Care Quality Commission

Eldercare (Halifax) Limited

Cowlersley Court Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

The inspection took place 14, 15 and 19 October 2015 and was unannounced.

The service was last inspected in April 2014 and was non compliant. This was in relation to respecting and involving people who use services and staffing. The service had not made the necessary improvements since our last inspection .We found that there had been further deterioration in the standards of care and there were multiple breaches across current regulations.

Cowlersley Court is a residential care service, who offer personal care for to up to 37 people. At the time of our inspection there were 25 people registered as living at the service although three were in hospital, which meant that there were 22 people using the service during our visits.

At the time of our inspection there was a registered manager, although they were not present during any of the days we were in the service. There was a new manager and an area manager in the service during these dates. A registered manager is a person who has registered with the Care Quality Commission to manage

Summary of findings

the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found that the standards of care in the service had deteriorated significantly since our last inspection. This was in relation to multiple breaches of the regulations.

We found that people's care needs had not been assessed and there were no care plans for some of the people who lived at the service. For those people who did have care plans these were out of date and the information did not reflect their current needs or describe the care which was being given to them.

We found that people in the service were not treated with dignity and respect. Some of the people living in the service were unable to access the toilet without assistance and were being left for long periods without being given this assistance. Staff did not recognise how people's dignity could be promoted and did not assist people when they needed help.

The people living in the service were not asked for their consent for care to be carried out. The provider and the staff failed to recognise restrictive practices which were in place. Mental capacity assessments were not carried out for the people living in the service to measure whether they were able to make their own decisions and which decisions they were able to make. Where people's liberty was being restricted there was no Deprivation of Liberty Safeguards in place.

The provider did not have safe processes in place to ensure that people were given the medications that were prescribed to them in the way in which they had been prescribed. We found that people were not receiving their pain killing medicines. There were very few risk assessments in place for people in the service and those that were in place were out of date and had not been reviewed. The equipment which was being used to assist people with poor mobility was limited. There were no assessments carried out to make sure that the equipment which was being used was safe or suitable for the needs of the person. We found that people who were unable to get out of bed were not receiving adequate pressure area care and there was a high incidence of pressure areas in the service as a result.

Staff did not recognise safeguarding incidents that were occurring. There were no safeguarding referrals made to protect vulnerable people living in the service until incidents were highlighted by CQC during the inspection.

We found that some people were not being adequately hydrated and were left without access to drinks. We saw that food records were inaccurate and were not filled in at mealtimes, which meant that staff could not monitor people's fluid intake. We found that there was evidence of significant weight loss in the people living in the service, and people told us that they were hungry. We found that people who required specialist diets did not receive these.

We found that the equipment in the service did not meet the needs of the people living there.

There were no processes in place to monitor the performance of the service or to maintain accurate records of the care which was being delivered. We found that there were no records for accidents and incidents, and that records were filled in retrospectively which made them inaccurate. We found that there was no effective leadership within the service.

There were not enough staff to care for people safely and to meet their needs. We found that the staff were not well trained and were not competent in all areas of their roles. We found that staff were tired as they were working long hours..

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

Summary of findings

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 or 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.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

The service did not have sufficient staff on duty to safely care for people.

The service did not manage medicines safely and people were not receiving their medication as it had been prescribed.

The service did not recognise when people were unwell, and did not act in a timely manner or report safeguarding incidents.

Inadequate

Is the service effective?
The service was not effective.

Staff were not adequately trained to meet people's needs.

People's mental capacity had not been assessed and there were unlawful restrictive practices in place

People were not given enough to eat or drink, and there were no accurate records of people's food and fluid intake.

The provider had not sought consent from the people living in the service for care to be provided.

Inadequate

Is the service caring?
The service was not caring.

The service did not recognise the diversity of the people living in the service and made no provision to respond to individual needs.

People were not involved in any aspect of their daily lives, there was no consultation with people living in the service about their care and support.

Staff lacked knowledge of how to support people's dignity; as a result people's dignity was not maintained.

Inadequate

Is the service responsive?
The service was not responsive.

People did not have person centred care plans. Care plans were not put in place in a timely manner and were not usefully reviewed regularly.

There were insufficient activities to occupy people who lived in the service

We saw that there were people who did not come out of their rooms and were socially isolated.

Inadequate

Is the service well-led?
The service was not well-led.

Inadequate

Summary of findings

There was no effective leadership in the service and there had been no regular manager since March 2015

Staff felt that they were unsupported and undervalued and were working very long hours

There was no evidence of quality monitoring taking place in the service since March 2015 and consequently failings were not being identified or acted upon.

Cowlersley Court Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 14, 15 and 19 October 2015 and was unannounced.

The inspection was carried out by two adult social care inspectors and a specialist advisor on days one and two and one adult social care inspector on day 3 . On day one we were accompanied by 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. The expert had a particular knowledge around care for older people who were living with dementia.

Prior to our inspection we had received information of significant concern from the local authority contract monitoring team and the local authority safeguarding team. We also spoke to other agencies who worked with the service to gather further information; these included Environmental Health officers, Infection Control officers, District Nurses and Social Workers.

During our inspection we looked at the care records of 18 service users, the medication administration records for all service users, weight records, bathing records, complaints file, incident and accident files, three staff recruitment files, all staff training records, staff rotas and handover records. We asked to see audits of records, the provider told us these had ceased in March 2015 for most processes, but was able to produce some for medication and weight management. We spoke with all the people living at the service, some of their relatives, a dietician, district nurses, social workers, nine staff members and all members of the management team.

Inadequate

Is the service safe?

Our findings

People told us 'Staff haven't got a lot of time to talk because they are so busy, there is not enough staff.' I'm not sure what my medication is for". 'They could do with more staff.'

Relatives told us, 'We have nothing good to say about this home it's frightening.', 'Medication is a big issue, I have made complaints about the medication not being on time' 'When we come most of the staff are outside smoking and we are the only ones in here.'

We saw that there were not enough staff to safely meet the needs of the people living at the service, and that people were moved between rooms depending on the time of day and were not allowed to exercise choice as they were not asked where they wanted to go or where they wanted to sit when they ate their meals, the only exception to this was one person who refused to leave the lounge, and was served their meal there on day one of our visit.

On the first day of our inspection we saw that people were taken into the dining area from 11:30 onwards and were left sat at tables without any staff being present for long periods. We saw there were arguments taking place between people who were living with dementia and there were no staff to intervene or distract people from this behaviour. The inspection team remained in the dining area and chatted to people. At 12:35 we raised this with the current manager that people had been sat at the tables for over an hour and were becoming agitated, upset and had been unsupervised throughout. The manager said they would chase up lunch. The meal was not served until 12:52.

A member of staff told us 'the home has changed so much, in a bad way. People are not being kept safe, partly because we are short staffed and partly because some of the staff are lazy and are slow carrying out tasks.'

We spoke to the area manager and current manager about our concerns about current staffing levels and the hours that staff were working. We expressed that staff appeared visibly tired and were telling us that they were working long hours. The area manager said that staff 'were not working much above their contracted hours.' We looked at staff rotas. The records showed that most staff were working increasingly long hours and up to 72 hours in one week. The area manager did not accept that this was the case despite being given examples.

A member of staff who did the staff rotas, told us the service were increasingly reliant on agency staff. This was because staff who had left were not replaced. They said that there had been five staff who worked days who had left and not been replaced, and two staff had moved to another home in the group. We asked about current recruitment activity to replace staff that had left, the area manager said that there was only one member of staff being recruited at present.

All the staff we spoke with told us that the staffing levels were 'ridiculous' and that having to work so many hours was having a negative impact on staff, as there was not time for breaks during shifts. Staff described that this had led to staff becoming ill and being 'snappy'.

Staff told us that they did not have time to do what they needed to meet people's needs, and gave the example of taking a to the shops, which was part of their care needs. This meant that this person wandered around the grounds constantly as they had not been able to go out.

This is breach of Regulation 18 (1) staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A member of staff who carried out domestic duties in the home, said that they were supposed to work 25 hours per week but had to do more as they are the only domestic employed at present. They said the laundry person did some cleaning on their days off and that they did not clean the conservatory or the dining room unless they were asked to do this as an extra duty. We saw food on the floor in the conservatory on two days of our inspection. People are served their tea in the conservatory. This means that the room was not cleaned as part of the daily schedule of cleaning, which increased the risk of infections occurring and spreading.

This is breach of Regulation 12 (2) (h) safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with staff who told us they did not have up to date training in safeguarding. We saw that staff did not recognise the signs of abuse within the service. At the end of each day of our inspection we requested that safeguarding issues we had identified be reported to the local authority safeguarding team, to ensure that these concerns were correctly investigated and safeguards put into place to protect people from harm.

Inadequate

Is the service safe?

This is breach of Regulation 13 (1) safeguarding from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that there were very few risk assessments in place and the ones which did exist were out of date and inadequate to protect people from preventable harm. We saw that there were no moving and handling plans or risk assessments and that there were unsafe moving and handling practices taking place, which put people at risk of serious injury.

We saw one person repeatedly attempted to mobilise independently without their walking aid as the equipment was out of reach and there were no staff to assist them. We had to intervene with this service user repeatedly over the first two days of our inspection. We saw that this person had sustained a fall on the evening of the first day of our visit, this was caused by them mobilising without support and resulted in a head injury which required medical treatment at the hospital.

This is breach of Regulation 12 (1) safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that people's human rights were not protected as people were restricted in their movements and were given little choice in their daily activities. They were not given access to drinks of snacks other than at prescribed times. People were not able to take themselves to the toilet as they did not have the aids which allowed them to do so.

This is breach of Regulation 10 (1) dignity and respect of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the processes the provider had in place for the safe ordering, storage, administration and disposal of medicines within the service, and we found that these were not safe.

We saw that there were large quantities of drugs stored in a cupboard which had been ordered unnecessarily, these were mainly paracetamols and other pain killing medicines. We saw that there were gaps in the medication administration records, which meant that it appeared that people had not been given their medication as prescribed.

The amounts of medicine in stock did not match the records, which meant that it was not possible to identify whether medication had been missed where there was no signature.

We saw that where people had been prescribed as and when needed (PRN) medications there were no protocols in place to tell staff how and when this medication should be given and there was no information in care plans to support the administration of these medicines. We saw that stocks of PRN medications were shared between people and were not given from their own specified supplies. We found discrepancies of over 100 tablets between the number in stock and the number the records showed should have been in stock. We saw that people in the service were in pain and we heard people complaining of pain. There was a large incidence of PRN pain killers being recorded as not required or refused by service users.

We saw that a service user had been prescribed antibiotics on 13 October 2015 and these had not been available to give the service user until the evening of the following day. People who had been prescribed antibiotics did not have short term care plans in place to show how this was to be given and for how long the treatment was to last.

We looked at the controlled drugs records and stocks. We found that there was a large bottle of liquid morphine which had a dispensed date of February 2015, there was no record of this medication in the controlled drug book.

We saw that medications which needed to be given a specified time before food to be effective were being given with food, and time specific medication was not being given at the specified times on a regular basis.

We saw there were no photos to identify some people on their medication records which meant that in cases agency staff could be administering medications with no way of verifying the identity of some of the people.

The cupboards where medicines were stores were kept unlocked. We were told that they were going to have new locks fitted later that week.

Whilst we saw that some medication storage temperatures had been recorded and were within the recommended temperature range from manufacturer's instructions, however some were recorded on loose pieces of paper and some months were missing.

Inadequate

Is the service safe?

Some people who were prescribed creams and lotions had body maps which showed where to apply the cream, this was not consistent and there was no care plan to support the body maps which were present. There was no process for staff to sign to show that the creams had been applied. Some of the creams we saw that had been left in people's rooms were out of date and it was unclear when they had been opened as this had not been recorded.

We saw that there were boxes and bottles of medication, including eye drops in the drugs trolley that had not been dated when they had been opened, this made it impossible to accurately audit stock levels. Some of the medications we saw in the trolley were dated as being dispensed by the pharmacy months previously.

There were no instructions for people who required thickened fluids. This meant that staff were not aware of their needs and did not thicken fluids, which increases the chances of these people choking or inhaling liquids, which can lead to infections.

There was not a clear system for re-ordering medications. The number of in stock mediations were not always added to the following months medication administration record sheets. This meant that there were discrepancies in the records of how much medication was in stock at any given time.

There was not an up to date authorised signature list for medication administration. Old staff were still on the current list at the front of the medication folder. This meant that if there was a discrepancy the signature of the person may not be identifiable.

We saw that there were Tramadol tablets in the medication trolley. This medicine should be stored in the controlled drugs cupboard as the category for this medicine changed in 2014.

This is breach of Regulation 12 (1) safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that there were two rooms in the service which were being used for storage, neither of these rooms were locked and had furniture and other equipment stacked unsafely within them. This was a health and safety risk as they were accessible to people who lived in the service.

This is breach of Regulation 15 (1) premises and equipment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked to look at the accident and incident records for the service. There was no evidence that this information was analysed or that there was any actions taken to reduce risks to people based on lessons learned or that there was any service improvements which resulted from the results of any analysis.

We asked to see the incident forms for an incident which occurred on the evening of 14 October 2015 and another incident which occurred on the morning of 15 October 2015. Despite numerous requests during our visit on 15 October, these forms were not available to us, as they had not been completed. The forms were supplied to us on 19 October 2015. The forms were both factually inaccurate as they had the wrong dates, and the version of events recorded did not match the verbal accounts we had received from staff during the inspection. This showed that the service was not maintaining accurate records of incidents.

This is breach of Regulation 17 (1) good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

The cook told us 'I know the residents likes and dislikes the residents have fresh fruit every day.' We did not see any fresh fruit in the service or being served to people throughout any of the days of our inspection. The cook also said 'The dish washer doesn't work properly , the fan is broken and we have no boiler I have to boil kettles all the time. I feel I need more help.'

We spoke with a member of agency staff who was working in the service and asked if they had received any induction before starting their shift, they told us 'No, but I have seen where the fire extinguishers and exits are.' The member of staff confirmed that they had not been given a handover or list of people's needs.

Staff told us that they had not had any training in the Mental Capacity Act (MCA) 2005, or in Deprivation of Liberty Safeguarding, which meant that staff did not understand legislation relating to protecting people's human rights when they did not have capacity to make some decisions for themselves. Staff told us that until the current manager had started three weeks previously, they had not been aware that training was mandatory, and believed it was optional. Another member of staff told us they had been trained to 'do most medications' and that they had been training as a senior care worker, but that they work they had done was not being documented.

We asked the provider to give us evidence of the training which had been carried out and that staff had been given adequate training to have the knowledge and skills needed to carry out their roles safely. This evidence was not provided.

We were told by staff that they were not receiving supervision or appraisals and that this had been the case for a long period. Staff told us the previous registered manager used to ask staff to put in writing what they wanted to discuss and the registered manager responded in writing. Supervision is an essential process, as this allows staff to discuss any concerns with their line managers and for the manager to remind staff of policies, procedures and best practice as well as addressing any performance issues and praising achievements.

A new member of staff told us they had received no training or induction since joining the service a month before and that their training was from a previous employer. They said they had not received any support from management since they had started.

Another member of staff told us that there had been two agency staff who had been barred from working at the service due to medication errors recently. Staff said that the medication training was not adequate and consisted of a book which staff read and filled in and observing a senior care worker to do the medication round. There had been no competency checks carried out.

This is breach of Regulation 18 (1) staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that whilst there had been some mental capacity assessments carried out , the assessments were from August 2014, and contradicted other information which was recorded about the individual. For example we saw that a person had restrictive practices put in place in February 2014, which recorded that the did not have and would not regain capacity. There was then an assessment of their capacity carried out in August 2014 which said they had capacity to make decisions.. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom

We saw that there were unlawful restrictions in place for service users. These included being kept in bed, and restricted to their rooms. These restrictions were unlawful as the correct processes had not been followed to assess people's capacity to make decisions, to carry out best interest decision processes which give families and other agencies who are involved in the person's care to discuss what is the best option fairly.

There were no deprivation of liberty safeguards in place for any of the people who were nursed in bed, all of whom were living with some level of dementia.

Inadequate

Is the service effective?

We saw that in all the care records we looked at there was a consent form. This asked for consent to take photographs and to be able to take out for trips. There was no section on the form asking for consent for personal care to be delivered.. This meant that there was o consent to care was not been being gained.

This is breach of Regulation 11 (1) need for consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some of the people we spoke with told us they were hungry. We looked at weight records for people and found that there was evidence of wide spread weight loss across the service.

We observed lunch service on two consecutive days and saw that food was served pre-plated and arrived with gravy without a choice being offered. There were no condiments available to allow people to add these if they wished. There was a choice of two hot meals at lunchtime, and a member of staff went round with a list in the morning to record which option people chose. There was a choice of blackcurrant or orange squash with meals. There was no option for a hot drink or water.

We saw that food was not always hot when it was served, this was evident as it was brought into the dining area with plastic plate covers, and there was no condensation on these. We heard a service user comment 'at least it's warm today' during lunch service on day two of our visit. We heard another service user say of their pudding 'it's awful, it's cold and the custard is lumpy.'

We saw from care records that there were people who required specialised diets, these included diabetic and gluten free. We looked at the food and fluid records for these people and found that there dietary needs were not being met. In the case of the person who needed a gluten free diet we saw that they were being given the same diet as the other service users, the only exception was that they used gluten free bread to make their toast. The people who were diabetic were being given puddings each day on at least two occasions which was not suitable for people with diabetes.

We saw on the second day of our inspection that during the morning drink round, people were asking for more biscuits as they were hungry, they were told by staff that they could not have more as they did not have any, and the shopping was not due until the following day. We discussed this with the area manager, and looked at the food store. We found that there were no snack food items available to people in the service including biscuits. We asked that this be rectified immediately.

We saw in people's care records that they needed dietary supplements, fortified diets and nutritious snacks to be available at all times. Another care record said that the service user was unable to eat large meals and needed to 'graze' throughout the day. These needs were not being met.

This is breach of Regulation 14 (1) meeting nutritional and hydration needs of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that staff were not always recognising when people were unwell, we raised concerns about the current health of 10 people during the course of our inspection. We saw people who were flushed and confused, and lacked appetite, there had been no referrals made to their GP's. We saw that people who had issues with their swallowing and chewing had not had referrals made to the relevant specialists.

We saw that people who needed assistance to eat who were confined to their beds were not adequately sat up and were fed large amounts from spoons. This posed a significant risk of choking and inhaling food, which can cause chest infections, this had been the case for one person who had become unwell and been prescribed antibiotics for a chest infection

We saw that some issues which were recorded as part of staff handovers between shifts were not being followed through, which meant that there were delays in medication being ordered and visits from district nurses and GP's being requested. We did not see any formal handovers being undertaken during shift changes on any of the days we visited.

We saw one person who had been admitted to the service in August 2015 had records which showed that they were diabetic. We had seen no evidence of this need being met in terms of diet. When we asked the provider about this we found that they had not acknowledged this condition and consequently had not recognised the needs of the service user for a period of three months.

Inadequate

Is the service effective?

This is breach of Regulation 12 (1) safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service caring?

Our findings

A relative told us, 'Today they are handing out biscuits with tongs and a plate that's a laugh. Normally they get the biscuits given to them by hand no plate they just put it on their lap.' and 'Mum's clothes are dirty and she looks bedraggled.'

A care worker told us on the first day of our inspection that a particular person was assisted to the toilet every 30-60 minutes. We saw that this was not the case and that the service user was left without assistance for long periods. We also saw that this service user was not able to communicate their needs, so would be unable to summon staff to assist them.

We saw that staff were rushing around which meant that they did not have time to interact with people living at the service. Staff told us they were tired. Staff told us being tired made them 'snappy' with each other, people who use the service and that they did not have the time to do a 'good job'.

We did see some examples of positive caring interactions between staff and people during our inspection, however we also saw that people were frequently ignored and people who were upset and distressed were not offered comfort. For example we saw a person who remained in bed was repositioned by two staff members, this person was crying and calling out as the staff left and was left in this distressed state. This was raised with staff who we asked to attend to the person.

We saw that whilst some staff knew some of the people well, and that they attempted to share jokes with them, this was not always appropriate and left people feeling confused and upset. For example we saw two members of staff who had been assisting a person laughing as they left, the person had not understood what they staff were laughing at and was upset by this.

We saw staff talking about the needs of people openly in the presence of other service users, which was a breach of confidentiality. We saw staff who were talking amongst themselves whilst giving assistance to people, rather than speaking to the person they were assisting.

We saw confidential records were left unattended in the lounge on one occasion during our visit.

This is breach of Regulation 17 (1) good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that when people were in need of assistance to eat their meals, that staff did not ensure that they were in a comfortable upright position, and they used a spoon which was much too large and had large amounts of food offered at each presentation.

We saw that staff did not interact with people during assisting them to eat other than to give them instructions.

We saw that people who lived at the service were not involved in making their own decisions through the day, and that people were moved from room to room for meals, rather than being given a choice of where they spent their time. For example there was a person who had been brought to the table for lunch on the first day of our visit, they were very unhappy with where they had been sat. We asked them what was wrong and they told us they liked to stay in the lounge to eat. When we asked staff about this they told us 'they do usually sit in the lounge, but they get food all down them, so we have brought them in here.' This showed that people's preferences were not taken into account and their dignity was not respected.

We were told that there were two people who were on end of life care and were cared for in bed. We saw that there were positioning charts in their rooms and that they required re-positioning hourly. We saw that staff were not carrying out these tasks, which meant that people were left in the same position for long periods. Assistance with their personal care should be offered hourly,. We found that this was not the case and people were being left wet and uncomfortable for long periods. The people who were at the end of their lives were not able to use their call bells to summon staff if they needed assistance.

We saw that there were repeated issues with people not being assisted to the toilet in a timely manner and this lead to people wetting themselves and being left in wet clothes for long periods. We asked staff to assist people repeatedly throughout our visit and found that staff were slow to respond to people's needs. On one occasion a person needed to use the toilet and pressed their buzzer, a staff member came and said they would bring the walking aid. The staff member did not return. The person was calling out in pain and distress and saying they were going to wet themselves. This was raised with the manager who sent

Is the service caring?

another member of staff, who brought a walking aid. The staff member then proceeded to clear dirty mugs from the room before assisting the service user. The service user had by this time wet themselves and was very upset. The walking frame which was brought was not the correct one, which the person told the staff member, who insisted they use it anyway. The person was able to get up and mobilise independently using the equipment. This incident showed a disregard for people and their dignity and privacy.

This is breach of Regulation 10 (1) dignity and respect of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that people at the end of their lives were thin and had suffered significant and sustained weight loss, and that they had or were developing pressure areas as a result of the lack of re-positioning and their frailty. We saw that the airflow mattresses which are put in place to reduce the risk of pressure areas developing were not being used correctly and that they were set to support someone who weighed 120-180kg in weight. In all cases the people who were being supported were less than 50kg in weight.

We saw that staff were not recognising when people were showing signs of being unwell. On the second day of our visit after sitting with people in the dining area we identified five people who were displaying signs of being unwell. When we raised our concerns to the provider and asked if any action had been taken, we found that none of these concerns had been raised by staff and no action had been taken. We asked that referral be made for a GP visit in all cases.

This is breach of Regulation 12 (1) safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke to told us that they were not kept informed of what was happening in the service or in terms of their own care. None of the people we spoke with had ever seen their own care plans, and told us they had not been involved in their creation.

We saw that people were not supported to be independent in the service. Throughout our visit we saw that people who were able to mobilise independently were restricted from doing so as their walking aids were moved out of their reach when they were sat in the lounge or the dining area. This meant that people were deprived of their ability to move around the service even when they were capable of doing so without needing assistance from staff.

Inadequate

Is the service responsive?

Our findings

A relative told us ' We don't get to know what goes on here the staff seem ok and friendly, they (service users) could do with more outings and activities there is no stimulation.' and 'we have never seen a care plan.'

We reviewed the care records of 18 people who lived at the service. In every case we found that the care records did not reflect the current needs of the service user. We found that people who had recently been admitted to the service (May and August 2015) had not had an in depth care plan written . The only records for them were very basic respite care plans. In one case we found that the information which was in the care plan had not been used in the person's care provision, as there were three separate references to a significant medical condition which staff were not aware the person was living with, and therefore no provision was being made to ensure there specific needs were met.

The care plans which were in place were not accurate, did not reflect any preferences of the people and were contradictory. For example we saw a care plan which said the service user was doubly incontinent, but then later said that they would call staff to assist them to use a commode. We saw care plans for people who were cared for in bed which clearly stated that the person was sat in the chair for periods each day. There was no information in the care plans to evidence why people had been restricted to their beds.

We saw that whilst there were entries for the review of care plans, there was no evidence of changes being made to the care records to reflect current needs and changed circumstances. We saw that where there had been significant changes to needs and directions from medical professionals to change how someone was cared for, these changes had not been made to the care plans. For example, there was a person who had been insulin dependent, this has been changed in July 2015 according to other records which stated they had been prescribed tablets to control their diabetes at this time. Their care plan however still instructed staff that this person was to be given insulin.

We saw that there were no activities carried out during our inspection and people told us that there were very few activities. We saw that whilst there was a television in the main lounge people were not engaged in watching it. We did not see any evidence that people were given any choice or control about what was on the television. The television was very loud and made undertaking any conversation in the room difficult. The member of staff who had been recruited to carry out activities told us they were only allocated six hours per week for activities and these were not being used for activities as they were so short staffed. They told us that they had been working in their own time at home in an attempt to plan activities.

We saw that there were televisions in the rooms of the people who were cared for in bed, these were playing music at all times. We asked staff why this was and had the people expressed a preference for their to be music playing, staff told us they did not know and it was always on.

We saw that there was a radio in the dining area, which was on constantly. The programme which was on during a period we spent in the dining area was discussing political issues and was not of interest to any of the people who were in the room when we asked them.

We saw that there were five people who were in their rooms for all or the majority of their time. We saw that there was very little interaction with these people from staff and other service user's did not interact with them despite their doors being left open at all times other than when personal care was being delivered. This meant that these people were very isolated and spent the majority of their time alone and without social interaction.

We saw little evidence that people were able to express their individuality, for example we saw that service user's asked for a drink, they were told they would need to wait for the next tea round. There was no access to drinks for people who wanted to have one between these times. This was also the case for snack foods. We asked the provider to ensure that there were drinks and snacks available at all times.

This is breach of Regulation 9 (1) Person centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we checked the complaints file we saw the last recorded complaint was from early 2014.

Inadequate

Is the service responsive?

A family member told us they had complained about their relative not getting their medication at the correct times as this affected the symptoms which the person suffered. We could find no record of a complaint being raised for this matter.

This showed that the provider was not recording and dealing with complaints adequately and was a breach of Regulation 16 (1) receiving and acting on complaints of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

A member of staff told us 'The registered manager asked me to lie about the boiler to say there were kettles in the kitchen when there was not. There is no staff support and the staff are stretched to the limit.'

A member of staff told us 'the (registered manager) was the worst manager I have ever been under'.

A service user's relative told us 'I think the home is going down hill. Mum's fingers are dirty with faeces. There is never any staff in the lounge and I don't know who the manager is, there have been quite a few managers recently.'

There was a registered manager for the service at the time of our inspection, however they had moved to another service and were not present during any of our inspection. Staff feedback was very negative in respect of the conduct of this manager.

We were told by staff that the registered manager had taken staff with them to the other service and left the home to use agency staff. They said that things 'had gone downhill since then.' This showed that the senior management team had not given due consideration to the impact these actions would have on people who lived at this service when managing their resources.

We saw that there was no leadership evident in the service throughout our inspection. The manager was in their office upstairs throughout the day and was not accessible to staff as staff would have had to leave their duties to speak to the manager.

Staff all told us that there had been no consistent management in the service and this has created a negative culture within the staff team as they feel they are being expected to work long hours, are criticised when mistakes are made but they have not been given the training or support to enable them to carry out their roles. Staff said that they felt undervalued and overworked.

We did not see any evidence of regular staff meetings, staff forums or staff satisfaction surveys being carried out as part of the communication between the provider and their employees. Staff reported that when staff meetings had been in place with the registered manager they felt that they were very negative and unproductive.

There was no evidence of team work within the service, staff were all working independently and there was little communication taking place across the staff team. This meant that staff were not aware of what care had taken place and there was no discussion about how best to use the available staff to meet the needs of the people in the service. For example at lunchtime on the first day of our inspection 3 members of staff asked the same person the same question in the space of 10 minutes, this confused the person who was living with dementia.

During the inspection when we raised concerns to the senior care worker, manager and area manager, we did not feel that they were accepting responsibility for the failings, yet they expected care staff to be accountable. For example when we raised issues where staff had completed records inaccurately there was no action taken to investigate this, the manager's felt that the staff should have taken responsibility in completing them correctly. This showed that the management of the service was not taking appropriate action to identify where accountability lay for actions taken by themselves or their staff and making sure that measures were put in place to ensure future improvements.

Staff said that staff meetings had not been useful as staff could not raise issues as they were not kept confidential and the registered manager took things out on the staff concerned.

We found that no audits had been carried out since March 2015 across most systems in the service and the auditing which had been carried out in terms of medication and weight loss monitoring was not effective. We found that issues that had been identified had not been actioned and there was no record of any follow up or changes to processes and systems to mitigate the risk of further occurrences of these issues. We saw one example of a weight loss audit which showed significant weight loss for a service user which had been recorded as 'intentional' by the registered manager. When we checked the records for this service user we found that they had significant mental health issues. This meant that the registered manager had not taken into account the person's capacity and action should have been taken to safeguard the person from harm.

We saw that there was little evidence of good quality care, and that records were inaccurate and often filled out retrospectively. In some cases records were completed by

Inadequate

Is the service well-led?

staff who had not given the assistance. We saw that there was no method for information to be recorded at the time of care delivery. For example we sat with a group of people on the second day of our inspection over the lunchtime period and recorded what and how much they ate as we had concerns about their well-being and weight loss. When we looked at the records completed by staff later in the day we found that none of the records matched our first hand observation, to the extent that the wrong main course had been recorded in three out of four instances.

We saw no evidence that there were systems in place which monitored the quality of the service. The area manager told us on the first morning of our inspection 'I can tell you the care plans are no good before you look at them.'. This showed that the senior management team knew that the service had inadequate care records, we saw no plans that had been put in place prior to our inspection to address these shortfalls.

The area manager told us that they 'had questioned staff' about a moving and handling technique they witnessed them performing. This was in relation to a drag lift being used, which is not allowed and poses significant risk of harm to both service user and staff members. There was no record of this incident and we identified that this practice was still in use during the third day of our visit which was after this date. This showed that the senior manager had not taken adequate actions to ensure the safety of the person .

This is breach of Regulation 16 (1) safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A member of staff told us that the management of the service had been 'awful', and said that they had met the owner only once and they made them feel belittled. The staff member told us the owner had told staff 'if you don't like it there is the door'.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9 HSCA (RA) Regulations 2014 Person-centred care** **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 9 (3) (b) Person Centred Care** **Care needs were not being met as there had been no recent assessments of people's needs and there were no up to date care plans. People were not involved in decision making about their care and there was no reflection of their preferences in their daily care.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Regulation 10 HSCA (RA) Regulations 2014 Dignity and Respect** **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 9 Dignity and Respect** **People were not treated with dignity and respect. Staff failed to recognise when people's dignity was not being protected and promoted.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Regulation 11 HSCA (RA) Regulations 2014 Need for Consent** **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 11 Need for Consent**

This section is primarily information for the provider

Action we have told the provider to take

People were not asked for their consent in relation to the care which was being given. There were no mental capacity assessments and there were no DoLS in place for the all but one service user who required one.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12 Safe care and treatment. Medication was not safely or routinely given to people as it had been prescribed. There were no risk assessments in place to mitigate risks to people. Measures were not in place to protect people from the spread of infection.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 HSCA (RA) Regulations 2014 Safeguarding peoplefrom abuse and improper treatment. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation Safeguarding peoplefrom abuse and improper treatment. Staff did not recognise safeguarding incidents and the provider was not make safeguarding referrals to the Local Authority or CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs.

This section is primarily information for the provider

Action we have told the provider to take

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 14 Meeting nutritional and hydration needs.

People were not sufficiently well hydrated. Records of food and fluid intake were not accurate. Special dietary needs (i.e. diabetic) were not being identified and were not being met.People were hungry and there was widespread and significant weight loss.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 9 Premises and equipment The equipment in the service was not appropriate to the needs of the people who were being assisted using the equipment. There were rooms with stacked equipment and furniture which were accessible to people living in the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 16 Receiving and acting on complaints. The service were not recording, acting on or responding to complaints appropriately or in a timely manner.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA (RA) Regulations 2014 Good Governance Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17 Good Governance There were no processes in place to ensure that accurate records were kept in relation to the care which was delivered. There was no evidence that auditing was taking place in the service. The service had failed to identify areas of failure which were putting people at risk.
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 HSCA (RA) Regulations 2014 Staffing Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 18 Staffing There were not enough staff to safely meet the needs of the service users. Staff were not well trained and did not have the skills needed to fulfil their roles. Staff were not competent in some areas of their duties. Staff were working very long hours.