Golden Age Management Limited

Attwood's Manor Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected this service on the 6 and 9 September 2016. The inspections were unannounced. The purpose of the second inspection was to talk to night staff and to establish if there were enough staff on duty at night to meet people's assessed needs.

We last inspected this service on the 11 May 2016 to follow up on areas of concerns raised by a whistle blower and to follow up on a number of incidents the service had not told us about. This was a responsive inspection to assess the safety of people using the service. The service was rated requires improvement in safe and a number of breaches of regulation were identified.

In the last eighteen months we have inspected this service on a number of occasions including on the 14 December 2015 when we found the service required improvement in every key area. In addition we identified three breaches of the regulations. We also inspected the service on the 25 November 2015 because we received concerns about people not receiving their medicines safely. We judged that the service was inadequate in the way in which medicines were managed. Following this inspection we placed two sets of conditions on the providers registration, firstly to prevent further admissions until such time as people were safely receiving medication and secondly to require that the provider made improvements to the administration of medication. When we inspected the service in December 2015 we found they had made improvements in terms of their medicines management and we agreed to allow the service to accept new admissions by removing this condition.

There is currently no registered manager at the service but an interim manager has been appointed in the last four weeks and said they would apply for registration with the Care Quality 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 service is registered for 65 people and had 49 people residing at the service at the time of our inspection with two people in hospital.

Before this inspection we were aware that the Local Authority were investigating a high number of safeguarding notifications, a number were raised by ourselves during the last two inspections to the service. The Local Authority are closely monitoring and supporting the service to help them improve and keep people safe. Whilst the service implements the changes the Local Authority have placed an embargo on the service which means the Local Authority will not place any one there which they fund.

During our inspections on the 6 and the 9 September 2016 we met with the new manager and discussed some of our concerns with them and the provider who is there most of the week. We found the following: The service had sufficient staff based upon its own assessment but not all demonstrated a sufficient

understanding of people's needs. People did not always receive timely care which we attributed to the poor organisation of the shift and delegation of duties. We had concerns about recruitment practices and how robust they were. This was a particular concern with agency staff members.
Staff received training to help them to be effective in their role but this was not sufficiently robust and staff were not effectively supported to develop and reflect on their practices to adequately meet the needs of people using the service.

The service was not effectively managing people's needs in terms of their health and safety. We saw poor documentation and inadequate staff's response to the identification and management of people's health care needs.

Medicines were poorly organised and poorly managed which meant we were not always assured people would receive their medicines as required.
Infection control practices required improvement there were areas of the home which were unclean and mattresses were not always fit for use.

Staff had some understanding of legislation relating to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberties Safeguards (DoLS). The MCA ensures that, where people have been assessed as lacking capacity to make decisions for themselves, decisions are made in their best interests according to a structured process. DoLS ensure that people are not unlawfully deprived of their liberty and where restrictions are required to protect people and keep them safe, this is done in line with legislation. We found people were restricted and could not move freely within the care home and its grounds. People were supported to make decisions but the rational for some decisions were not always clearly documented. There was no system in place to ensure that people who do not want to be resuscitated can be easily identified in case of an emergency.

People were not adequately supported with their diet and we were not assured staff always acted on the advice given by other medical health care professionals which potentially put people at risk. People were monitored in terms of their food/fluid intake but this was not evaluated and acted upon when necessary.

People's health care needs were not being met and not being adequately monitored to ensure people got the right support. For example people at risk of unplanned weight loss were not being closely monitored.

We found staff caring but also found staff did not have enough time to recognise individuals needs and provide care in a way which was individualised and responsive. This meant people's emotional well- being was not always met and people's physical care needs were not always responded to adequately. This in turn did not uphold people's dignity or promote their well- being.

The service has a range of different activities to try and help keep people occupied and stimulated. However this is insufficiently planned for and people are not getting their individual needs met.

Pre admission assessments and care plans poorly describe people's needs and risks are not adequately evaluated. Not everyone was consistently given an assessment of their needs before moving into the service with a corresponding care plan developed. This resulted in compromised care for some.

Recent changes in the management team have occurred but it is too early to judge how effective this will be. We have found a sustained history of non-compliance with this service which we attribute to poor processes in place to identify, assess and monitor the quality of the service provision. Stability in terms of the management of this service and staff retention has also been a contributing factor. Given its previous

history, current information of concern and repeated breaches we have rated the service overall as inadequate.

We found multiple breaches of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014 in multiple regulations. You can see what action we told the provider to take at the back of the full version of this report.

Following this inspection the overall rating for this service is 'Inadequate' and the service has been placed 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 the 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.

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.

Not all staff were sufficiently familiar with people's needs and despite there being an increase in the number of staff on duty, people did not always receive effective, timely care.

Risks to people's safety were not well managed.

Staff were aware of how to safeguard people in their care and how to raise a concern if they suspected a person to be at risk of harm or actual abuse. However they were less aware of outside agencies who would also have a responsibility for safeguarding people. Staff were unable to recognise poor practice within the service.

Medicines were poorly organised and managed which increased the risk of people getting the wrong medication

Is the service effective?

Inadequate

The service was not effective.

People's capacity to make decisions was assessed but only in relation to day to day tasks. More complex decisions were not recorded or how best interest decisions were being made. People had their liberty routinely restricted without the relevant approvals in place.

Staff were not effectively monitoring what people were eating and drinking or referring people to the GP or other health care professional when required. People were satisfied with the food they were provided with but not everyone received sufficient or timely support with their meals.

People's health care needs were not responded to quickly enough and there was inadequate monitoring of people's needs.

Is the service caring?

Requires Improvement

The service was not caring.

Staff worked very hard and a number of staff's practice was observed to be positive. However staff had insufficient time to meet people's needs in a timely, holistic way.

This in turn meant people's independence and dignity was not always upheld and contact time was limited.

People were asked about their care needs but there was limited evidence of how people were able to contribute to the overall service delivery and effect change.

Is the service responsive?

Inadequate

The service is not responsive

Activities are provided but they are not organised and planned around people's individual needs.

People's care is not properly assessed and planned for which means staff are not always identifying or responding in a timely way to changes in their needs.

Is the service well-led?

Inadequate

The service was not well managed.

There was no effective leadership or deployment of staff.

There were poor systems in place to judge the effectiveness of the care provided which would ensure people's needs were being met.

Health care needs and risks to people's safety were poorly monitored and managed.

Attwood's Manor 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 the 6 and 9 September 2016 and was unannounced. It was carried out on the first day by two inspectors, a specialist advisor who was a qualified general nurse 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. An inspection manager also accompanied the first inspection. A second day of inspection was undertaken with the lead inspector and the specialist advisor.

Before the inspection we looked at the information we already held about the service including notifications which are important events affecting the safety and, or well-being of people using the service. We reviewed our previous inspection reports. We reviewed information received from the provider in relation to action taken following safeguarding meetings.

During our inspections we observed the care being provided to people. We spoke with 25 people, f our visitors, and 18 staff including the provider, the acting manager, care staff, the housekeeper, activities co-ordinator and a chef. We looked at a number of records including eleven care plans, staff recruitment and training files and other records relating to the management of the business.

Inadequate

Is the service safe?

Our findings

At the last inspection on the 11 May 2016 we found there were enough staff on duty on the day of our inspection but staffing rotas indicated this was not always the case. We had concerns about the skills mix and the competence of some of the newer and temporary staff. We identified a breach of Regulation 18 as there were not always enough staff sufficiently familiar with people's needs to deliver safe and effective care. At our previous inspections we had also raised concerns about people having insufficient attention and stimulation to help them maintain their well- being.

During this inspection we continued to identify concerns in relation to the skill mix and competence of the staff. The use of temporary staff did not enhance the level of care people were receiving as they were not familiar with people's needs and had very little training or experience for the role. People were not given enough attention or opportunity to take part in planned activities There were missed opportunities for staff to engage with people as they focussed on completing tasks. This had a big impact on people particularly as some people did not have regular visitors and relied on staff for interaction and interest throughout their day.

People commented on the high turnover of care staff which they felt impacted on their familiarity with staff. A person said, "There have been so many different carers; you get to know them and then they move on." A relative said, "The only thing we've noticed over the years is that staff change a lot." People commented on the increasing dependency of people and its impact on others; One said "It seems that there are more (people) with dementia being admitted now." Another told us, "The nurses get tired they have too much to do, but it's not a bad place."

The deployment of staff and leadership on shift was ineffective because job roles were not clearly defined and no one took control to organise the team to ensure that needs were being met. On 6 September 2016 we found most of the staff were permanent but two were from an outside agency. The agency staff had minimal experience and had no induction to the service and people living there. They were not being adequately supported or being shadowed by more experienced staff. They did not know people's needs and were observed moving and handling a person using the wrong sized sling which could have been potentially dangerous for the person. They confirmed they were not aware of the needs of the people. The manager said that she had noticed them working together and had intervened, however they continued to be observed working with no support from experienced staff.

People were assisted up in the morning and a number of people told us they had baths which they had enjoyed. They were supported to have breakfast and then assisted into the lounges. The person employed to provide activities did not start providing activities until after 11am because they were supporting care staff in assisting people to get up. This meant that most people were not sufficiently occupied throughout the morning and some people were asleep. Lunch was shortly after 12.00 pm when some people had only recently finished breakfast.

On the second day of our visit we checked if there were sufficient staff on night duty to meet people's needs.

The home had five night staff which included a senior. Staff confirmed there were usually four staff but in addition a senior member of management was in the building should they need to be called upon.

Four people were observed to need 15 minute observations and everyone else was observed at least every two hours. There were 48 people using the service at the time of our visit and three people in hospital. A number of people were near the end of their lives and required additional support to ensure they were comfortable, hydrated and pain free. Staff told us that fifteen people required two staff to assist them with their manual handling requirements. Through our observations and on arriving to the service about half the people using the service were either already in bed by 7.00pm or were being assisted to bed. Other people were in the lounges and required staff to be present, as a number were becoming distressed resulting in some minor conflicts. For example one person started to scream as they were approached by a person living with dementia and an argument broke out.

The senior on duty told us it could take up to two hours to administer the evening's medication from 10.00 pm until about 12.00pm. The deputy manager confirmed this. This meant they were unable to support care staff until after medication had finished. It also meant people were routinely being disturbed at night to be given their medicines when they were sleeping.

We left the home at 10.30 pm and there were still eleven people up. A number of people were asleep in their chairs/wheelchairs, some in a poor position, others looked visibly tired and asking to go to bed but were told they would have to wait until staff were available to take them rather than at the time of their choosing.

This demonstrated a breach of regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staff recruitment process was adequate for permanent staff; however there were shortfalls in relation to the employment of temporary staff. The leadership had not taken the necessary steps to demonstrate that those staff had been safely recruited and trained to carry out the role required.

A number of outside agency staff were working at the service. We asked the manager how many agencies they used and were told two, however, there were in fact three agencies being actively used. The manager was unable to demonstrate that the agency supplying staff had all the recruitment checks in place for it workers. They were unaware of the level of experience agency staff had or if they had the necessary skills to be employed at the service. We spoke with the agency staff and they told us they had not been in the care industry long and had limited experience and training in care

The above demonstrates a breach in Regulation 19 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in May 2016 we had concerns about how safeguarding concerns were managed by the service. Safeguarding concerns were often not identified by the service independently. We also had concerns about staff knowledge and limited communication so could not be assured all staff would recognise potential safeguarding concerns or when and how to report concerns.

Since the last inspection, we have also had concerns raised with us that the service has failed to act quickly enough or report changes in people's condition. We have met on a number of occasions with the Local Authority and safeguarding teams and had asked for assurances from the provider as to how they were learning from any adverse event to ensure the safety and well- being of people using the service. At this inspection, we found the provider still had not ensured that systems and processes were established and

operated effectively to ensure staff knew what they needed to do to prevent abuse of service users.

We spoke with staff and found their knowledge varied, some were comfortable in raising concerns and familiar with the whistle blowing policy. Whereas other staff were either hesitant to discuss this and did not fully recognise other agencies roles and who they could refer to. Staff were not always identifying poor practice with in the service and this left people at risk of poor quality of care and encouraged a culture of poor practice continuing. For example, experienced staff did not recognise the risk or attempt to stop and help the agency staff when using the incorrect sling when moving a person. Using the incorrect sling could mean a person falls during the move. Staff did receive training in safeguarding adults from abuse which was completed through e-learning with questions and answers but the training was basic and there was no competency assessments completed or checks of staff's understanding.

The above demonstrates a breach in Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in May 2016 we found risks to people's safety were not always being managed as we identified a number of gaps including: monitoring of people's skin and incorrect monitoring of air mattress settings. We also noted poor recording in relation to bruising and falls. We also had concerns about the monitoring of people's food and fluid intake.

At this inspection we found that risks to people's safety and well- being were still not well managed. We looked at the manual handling risk assessments and found that they did not give specific details as to the equipment required and there was no manual handling plan in place for people. When looking at care plans we found that there was no record stating the specific size or type of sling needed for people or instructions on how it was to be used. Therefore all staff were unable to ascertain what was required for each individual so they could ensure that they could deliver care safely.

People had been provided with pressure relieving mattresses to reduce the risk of pressure areas developing or worsening. However we found two mattresses on the wrong setting so they would be less effective in reducing the risks for people using them. There was not a clear plan in place for monitoring people's skin conditions and records showed infrequent recording of re-positioning people to avoid pressure areas becoming compromised.

Fifteen people had bedrails in place. However staff were not clear why they were in place and people's care plans did not make the rationale for using bedrails clear. The risk assessment was in a tick box format with subjects such as 'entrapment' ticked and there was no additional evidence that the risks associated with these had been fully explored. For example staff did not know if anyone had sensor alarms or mats which might alert staff when people were on the move and more likely to fall. The bedrails assessments did not explore what options had been considered and discounted in terms of keeping people safe whilst in bed.

Staff were not able to tell us who could and who could not be able to use their call bell. Most people were monitored two hourly but staff could not explain the rationale for this.

Risk assessments were very poor and did not show how risks were managed well or how staff monitored people's well- being to ensure their health needs were effectively managed. During our inspection we picked up on concerns not already identified by the service. For example a person had lost a lot of weight. Their records did not show us this was being monitored by staff and the deputy manager confirmed they had not been referred to the dietician. Unplanned weight loss was identified in other records and staff confirmed that no one was currently being weighed weekly to increase the monitoring and any subsequent

intervention. We could not see how weight loss was being adequately monitored.

One person was identified as having superficial injuries to their legs and cellulitis but this had not been identified in the person's care plan so we were unable to see what treatment if any was being given. There was no record of this on a body map, accident record or daily notes to demonstrate how this area of their care was being addressed. This was referred to the manager so they could ensure the person had input from medical professionals.

Staff were required to monitor a person to ensure they were not suffering from constipation. However the information was not recorded to help staff assess and monitor this. Staff could not demonstrate to us how they protected the person from risks associated with this condition.

The manager told us one person had a pressure ulcer, who had come into the service with it. This was subject to a safeguarding investigation. However during the course of our visit we found two other people who had pressure ulcers.

A person's record stated they were at high risk of falls. Their care plan stated that staff should, monitor their ability and report any changes. The assessment did not provide staff with sufficient information about keeping them safe and minimising the risk of further falls.

A gate across the main stair case was in place to prevent people going upstairs unsupervised. However it could easily be opened. This posed a risk to people's safety as people with more mobility could potentially open it independently. We discussed this risk with the manager on our first visit but noted that no action had been taken when we returned to the service two days later.

The above demonstrated a breach of Regulation 12 Health and Social Care Act (Regulated Activities) Regulation 2014.

A number of people had poorly maintained personal hygiene which meant a number of areas in the service had odours. For example, a number of people wearing clothes that did not smell clean and this meant that chairs had odours which were unpleasant.

During our night visit we identified a mattress was heavily stained, had been soaked with urine and was not fit for purpose. We asked the deputy manager to remove this mattress and were assured that this had been done so that the person was able to sleep on a clean bed. There were chair cushions with a strong odour stored under the stairs.

We noted that one of the bins was overflowing with used plastic aprons and gloves. The bin was unlined and there was a risk of contamination on emptying. In some people's rooms there were no toiletries for handwashing and/or no paper towels or waste bins.

Staff were not always following good infection control practice. For example we observed two staff carrying armfuls of soiled linen to the laundry. This practice left staff at risk of spreading infection via their own clothing and body. Given people using the service are mainly frail and elderly this means they are more vulnerable to infection.

The laundry was small and untidy with piles of sheets in baskets waiting to be ironed. Rails of clean clothes were placed alongside bins of soiled laundry which posed a risk of cross infection. The housekeeper had a good knowledge of infection control procedures and was currently doing a course in infection control. They

confirmed they were well supported and had ample personal protective equipment to help prevent the spread of infection.

The above demonstrated a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in May 2016 we found practices around the administration of medicines had improved since the previous inspections in December and November 2015 when serious concerns had been identified. However the improvements identified in May 2016 had not been maintained. Prior to our inspection we received a number of safeguarding concerns which have since been substantiated. These concerned unsafe medication practices which could result in significant harm to people. During our first visit on the 6 September 2016 we observed two staff administering the morning medications. The service had recently changed their medication system to a system called Bio dose where all the medicines are already dispensed into individual sealed pots. Each person had a clear plastic tray with their name and small photograph of them printed on it. The medication administration chart has a page sent with each month's medication, showing size and colour of the tablets for each person.

We observed people being asked about their medicines and if they wanted pain relief and offered their medicines with a drink. Medicines were stored securely throughout our inspection. The drugs room had hand washing facilities, but no hand soap or paper towels which could increase risk of contamination.

Controlled Drugs were not managed in line with best practice which left people at risk of poor administration. The Controlled Drug record book did not have the correct index which made it difficult to understand. Medicines were labelled and stored correctly but some controlled drugs had been prescribed for persons who no longer lived at the service and should have been returned to the pharmacist. We noted one controlled drug only had one signature to say it had been administered. This is not in line with best practice guidelines as the administration of controlled drugs should be monitored and checked by two people to help reduce the risk of any errors.

Medication stock records were not accurate and an audit of the services' medication indicated a large number of discrepancies. Medicines that were no longer required remained in the stock cupboard and there were a large number of unnamed and unaccounted for medicines mixed with used stock. Staff were not aware of the procedures for recording and disposing of unwanted medicines and were therefore not returning medicines as required.

Syringes in storage were 3 years passed their use by date and we found large stocks of dressings which were not required. There was no system in place to check stock dates and manage the stock held of syringes, dressings and drainage bags.

Topical creams were poorly managed. Records showed inconsistent recording of application. For example staff were not recording when a cream was being refused so there were no accurate records of a person's cream application. There were a number of required creams which were not held in stock which meant people may not have access to a prescribed cream and where creams were available, there was limited instructions for staff to follow to ensure effective application. We found cream tubes and pumps with no start dates recorded, this meant there was no system in place to ensure that creams were disposed of correctly following the maximum usage date following opening.

We identified risks in relation to the recording of a person's pulse prior to medication administration. In an example identified a person should not have their medication administered if their pulse was below 60

beats per minute. There was a monitoring sheet for the pulse recording but this was unnamed and not dated. There was no way for staff to fully understand what to do in relation to the administration of this medication and a real risk that this person could have been administered the medicine when it was not needed and could have caused major health issues.

We identified examples of where medicines prescribed as required such as Ibuprofen and Paracetamol had not been administered and it was not clear if offered, refused or required. For one person, there was nothing in their care notes in relation to pain management and staff would not have known if this person was in pain. We found examples of where a person's medication record did not have a photograph of the person. This is poor practice to have no visible method of checking a person's identity, as they may be unable to confirm their date of birth or other identity questions.

We looked at staff competencies. Staff had received training but we could not see evidence that this was refreshed regularly to ensure staff had the necessary skills and competencies. Our evidence around medication showed not all staff did.

We observed the staff member giving out the evening's medication. They confirmed that they had received training and had been assessed a number of times to ensure they were able to administer medicines according to the laid down policies. They said it took a long time to give medicines and they did not usually finish till around midnight as almost everyone had night time medication. They said this resulted in a number of people refusing their medication because it was so late and people would be asleep or resting. It also meant people were not being given their medicines at the times they needed them.

The above demonstrated a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Inadequate

Is the service effective?

Our findings

At the last comprehensive inspection, we identified the service was not meeting Regulation 11 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014. This was because people were not being appropriately supported to make decisions when lacking the capacity to do so and we found some unnecessary restrictions placed upon people without clear rationale. The provider sent us an action plan, detailing how they would address the shortfalls.

At this inspection we found the provider was still not complying with the Mental Capacity Act 2005 (MCA.). The MCA provides a legal framework for acting and making decisions on behalf of individuals who may lack the mental capacity to do so for themselves. The Act requires as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals is called the Deprivation of Liberty Safeguards (DoLS).

The registered manager was aware of their responsibility to ensure they complied with the MCA. They were able to explain how, if someone lacked capacity to make a specific decision, they would deal with this. Staff had received training in the relation to the MCA and DoLS but did not all have a clear understanding of the topic.

Restrictions were still placed on people without a clear rational for doing so. For example people had access to the garden but could only do so when staff were free to open the door and accompany them if they wished to go outside. The main door to the back garden had two high buttons which requires considerable dexterity to open, both had to be pressed simultaneously and then the door bar pushed. Once people were outside the only way they could get back in was by knocking on the door and waiting for a member of staff to pass by. We did observe a small group of people who liked sitting outside and staff were observed facilitating this.

We observed that the dining room was locked for significant periods throughout the day and people were not allowed to enter this area. In addition we found people did not have the option of having their own room door open if they chose to as there were no automatic door closures in place and we observed some cases where room doors were propped open using objects and this presented a fire risk.

There was no system in place for staff to be aware of which people had Do Not Attempt Cardiopulmonary resuscitation (DNACPR) in place in case of emergency medical attention. Some people had these in place and this was highlighted in the care plan on the computer system. However during an emergency a member of staff would be required to log on to the computer and double check the status which would not be possible in an emergency situation. There were copies available in people's paper care records but it took staff a significant amount of time to find them. This meant that there was a risk that people's choice would not be respected in case of a healthcare emergency.

A central folder was kept recording Mental Capacity Assessments for people who required assistance with everyday decisions such as dressing or washing. Copies were not in people's individual records therefore staff who were unaware of people's needs would not know how to best support people to make their own choices. There were a large number of people who had bed rails and it was not always clear why these were in place. There were risk assessments but no best interest decisions for individuals who were not able to consent. There was no evidence of consultation with people or their representatives about health and welfare issues. We saw no evidence of lasting power of attorney for people as this was not recorded in people's records so could not be assured staff would know who to contact about important decisions.

The manager showed us a folder of applications made to authorise restrictions for some people and these had been processed and approved by the Local Authority, the supervisory body but had not been renewed appropriately as required to ensure the people were appropriately protected.

The above demonstrated a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulation 2014.

At our last comprehensive inspection we identified some positive practices around hydration and nutrition but found people's records did not accurately reflect what people had been offered to eat and drink and what they had actually consumed.

At this inspection people were mainly positive about the meals. One person told us that the food was, "Quite nice." Another person said, "It looks nice doesn't it." Another said, "The food is good and you get a choice." Another said, "The food's ok, but it can be a bit boring. If we have chicken roast one day then we'll have chicken something the next day or two. However I liked the stew today."

We carried out observation of breakfast and lunch on the 6 September 2016 and observed people being offered a choice of several options including a cooked option for breakfast. Menu options were given verbally by staff which some people found difficult to respond to. At lunch time people were given their meal already plated up which meant people were denied a meaningful choice.

We found that people were at risk of choking due to a lack of awareness of people's food and fluid needs. People's specific dietary needs were not known by all staff which increased the risk of harm to some people. The Chef was aware of who needed a specialised diet and there was also a folder in the kitchen providing information about dysphasia and different types of food consistencies. This was not followed by all staff. For example, there was a handwritten poster in the kitchenette telling staff that one person was on a soft diet and there was information from the speech and language team about their diet. They were to only have soft food which was easy to swallow. We observed staff serving them sprouts, carrots and chunks of meat. The food was not mashed or finely chopped. We spoke to a member of the kitchen team who said the meal served was soft. This was not the case. We then observed a senior member of staff coming into the dining room who recognised the meal was unsuitable for this person and replaced it with pasta.

We saw on the handover sheet that another person should be provided with thickener to thicken food and fluids to help people with swallowing difficulties. This was not followed by staff. We saw the person drinking juice which was not thickened, staff confirmed this.They did not eat their meal and when we asked them about it they told us they required a soft diet which was not provided to them. We checked their records and could not find any documentation regarding swallowing and meals but it did state, I am prescribed thickener for my fluids. They told us, "I have a problem with swallowing." A previous safeguarding concern had been raised about this issue but records showed it was still unresolved.

A number of people living at the service had diabetes. We asked staff about the dietary arrangements for those with diabetes and they told us they could have custard for pudding but not the fruit pie. There were no low sugar alternatives available which were suitable for people living with diabetes. People with diabetes were not provided with appropriate choices to enable them to keep healthy.

Tables were set for meals with napkins. However there were no condiments /sauce or salt and pepper which could have supported people with more choice. We also observed that people were given drinks in disposable plastic cups. We noted that the disposable cups were flimsy and were not appropriate for those who struggled with their manual dexterity.

After the meals staff who had not been in the dining room at the time completed people's food and fluids records stating what people had eaten. This was not a reliable record as staff had to ascertain from staff in the dining room how much people had eaten and many people. Staff could not have been aware how much everyone had eaten and drank during the course of the meal time and we saw most people were on food and fluid charts.

The cook told us that they provided high calorie shots and fortified smoothies for individuals who were identified as being at risk. We saw that these items were provided on the tea trolley and saw that people in the main lounges were being offered them. However we did not see any evidence that people who were in their rooms and those who had been identified as being at risk being offered these fortified items.

People's weights were monitored on monthly basis but some people were identified as requiring weekly weights because of recent weight loss but this was not happening. This meant we could not see that staff had always acted on recorded weight loss. For six people case tracked with recent weight loss there was no evidence in their care plan of a referral to the Dietician or a management plan to weigh weekly and monitor their food intake closely.

Food and fluid charts were in place and staff were recording amounts taken. Totals were available but these were not being analysed. People's records did not have a clear target for fluid intake and records seen could not be verified for accuracy. We saw people's records showed that they had taken in excess of 1.5 litres of fluid; However our observations did not confirm the records as many people were reluctant to drink large amounts. Fluids at night were given out just after 8.00pm. Night staff said they promote fluids throughout the night. However records showed fluid intake between 9.00 am and 7.00 pm with nothing else recorded.

The above demonstrated a breach of Regulation 14. Health and Social Care Act (Regulated Activities) Regulation 2014.

At this inspection on 6 September 2016 we had concerns about poor care and delays in seeking appropriate medical attention as required. People's health care needs were not always responded to appropriately or referrals made to other agencies in a timely way. We saw evidence from care plans that advice was sought from District nurses, speech and language teams and the GP. However the District nurses were present during both of our visits and were monitoring a high number of people they were concerned about and said information from the service had not always been forthcoming. Essex county council were also monitoring the service and had similar concerns. A communication book was in situ which highlighted any issues identified by the district nurses during the daily visits. Entries highlighted concerns around poor care practices and a delay in reporting and monitoring changes to people's health care needs. These included things like drinks out of reach, no monitoring charts available or insufficient detail about how a person's care was being provided. Issues also identified either no pressure relieving equipment available or not being used correctly. These were matters that we have also found and highlighted as still ongoing at this

inspection.

We found people with catheters were not having their bags changed as required, people did not always have the equipment they need to promote good skin care, discrepancies in cream administration to prevent good skin condition, poor personal care and some people visibly uncared for.

There were details on people's records regarding optical prescriptions although there was no clear guidance on people's plans as to whether they wore glasses or hearing aids. Gaps in records meant we could not see if people received regular visits from the chiropodist so we were not assured people's health needs were always fully recognised. .

We identified poor monitoring of people's bowel movements which have negative outcomes for people. We spoke to a person who was experiencing pain and had recently being prescribed medication to help them with their bowel movements. They had a medical condition which could increase their risk of constipation and needed medication. Medication had been prescribed on 2 September but had not been collected or administered There were no monitoring records seen on this persons care plan in relation to bowel movements. We viewed the care plan of another person at risk of constipation and found that they were not being monitored in this regard. This meant they were being placed at further risk.

Forms were in place in people's rooms for staff to complete when repositioning people to prevent their skin breaking down. Some people were on two hourly turns which we checked a number of times throughout the day and turns were being recorded as undertaken. However we did identify gaps where this had not happened so could not be assured people were being turned as required and a number of people had skin which was not intact. A number of people had acquired pressure sores whilst at the service and had not taken appropriate actions to manage it.

The above demonstrated a breach of Regulation 12: Health and Social Care Act (Regulated Activities) Regulation 2014.

At our last comprehensive inspection we found staff training was not always updated as required to ensure the staff had the right job competencies and skills. Some staff had not received any training around the specific needs of people they were supporting. At this inspection we saw that most staff had completed basic e-learning on a computer for essential topic areas and some training such as manual handling was provided face to face. However there were gaps in staffs training records. For examples out of 20 topics one staff had not completed three. One of these was practical manual handling. Most of the e-learning had been done over several days and there was no evidence of direct observations of staffs practice to ensure they were able to deliver care safely with the exception of medication competencies.

There was limited evidence that staff had undertaking additional study around people's specialist needs particularly around long term conditions such as dementia and positive mental health. Whilst speaking to staff some told us they had recently or were still studying some courses through distant learning in subjects such as end of life care. A number of staff were doing additional care qualifications.

We looked at staff records and there was no evidence of shadow shifts, or evidence of how staff's performance was reviewed throughout their probationary period. Supervision of staff was taking place but it was difficult to establish the frequency of this because staff records were kept in one large file and were not clearly sectioned to show whose records were who. Staff confirmed they did receive supervisions about every three months and had opportunity to talk about their work practices. They said staff meetings were also held and we saw some evidence of this.

The above demonstrates a breach in Regulation 19 (Regulated activities regulations) Staffing.

Requires Improvement

Is the service caring?

Our findings

At the last comprehensive inspection of this service we identified some positive practice and saw that staff knew people's needs and were caring. However, we had concerns that good care practices were not universal across the whole team Since the last inspection there have been a number of staff who had left and staff vacancies were on-going. During this inspection we found that not all staff supporting people were familiar with their needs and some had poor English language skills which made communication difficult.

Most people spoken with told us positive things about the staff. For example one person said, "Staff are doing their best…I am lucky to be here I have no complaints." Another said, "Staff are caring."

We observed care staff to be very busy, and saw the care was mainly task focussed. There were some staff on duty who were seen to be rushing around. We waited to speak to staff but this proved difficult as staff were busy throughout the whole shift. Staff did not have time to sit down with people and chat with them.

When staff did interact with people this was done appropriately although we found a number of staff had poor communication skills. We observed staff gently waking people up to ensure they had a drink. We observed a staff member assisting a person into the garden and taking their time to find them a chair where they wanted to sit and made sure they were comfortable. We heard staff reassuring people and checking that they were alright and comfortable… "Are you ok …let me move you in?"

Throughout the evening of the 9 September 2016 we saw staff observing people for their safety and we saw some meaningful relationships with some staff validating how people were feeling and reassuring them. For example one person became distressed by the death of a spouse. Staff told us that initially they had been told they had died but could not retain the information and often asked where they were. Staff provided them with reassurance and validated their concern without causing them further distress by telling them their spouse was not there at the moment and trying to divert their attention in a positive way. It was clear that some staff were very fond of people. One staff member told us a person had lost the ability to walk and it was their goal to learn how to walk again. The staff member told us every night they supported the person to walk a little further each time to develop their confidence.

Although staff were observed to be caring they did not appear to have sufficient time to spend with people and demonstrate meaningful relationships. Staff acknowledged they were always busy and might be able to spend more time with people if there were additional staff. A number of people observed had poor personal hygiene, dirty clothing and poor mouth care. It was not clear if staff simply did not have time to meet people's basic care needs or if some people were reluctant to accept staffs help. We listened at staff handover and heard that some people could refuse help with their personal care and different staff would try and assist the person. However there were no clear strategies for staff to follow in terms of supporting people who might become distressed during personal care and it was clear that staff could not afford the time that some people needed.

We observed staff knocking on doors before entering and doors were closed when providing personal care.

People's independence was promoted when eating, we observed people had plate guards and one person had specialist cutlery. People said that staff were caring, respected their privacy and treated them well; Examples included: "The staff are very good; an occasional language difficulty." And, "The girls are lovely." A different person said, "They talk to me properly."

One person spoken with said, "They keep doing things to make us comfortable like new chairs and carpet; they make us as comfortable as they can."

We observed one person with ill-fitting clothes, on the wrong way and trousers they could not do up. We discussed this with staff who did nothing about it and left the person walking round. The person kept trying to do up their trousers and was unable to because they were too small and not theirs. This was very undignified and the person was not shown the respect they deserved.

A further concern when speaking to staff was they were not able to identify any poor practice within the service. The care provided had become acceptable practice. Staff felt the only thing which could be improved was more staff so they could spend more time with people. This showed us that the culture of compassionate, personalised care and kindness was yet to be visualised and developed within this service.

There were no restrictions on visitors and there were opportunities for people and their relatives to meet and comment on the service either formally or through posting suggestions. We found however there was poor involvement in the meetings which meant we could not see how they were used to effect positive changes within the service. A weekly surgery had been set up and the manager was available at other times to respond to any comments or suggestions and there were a number of compliments received about the service.

Inadequate

Is the service responsive?

Our findings

At the last comprehensive inspection we had concerns about the level of inactivity for people and found people's care records poor as they did not always tell us about people's needs or how risks were mitigated.

Before our inspection we received concerns about the standards of care and that people's health needs were not always being met. Concerns were expressed about new admissions to the service and whether the staff had the right skills to meet people's needs. In at least two instances an assessment of a persons' need had not been completed before the person moved in. One person had no plan of care in place despite being at the service for a month. We wrote to the provider asking them about their admission process and how they assessed if they were able to meet people's needs and what lessons they had learnt from safeguarding concerns. The information was received from the provider as requested. However we found the service was continuing to fail to follow the procedures in terms of assessing, identifying and planning for people's needs, whilst ensuring there were enough staff to meet people's assessed needs.

We case tracked a number of people and we saw that prior to a person being admitted an assessment from the Local Authority would be completed to help the service determine if they were able to meet the person's needs. However we could not always see if the service carried out their own assessment and when they did the information they obtained was very basic and did not help us determine how the service had decided they could meet their needs.

There was inadequate planning to ensure people's needs were met. We spoke with people living with dementia about their lives and previous occupation. One lady was distressed and they told us they were worried about their children and needed to go and find them. We were able to minimise their distress but did not observe throughout our visit staff establishing why this lady was becoming increasing anxious. We spoke with another person who often did not sleep. They talked about their former job and the long hours they worked which was an important factor in establishing what their routines might have been. The staff had not established an understanding of these routines and were therefore unable to provide effective, knowledge based support. Staff had not had recent training around dementia care or mental health which might have helped staff provide individualised care.

There was limited evidence that care was provided according to the person's needs or preferences. Staff had insufficient time to meet people's needs in a timely way. When we spoke with staff some were not able to demonstrate sufficient knowledge of people's needs. For example staff told us that at least 15 people had bedrails to reduce the risk of falls but were unclear if any other technology such as pressure mats were used. They were unable to tell us who was not for resuscitation and this information was not easily retrievable if required in an emergency.

During our inspection at night we were told about a number of people who were wakeful at night and spend most of their night in the lounges. We were unable to see from their records how staff promoted a good night's sleep or what the person's preferred night routines were. Staff confirmed that some people stayed up and could not explain how they tried to encourage people to go to bed. For one person we found their

bedroom to be very sparse with poor quality bedding and a strong odour. This would not help promote a good night's sleep. Another person's side light was not working and they were on hourly checks which meant staff were putting on their main light to assist them with changing their position. We found the bedroom was too small for staff to assist them safely with their manual handling needs. We saw two adjacent rooms with the doors open and could not ascertain if it was people's choice to have their doors open. One person was in bed the other person had their television on very loud which could cause a disturbance to others. We observed another person who we was told did not go to bed. We saw that their bedroom door was locked so it was difficult to assess how they would find and go to their bedroom if they wished to.

The above demonstrated a breach of Regulation 9 Health and Social Care Act (Regulated Activities) Regulation 2014

Monitoring of people's healthcare needs was not effective. For example, people were not being monitored for food or fluids in a system that could be used to identify any concerns as the forms used were not being monitored. Staff were not able to tell us who was responsible for doing this. In addition people's bowels motions were not being monitored closely, especially for people with a history of constipation; this means that effective and timely interventions were not being given. Also weights were not being taken regularly as stated in the care plan, from the recorded weights a management plan or guidance for care staff were not in place.

We found care standards for some were very poor. For example a person had been identified in their care plan as needing lots of fluids due to kidney disease. This was not being achieved. Fluid levels ranged from 450 to 900 in the preceding days. It was acknowledged this person was not in good health but not what actions were being taken to promote their health. The care plan did not reflect their changing needs or actions taken. For the same person they were identified as having reddened skin when in fact when checked by the nurses they had an untreated pressure area which staff were not aware of.

Staff did not meet people's social needs. During our inspection on the 6 September 2016 we saw a large number of people spending a large percentage of their day disengaged with insufficient occupation. A number of people were observed knitting, reading or watching television and others were tapping to some music playing. We observed shortly after 11:00 that 34 people were sitting in the lounge areas of whom six were playing bingo and two were playing cards. There were no organised activities in the afternoon and after lunch people sat in the lounge areas waiting for drinks to be served from 3pm; during this time eight people were observed singing along to tapes of old songs, two people played cards and filled crosswords and two people were talking with visitors. The other people in the lounge areas spent the time sleeping or watching television.

People spoken with in their rooms said that they weren't interested in organised activities. One said, "I have a TV and a phone in my room and I'm comfortable in my own room"; another said, "I'm not bothered about activities." Other people told us that activities were planned, One said how much they had enjoyed the music the previous day, and another person said they hadn't cared for it. One person told us, "I like it here, I join in the bingo, and it's nice and spacious, plenty of room."

There was little one to one social interaction observed taking place between staff and people during the visit beyond the interaction required to provide personal care, assisting to mobilise, take drinks and eat etc.

Relationships between people were observed as being mostly positive with some genuine friendships. We did however observe a number of people whose behaviour caused distress in others. This was not managed

well by the staff on duty and there were limited plans in place to try and mitigate some of the distress caused.

The above demonstrated a breach of Regulation 9 Health and Social Care Act (Regulated Activities) Regulation 2014. Person centred care.

There were four visitors to the service during the period of the visit. They said that there were no restrictions on when they could visit. Visitors were warned that at weekends they may have to wait for a period before being permitted entry because of staff responding to care needs of people, which reflected reduced staffing levels at weekends rather than increased care needs at this time. There had previously been complaints from relatives about the delay in staff responding to the doorbell.

Visitors spoken with said that they had no problem in raising any concerns and that the service had "been pretty good in sorting things out" when they had raised issues eg "when she needed repairs to her glasses they fixed that straight away." We looked at the recorded complaints about the service and there was a file with only two recorded complaints and these were from more than a year ago. We were told that the provider was currently dealing with an outstanding complaint and would be following the complaints procedure to look at this. We looked at the responses to surveys and some of these contained minor issues which should have been addressed, mainly relating to lost items of personal clothing and or belongings. There were no actions recorded anywhere to evidence that these complaints had been taken forward or if there was any resolution. A number of people told us about items which had been lost and they had reported this to the office but there was no record of any investigation or action taken to address these issues.

The above demonstrated a breach of regulation 16, Health and Social Care Act.(regulated Activities) Regulation 2014. Complaints.

Inadequate

Is the service well-led?

Our findings

At our last full inspection in December 2015 we identified wide spread and continued failures across all aspects of the service. This gave us concerns about the leadership of the service. Since this inspection there have been a number of changes to the leadership team. On the day of our inspection we met with the newly appointed manager of the service who had been in post for just one week although they had been at the service for approximately a month, three weeks in an advisory capacity. They told us they had previously been registered with the Care Quality Commission for other management posts elsewhere so had a good knowledge. They told us they were a qualified general nurse.

It was too early to judge their effectiveness in managing the service as they were clearly getting to know what systems were already in place and what needed to be addressed. They told us they would be reviewing everyone's needs and ensuring their records were up to date. They had already increased the staffing levels in accordance with people's dependency levels but this had not yet been effective in improving the levels of care provided. The new acting manager told us about their intention to register with the Care Quality Commission. Historically there have been a number of managers and all have failed to make the required improvements and sustain them.

Staff told us that they had confidence in the new manager; one staff member told us that they felt that finally the home will start to improve. One staff told us, "Things are improving here. The manager has the experience. There has been some problems with paperwork but this has picked it up. We have been going through a difficult patch things don't change overnight, we need to be given the opportunity to do that."

We observed supportive and friendly interactions between staff and the manager who was getting to know the processes within the service and starting to prioritise the required improvements. However we had concerns about the leadership and deployment of staff. Two senior staff and the deputy manager were on duty but were not always visible at key periods such as mealtimes and were not proactive in supporting staff or assisting with people and their personal care needs. Senior staff spent a lot of time in the office updating records and we were not clear who was overseeing the shift. The manager was asked about the leadership of the shift and told us they, were leading the shift. Staff were not sufficiently directed to ensure good care was given to a large number of dependent people.

We spoke to the manager about their view of the priorities within the service and whilst they had identified some of the shortfalls with regards to documentation, risk assessments, care planning and communication, they did not yet recognise the real risk to people using the service. This was particularly true for those who were very vulnerable due to health conditions. For example all staff, including the manager were not aware of the number of people who had pressure sores within the service. The district nurses, who attended the home on the day of inspection, identified three people whose skin integrity was compromised and were not being provided with appropriate care or had the risk appropriately identified.

The systems in place to identify issues and concerns were not effective. The manager was therefore unable to prioritise actions and put into place a service improvement plan. Whilst there were audits in place that

covered the basics such as use of bed rails, falls and health and safety, these were not effective at identifying the root cause of any issue and did not have corresponding action plans to address identified concerns. The bed rail audit was clearly ineffective given our findings in this report about usage and assessment of this equipment. We looked at the medication audit and whilst a large number of errors and issues had been identified, the action plan consisted of post it notes within the medication charts, actions were not consolidated and there was no structured plan in place to support improvements that could be sustained.

The manager talked about their plans to ensure that the staff were all trained to a high standard, by implementing the care certificate to all staff, both new inductees and established staff. We spoke with an NVQ assessor who was there to support staff and assess their competencies against agreed standards they should be achieving as part of their induction and towards additional qualifications in care. They commented on how busy staff were and how many people using the service were heavily dependent.

There was a skills audit available which identified which staff were trained in each of the required areas and which were not, this identified that a number of staff were not adequately skilled or experienced to meet the needs of people using the service. Whilst the care certificate would be a start to ensure that this was addressed, we observed staff working with people who were not appropriately trained in pressure area care, moving and handling, nutrition and meeting the needs of people with advanced dementia or mental health issues. The lack of oversight of the risks due to failings within the service and the lack of effective quality monitoring placed people at real risk of harm and whilst there was a basic plan in place to try to address this, it lacked the urgency and impetus needed to ensure people's safety that were using the service now. For example, people's nutrition was being monitored through food and fluid charts however where people needed a soft diet this was not always being delivered. There was no overall monitoring of the delivery of lunch service against people's assessed needs, such as diabetes and choking, so the manager was not aware of the risks posed to people and this was not being addressed.

The provider was at the service throughout the inspection and it was clear that they had a good rapport with the staff and people using the service who knew them well. However due to a lack of effective oversight and no quality monitoring system to identify and rectify concerns, the provider was unaware of the real risk to people using the service. Assurance has been taken from previous managers in the past and there had been no testing or monitoring to assess if the improvements needed have been implemented and were effective at addressing the concerns. The provider relied on an effective manager in order to ensure the home was well led. Due to a lack of systems in place to identify failings, the provider was unable to effectively assess the competency and capability of the leadership team which had led to failings within the service which were not addressed.

Relatives meetings are held monthly and the manager holds a weekly surgery every Thursday between 5pm and 8pm as an opportunity for anyone to raise issues, concerns and suggestions. However staff said these were not well attended. We looked at the records relating to these meetings and found that there was ineffective follow up or action taken to address any concerns identified.

Previous inspections have demonstrated a lack of provider oversight, and poor delegation of responsibility and accountability at all levels

There was ineffective monitoring of the quality of service provision. This demonstrated a breach of Regulation 17, Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.