw staff did not always show a respectful or involving approach to people. One person's care plan documented they did not want a male care worker for personal care. However at 12 midday we saw the person being escorted to the toilet by a male care worker, although there were female care workers on duty. One member of staff called out loudly across a sitting room that a named person wanted to go to the toilet. We heard one person calling out loudly for the toilet. Staff did not attend when the person wanted, and they became very anxious. An activities worker was reading to a person, staff in the area were talking loudly over what the activities worker was doing. In one dining room people were assisted to sit down for lunch 35 minutes before the meal. Staff did not support people into making this an enjoyable, social occasion.

We saw a large container of net underwear in the laundry. Some of the net underwear had been used and n washed. None of them were named. We asked the laundry worker about them. They told us staff came and helped themselves from this bin when needed. They said net underwear was meant to be named, but staff did not always do this. When we went into the room of a person who had decided to get up later in the day, we saw their clothes had been prepared and were placed on the back of a chair. On top of the clothes was there was some clean, but used net underwear. It was not named. The provider had not ensured people's dignity by ensuring risk of communal use of clothing was not taking place.

Before the inspection, we had several issues raised with us about lack of attention to people's appearance and bedding. We saw a person at 1:50pm whose sheets showed some marking, with what seemed to be food. The person also used protectors for their hands; they were also not clean. One person's relative told us it was the little things that were forgotten such as removing people's socks in hot weather or not using the shawls they liked in colder weather.

Where people had additional needs, some rooms did not look homely because of the items stored there. For example, one person who had a catheter had several piles of spare catheter bags and other equipment visibly stored under and on a piece of furniture in the entrance to their room. Another person's family had put work into making their en-suite more homely but the quantities of equipment they needed for care which had been stored there lessened this effect.

These observations all show improvements were required to ensure people lived in a caring environment

and were treated with dignity and respect.

People told us staff were caring in other areas. One person told us, "Staff are definitely helpful," another, "The staff are absolutely super," and another, "The staff have been very nice to me." People also commented on the humanity of the staff. One person told us, "Yes the staff understand me well" and another, "The staff joke a lot, which is nice." One person told us, "The staff treat us with respect and dignity" and another, "Our privacy is respected yes." People commented particularly on the support given to them by the new home administrator and the friendliness of the domestic workers. We saw staff were polite when supporting people, listening to what people were telling them. One domestic worker took a lot of time to listen to a story a person was telling them, showing empathy and understanding towards them.

People said their independence was supported. One person told us, "I can go to bed and get up when I like," another, "There's no restrictions on what we do," and another, "The staff encourage me to be independent." We saw staff supporting people in making choices and being independent. One care worker made sure they asked a person where they wanted to sit down when they escorted them into the sitting area. One person who usually got up, wanted to have a day in bed and this choice was respected. Staff asked people if they wanted to go to the dining room or remain in their room for their meal. They respected each person's choice.

People said how much they appreciated their relatives and visitors being able to visit them. One person told us, "Visitors are made welcome and can have lunch here" and another, "Visitors and family are encouraged to visit and made welcome." We saw people's visitors and relatives coming and going as they wished throughout the inspection. The home's receptionist was consistently polite and helpful to people's visitors when they came into the home, passing the time of day with them and other pleasantries.

Some people told us they appreciated being able to bring things of their own into the home so they made it more homely. One person told us, "I have my own things in my room, a lot of furniture" and another, "I have my own bits and pieces in my room." We saw some people's rooms were set out with people's own photographs and pictures and small pieces of furniture to reflect their individual choices and wishes.

The provider had taken action since the last inspection to ensure people's personal records were now securely stored and could not be viewed by third parties.

Inadequate

Is the service responsive?

Our findings

At our last inspection in October 2017 we rated this key question as requires improvement and we identified one breach in Regulation. This was because some people's care plans did not clearly set out how they needed to be cared for and some staff did not follow people's care plans. We also found some people were not involved in developing their own care plans. People who were at the end of their lives were not consistently supported in the way they needed. People also felt some of their concerns and complaints had not been responded to.

At this inspection, we found a range of actions had not been taken to address issues raised at the last inspection. We also found some other areas where attention was needed to ensure people's needs were met in a responsive way.

People told us some staff did not know how to meet their individual needs. One person's relative told us, "Staff are not properly briefed." As at the last inspection, people commented on the use of staff who were not familiar with their needs. One person's relative told us, "Far too many agency" and another said, "Continuity is not good," because of the use of agency staff. Records showed the service continued to need to use agency staff, at all levels. On the third day of the inspection, the registered nurse on the ground floor was an agency nurse, the one on the second floor was also an agency nurse; this was their second shift at the service. Some agency staff were not familiar with people's records. We asked one agency care worker for a person's records, they told us they did not know where they were kept and had only been told verbally how to care for people for their shift of duty. Staff also commented on people's care plans. One newly employed member of staff told us, "I can't understand the care plans" and a permanent member of staff told us, "I don't have time to read the care plans." This placed people at risk of receiving care that was inconsistent with their assessed needs and preferences.

As at the last inspection, we found the service did not have systems to ensure people's care and treatment needs were met in a responsive way. This continued to include supporting people who were living with dementia. One of the people called out two people's names much of the time. We asked a care worker about this but they could not give us any information. The person's care plan did not include any information about what these two people had meant for the person. When the person called out, staff did not acknowledge this. One care worker told us said they usually said to the person they will go and look, and this placated the person. The person's behaviour chart showed they frequently shouted out or showed anxiety. The information on the chart had not been analysed to assess factors which might affect the person, for example certain times of day or when the person wanted a drink, or to go to the toilet. The person did not have a care plan about how staff were to respond when they called out or showed anxiety. The person's communication plan documented that staff should use photos to discuss memories. This care plan did not include any further detail or information about this. The person's care plan for agitation, confusion and distress only documented staff were to refer the person to mental health services, with no plan about how to respond when they showed agitation.

The service was not responding to other people's needs. One person could not take anything in by mouth.

They had no care plan about how their mouth was to be kept fresh and clean. We asked three staff about this. They said they cleaned the person's teeth twice a day. When asked for more information, staff did not outline any measures they used to make sure the person's whole mouth was comfortable, clean and moist including during the hot weather at the time of the inspection.

Where a person did have a care plan about mouth care, it was not being followed. One person had directions from their SALT that they should have mouthcare four hourly. They did have a care plan about this, which reflected the SALT's directions and documented mouth care was to be done with a mouthcare kit. The person did not have a mouthcare kit visible in their room. We asked two care workers about what they did about the person's mouthcare. They told us they cleaned the person's teeth twice a day.

One person had had a stroke and had directions in their care plan about exercises for their affected limb, which were to be done three times a day, and for their throat which were to be done five times a week. The person had two different records to document their limb exercises. These records documented different matters. At the time of the inspection, the person had no records in either their room or notes folder about their throat exercises. We asked staff about this during the inspection but they could not provide us with relevant documentation. After the inspection, the provider sent us a record which had been commenced on 1 June 2018. We asked staff about these throat exercises. They told us, as shown by the record sent in by the provider after the inspection, that the person often refused to do their throat exercises. There was no evidence this had been referred back to their therapist for further advice.

From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard (AIS) in full, in line with section 250 of the Health and Social Care Act 2012. Services must identify, record, flag, share and meet people's information and communication needs. One person's stroke meant they could not communicate verbally, however they could move their head to signify 'yes' or 'no' and could also indicate matters with their eyes. Their relative brought a tablet computer in and we saw the person was actively using this to communicate when their relative was in the service. The person's care plan did not indicate any means had been considered, in accordance with AI standards, to support their communication. We asked staff about this. One care worker told us the person used to have a picture chart where they could indicate things they wanted assistance with, but they did not know where it was now. This chart was not visible in the persons' room. We asked the registered nurse about it. They told us they did not know where the chart was and thought it might be filed away. The service had not ensured they had followed AI standards in relation to this person to assist them to communicate effectively.

We asked people about their involvement in care planning. We received mixed replies. One person told us, "No one talked to me about a care plan," another, "No never seen a care plan or had it discussed" and another, "No one has ever discussed my care or treatment." However, another person told us, "They come and discuss our care with us," and another "A care plan was discussed when she came in and got reviewed." We saw systems were being started to ensure people or their representatives were involved in care planning. This included the previous manager writing to people's relatives about care planning meetings. Some of these had not yet taken place and many people's care plans were unsigned.

We received mixed comments about activities. One person told us, "Activities not good really" another, "Activities are poor" and another, "We were supposed to go out on Mondays in a mini bus but it has not happened." One person's relative told us, "A lot of the activities are not suitable now." These comments were not echoed by everyone. One person told us, "Saturday is the best day as we have music and singing, dancing," another, "They offer activities, quizzes and music, we are given a list" and another, "I enjoy knitting, I sit in the sun when I can."

The service employed two activities workers. An activity programme was available for people and included exercise classes, quizzes, games, music and singing. Some people told us some activities were not appropriate or available. One person told us they liked to go outside. The activities worker told us the person preferred indoors activities when asked but they had taken them outside recently. None of this information was documented in their records.

Records of people's past and present interests were sparsely completed. This included the area of the service which specialised in supporting people who were living with dementia. This meant staff, including agency staff who were not familiar with people would not be aware of relevant information to support them in how they wanted to be supported with diversional activities. It also meant the service could not assess if activities provided were effective for the people or related to people's past and present interests.

This is a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed comments from people about responses to complaints. One person told us, "I wouldn't know who to complain to." One person who said they had raised complaints in the past, but had been, "Ignored." One person's relative told us said they had raised issues in the past but felt there was, "No point" in doing so because, "Nothing changes." Such comments were not echoed by other people. One person told us, "I would complain to the manager, but I have not had to yet" and another, "Yes I would complain to the office, never really had to."

At the last inspection, we identified some areas where people felt they had raised issues of concern and complaints but the manager at that time was not aware of such issues being raised. We identified it as an area which required improvement. The service had not made the relevant improvements.

The service had a complaints policy, in which it was documented that any member of staff who received a complaint should document it on a complaints log form, so it can be communicated to management. If the complaint cannot be sorted out promptly, an acknowledgement needed to be sent to the complainant within 10 working days and a full response to the complainant within 28 days. It also stated if the complaint could not be responded to within 28 days, the complainant would be contacted to outline the reasons for the delay. The service was not doing this.

We received a complaint from a person who wished to remain anonymous. We sent it to the manager of the service, requesting them to respond to us about the complaint. They did not do this, even when we reminded them they had not responded to us. When we looked at the complaints log during the inspection, this complaint had not been recorded on it. The CQC have also been contacted by the relative of a person about a complaint they made to the provider about their relative's care. This complaint was also not documented on the service's complaints log. The complainant has confirmed to CQC that the service had not acknowledged their complaint or written to them to inform them of the reasons for delay in response after 28 days.

Where complaints had been documented, the provider was not working within its procedure to review and respond to them. This included two persons who made a written complaint to the manager. They did not have a record on file that their complaint had been acknowledged within 10 working days of them raising the issue, in accordance with the provider's policies.

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

The service was not currently caring for any people who were at the end of their lives, so we could not assess if they had met the issues raised at the last inspection about meeting the needs of people at the end of their lives.

Inadequate

Is the service well-led?

Our findings

At our last inspection in October 2017 we rated this key question as inadequate and we identified one breach of legal requirements. This was because whilst monitoring systems were in place, they were not embedded and not effective in detecting shortfalls identified during our inspection. Also, a range of records were unclear or inaccurate. At the last inspection, the service did not have a registered manager in post and had not had one for over a year. At this inspection we found that concerns remained with the leadership and governance of Southlands Place.

At this inspection, 10 people commented negatively to us on the service provided. One person told us, "The managers don't come to see me," another, "I thought the service would be better," and another, "It's so bad I don't know why you've not withdrawn their licence." Some people felt they were not consulted or informed about matters. One person told us, "They don't tell us anything about things going on," and another, "Yes I have been to residents' meetings but they fell apart." This was not echoed by everyone. One person told us, "It's all right here," and another, "The environment is very nice."

We followed our enforcement policy after the last inspection. We added a formal condition to the provider's certificate of registration that they must draw up an action plan and submit it to us every month to show what they would do and by when to improve all five key questions to at least good. Reports were to include the outcome of the audits, including reviews of care provided to people and any action taken as a result. Reports were also to include assessment of staff skills to meet the care and treatment needs of people and any action taken as a result. Additionally, the provider was to report on actions taken to meet breaches of regulations. The provider had sent us their action plan as required every month.

At this inspection we found that although the provider had been completing reports and submitting them to us, they had not identified a wide range of areas for action, or ensured progress was made towards addressing the five breaches identified at the last inspection. These breaches were in relation to personal care, need for consent, safety, safeguarding people and good governance. The provider had also not taken action where we had advised they needed to make improvements in relation to complaints. The provider had also not identified or taken action to ensure their staff were appropriately trained and supported to perform their roles.

Some issues brought up at the last inspection had not been audited by the provider. At the last two inspections, we outlined that people had raised issues relating to concerns about the adequacy of staffing levels, including response times to call bells. These were continued concerns raised at this inspection. One person told us they told us they felt managers ought to know there was an issue about staffing levels. The provider's monthly audits did not include any reference to auditing people's opinions about staffing levels. Monthly audits had not identified that management had made no progress at all on assessing response times when people used their call bells.

At the last inspection, we outlined issues with making sure people's own clothes were returned to them from the laundry. One person told us during this inspection that they had lost, "Quite a few things," in the laundry.

Although this matter had been reported at the last inspection, it was not included in the provider's audit. When we visited the laundry we saw, as at the last inspection, there was a large pile of people's un-named clothes on a table top. The laundry worker told us they did make efforts to return clothes to people but it was difficult if they were not marked before they came to the laundry. The provider continued not to have appropriate systems to ensure all people's clothes were returned to them from the laundry.

The provider's audit was not accurate in identifying certain areas. Although their action plan for 29 May 2018 documented that falls had been analysed for January, the analysis had not identified the person who had sustained a fall and been admitted to hospital as an emergency that day. Although their action plan for 29 May 2018 documented that 'all PRN protocol written and placed with MARS sheets' the action plan had not identified that a person who had a prescription for a medicine for their catheter did not have any instructions or PRN protocol relating to its use. Although the action plan for 29 May 2018 stated 'manager checks wound Turns/Pressure Mattress checks' the action plan had not identified that three people did not have any information in their records relating to appropriate checking of their air mattress settings.

The provider had also not identified other matters and taken action to address them. Although the service had provided care and treatment to a person who had a PEG for well over a year, the provider had not identified in its audits that no staff had been trained on how to support people who were PEG fed. The laundry worker told us they had issues relating to some staff not routinely following the provider's systems for placing potentially contaminated laundry in the correct bags. They said due to the risk of this to people and staff, they reported this to management on every occasion it occurred. We asked for documentation about this but, there was none, this meant the extent of the issue had not been analysed by management. This matter had also not been identified in the provider's internal audit of 30 April 2018 for either clinical waste or the laundry.

The provider had not identified that insufficient action had taken place to address other areas reported on at the last inspection. At the last inspection we outlined a wide range of issues relating to record keeping. This continued at this inspection. One person was having their food intake measured. We saw a member of staff supporting them with eating their breakfast. We saw they were not able to eat much and when we asked the member of staff with them how much they had eaten, the member of staff told us the person had only managed two spoonfuls. Their food intake record documented they had eaten a quarter of their breakfast, which was not accurate. One person had a care plan from the SALT which specified the amount of fluids they needed to take in via their PEG each hour. Their fluid intake record for one day did not show this had taken place, and the issue had not been identified by the next day, to ensure the person was not at risk of dehydration. Another person's records showed they had a history of high blood pressure. The area on their blood pressure monitoring chart for documenting their usual observations had not been completed. The person also did not have a care plan about management of their blood pressure. This meant staff did not have records to enable assessment of if the person was outside or within their usual blood pressure range. For another person, staff were recording bath and shower temperature every day but this did not reflect the person's daily notes in terms of personal care provided. Certain records, for example records of night checks on people, were documented as taking place on the hour. In a large service with people who had a range of night care needs, it would be unlikely that every single person could be checked at exactly the same time. Therefore it was likely that the records of these checks were not accurate or contemporaneous.

Where the provider's own internal audits identified issues, there was no evidence of relevant action taking place. The provider's health and safety audit of 30 April 2018 showed a score of nought out of 10 for fire evacuation plans. No action plan was attached to the audit and we found the situation had not improved five weeks later because the folder for PEEPs included some people who were no longer living at the service and PEEPs which had not been updated when people's conditions changed. In the section relating to staff

training in health and safety, the provider's audit showed a score of five out of 10. There was no action plan attached and the training audit for 31 May 2018 showed the situation had not improved because about 22% of staff continued not to have completed their mandatory health and safety training.

This is a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was no shared understanding of the service's vision and values and a culture of task-centred instead of person-centred care was embedded.

This service had not had a registered manager for well over a year. One member of staff told us, "We've had so many changeovers of managers here." Another member of staff told us due to management changes, there had been no staff meetings since January. The manager who was in post at the last inspection, left soon after the inspection took place, before they completed their application for registration with us. The provider then informed us they had appointed a new manager. Three months later, the provider told us that manager had left their post. The provider told us they had placed a peripatetic manager in charge until they appointed a new manager.

The new manager started in their role on 4 June 2018, the same day as we started this inspection. The service's deputy manager, who had then been responsible for managing training, left their post after the last inspection. The peripatetic manager told us the responsibility for staff training was now the newly appointed home administrator's responsibility. The peripatetic manager told us they would be appointing two clinical leads, who would jointly perform clinical management roles. One of these members of staff was in post and the other post was being advertised. Other staff had changed since the last inspection, this included the activities workers, as well as care workers and registered nurses. This had impacted upon the continuity of care people received. At our next inspection, we will assess how these changes have been embedded to ensure improvements are made and sustained.

Now a new manager had been appointed, some people and staff were more positive about the future. One person told us, "We have just met the new manager, I am quite happy here." One newly employed member of staff told us, "I've just started here, I hope things will improve with a new manager." One permanent member of staff told us, "The change of manager will be good." Some people made positive comments about the service provided. One person told us, "Pretty good service here I think" and another, "Overall the service is pretty good." One member of staff described the, "Homely atmosphere." One member of the housekeeping team told us, "Senior managers do come and talk to us when they come round."

The service has been working with a wide range of external professionals since the last inspection, including the local authority and members of the CCG. These professionals report the services' managers had been working with them and had supplied them with information they requested.