Visram Limited

Ranvilles Nursing & Residential Care Home

Inspection report

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15 February 2019
20 February 2019
21 March 2019

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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

About the service: Ranvilles Nursing & Residential Home is a residential care home that was providing personal and nursing care to 43 people at the time of the inspection. Care and support was provided to older people living with dementia and mental health needs.

People's experience of using this service:
• People were at a significant risk of avoidable harm. Risks to people were not fully assessed and measures were not sufficiently put in place to mitigate risks to people.
• The culture of the service was task focused and staff did not always recognise poor practice. For example, incorrect manual handling practice. We observed some poor manual handling practice during the inspection that put people at risk.
• People in the service displayed a significant number of physically aggressive behaviours. There were a high number of unexplained incidents including bruises. Accidents and incidents were not always recorded and notified to the appropriate organisations such as the local authority. Accidents and incidents were not fully investigated and analysed to prevent future occurrences.
• We received mixed feedback about how open and transparent the service was.
• A staff feedback survey demonstrated concerns about a lack of teamwork. Feedback from staff and relatives was not appropriately acted upon. We have made recommendations about this.
• Staff were not consistently caring and people were not always treated with dignity and respect.
• The provider was not person-centred. People's diverse needs were not always respected and met.
• The provider was not providing care in accordance with the Mental Capacity Act (2005).
• Staff training was out of date and staff did not always have the skills and expertise required to provide safe care and support.
• The service met the characteristics of inadequate in most areas.

Rating at last inspection: The service was last rated Good, published in December 2017.

Why we inspected: This inspection was brought forward due to information of concern.

Enforcement: Please see the 'action we have told the provider to take' section towards the end of the report.

Follow up: Following the inspection we took urgent action to ensure the provider improved the safety in the service. We informed the local authority and clinical commissioning group (CCG) of our concerns.

The overall rating for this registered provider is 'Inadequate' and the service is therefore in 'special measures'.

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

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

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

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

Full information about CQC's regulatory response to the more serious concerns found in inspections and appeals is added to reports after any representations and appeals have been concluded.

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 Details are in our Safe findings below.	**Inadequate**
Is the service effective? The service was not effective Details are in our Effective findings below.	**Inadequate**
Is the service caring? The service was not always caring Details are in our Caring findings below.	**Requires Improvement**
Is the service responsive? The service was not responsive Details are in our Responsive findings below.	**Inadequate**
Is the service well-led? The service was not well-led Details are in our Well-Led findings below.	**Inadequate**

Ranvilles Nursing & Residential Care Home

Detailed findings

Background to this inspection

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

The inspection was prompted in part by notification of an incident following which a person using the service sustained a serious injury. This incident is subject to further investigation and as a result this inspection did not examine the circumstances of the incident. This inspection was also prompted by information of concern received from the local authority and local Clinical Commissioning Group.

The information shared with CQC about the incident and other concerns indicated potential concerns about the management of risk of falls, falls from moving and handling equipment and behaviour that may challenge others. This inspection examined those risks and risks in relation to other accidents and incidents.

Inspection team:
This inspection was carried out by five inspectors, a specialist advisor specialising in the care of people living with dementia and one expert by experience, specialising in the care of older people and people living with dementia. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type: Ranvilles Nursing & Residential Home is a care service with nursing.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection: We gave the service less than 24 hours notice of the inspection visit as we knew the manager would be unavailable on the first day and needed to put plans in place for other senior staff to be available to speak with us.

Inspection site visit activity started on 12 February 2019 and ended on 21 March 2019. We visited the location on 12 February 2019, 15 February 2019, 20 February 2019 and 21 March 2019 to see the manager and staff; and to review care records and policies and procedures.

What we did:
Prior to the inspection we reviewed all the information we held about the service including notifications received by the Commission. A notification is information about important events which the service is required to tell us about by law.

During the inspection we spoke to four people, five relatives and visitors, two registered nurses, 12 care staff, the quality assurance manager, the deputy manager, the registered manager, the provider and another director of the healthcare brand. We looked at how the provider managed medicines and observed care in communal areas throughout the day. We reviewed documentation including 10 people's care records, medication records, five staff employment files, staff rotas, training records, staff supervision records, accidents and incident records, quality assurance records, policies and procedures and safeguarding records. We also received feedback about the service from two external professionals.

Following the inspection we sought further information from the provider and registered manager to seek urgent assurances about the safety of people living in the service.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

People were not safe and were at risk of avoidable harm. Some regulations were not met.

We received inconsistent feedback about the safety of the service. One person told us, "Yes, I'm well looked after and I feel safe". One relative expressed concern about some of the recent incidents that had occurred in the home. They told us, "This [person] got punched in the face the other day by another resident, a full punch. It was dealt with but my concern is that it could have been my [family member]".

Assessing risk, safety monitoring and management

- We observed moving and handling practice during the inspection. One person was observed to be manually lifted with a handling belt from a wheelchair to an armchair by two members of staff. This equipment should only be used with people who can completely weight bear but the person was not encouraged to participate and not weight bearing during the movement. The way the person was moved placed them at significant risk of injury or harm. This was fed back to the registered manager who agreed to take action to prevent another incident from happening again.
- Despite feedback to the registered manager about the poor practice observed, a similar incident occurred on the following day. The same piece of equipment was used to inappropriately to lift someone from the floor to a wheelchair. The registered manager failed to inform us about this subsequent incident and we were informed by a member of staff who had recognised this was poor practice. Although the provider had made the decision to remove the piece of equipment and had ordered another device to support moving and handling, no alternative measures had been implemented to ensure safe moving and handling for everyone, until the new equipment arrived.
- There had been previous incidents of poor moving and handling including a person who started to slip out of a hoist sling during a transfer in November 2018 and in January 2019 where a person had been manually lifted off the floor after they had fallen and sustained an injury. The moving and handling practice and care records demonstrated a lack of understanding of how to use manual handling equipment which had placed people at risk of harm. One person's care records incorrectly detailed that they required a handling belt and one to two carers to help them stand or walk. One staff member told us, "The times I've come in and picked carers up for moving and handling like picking up under the arms". All of these concerns demonstrated a consistent culture within the home that placed people at risk of harm due to poor moving and handling. It also demonstrated that the provider had not recognised these risks or learnt from previous incidents.
- At times people appeared to be sat in an uncomfortable way, slipping down in their chairs. One person who was asleep appeared to be at risk of falling out of their chair but staff did not assist the person. After some time the person awoke and managed to reposition themselves.
- Some people were inappropriately sat on hoist slings with straps underneath their legs for long periods of time during the inspection. This was not noted in their care plans and placed them at risk of pressure sores.

The failure to carry out safe moving and handling practice and ensure equipment was used in a safe way was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

The above concerns were shared with the registered manager and provider during the inspection. Handling belts were removed from the service and staff were given extra training and support in moving and handling, including the use of hoist slings. The provider was in the process of implementing thorough moving and handling competency assessments but these had not been embedded.

● Many people living at the home presented with behaviours that may challenge others. People had displayed a significantly high number of incidents of verbal and physical aggression towards other people, staff and visitors. We identified during the inspection that there were at least 11 people living at Ranvilles Nursing & Residential Home who were at risk of displaying physically violent behaviour. One person had been involved in 11 incidents in the first 12 days of February 2019, all of them involving physical violence towards staff and other people. The incidents had been recorded and gave information concerning where and when these incidents occurred. Some people had 1:1 support and some had been referred to the Older People's Mental Health (OPMH) team for assessment. However, limited investigation and analysis was carried out as to how and why these incidents were still occurring so frequently and how the service planned to reduce these. There was no information to demonstrate that staff had learnt from previous incidents or alternatively, exhausted all options to support the person. Behaviour support plans were in place but they lacked detail and triggers to people's behaviour were not fully explored and not appropriately managed.
● Staff had received no training in physical intervention which placed people and staff at risk during episodes of physical aggression. It was noted that changes to care plans following incidents or reviews from healthcare professionals were not always documented in the care plans and there was limited evidence of reviews from OPMH.

The failure to assess and mitigate risk to people was a breach of Regulation 12 Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

● Many people living at the home were at risk of falling. Risk assessments were in place regarding this, including those concerning the use of bed rails and sensor mats. However, we did note risk assessments were lacking in detail. Where necessary, care plans detailed that staff should be checking the whereabouts and safety of individuals every fifteen minutes however, these safety checks were not always recorded to show they were taking place.
● Some care records included useful safety information regarding health conditions. For example, two people living at the home lived with insulin dependent diabetes. Their care plans contained clear guidance for staff which included protocols for the management of emergency situations, such as hypoglycaemia (low blood glucose) and hyperglycaemia (high blood glucose). There was also guidance for staff concerning possible complications of diabetes, such as poor skin integrity and visual problems.
● Equipment had been regularly and recently serviced.
● People had Personal Emergency Evacuation Plans (PEEP) in place within their care plans. These outlined how individuals could be quickly evacuated or kept safe in the event of an emergency, such as fire or flood.

Learning lessons when things go wrong
● The recording and analysing of incidents and accidents was poor. The service was unable to demonstrate that learning took place to prevent incidents from happening again. This was concerning because the service was experiencing a high number of incidents on a daily basis. Two incidents that occurred during the inspection and the day after had not been recorded when we returned to the service three days later. We informed the registered manager of this who told us they would ensure they were recorded as soon as possible. We spoke to the registered manager 15 days after the inspection and they had not been referred to the appropriate agencies.
● We received feedback from the local authority and clinical commissioning group that the service was not

investigating incidents appropriately or accurately. They also informed us that there were inconsistencies between the investigations completed by the service and those of other agencies.

The failure to analyse incidents and accidents and do all that is reasonably practicable to mitigate risks to people was a breach of regulation 12 Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Preventing and controlling infection

● The provider had not carried out all appropriate water checks required in the prevention of legionella bacteria as detailed in the Health and Safety Executive (HSE) guidance. There was not a sufficiently robust risk assessment in place. The provider made arrangements for an external organisation to advise the service about water checks and carry out a legionella risk assessment promptly after the inspection.

● The provider had ensured the adequate provision of personal protective equipment (PPE) for staff, such as gowns and gloves. We noted all areas, both communal and those used by staff, were in a good state of repair.

Staffing

● We received mixed feedback from staff about staffing levels. One member of staff told us, "You just can't be where you always need to be which has resulted in some violent altercations". Other staff members told us, "No we need more staff", "Yes, I think we have enough to provide good care. We make sure the care is done". One relative told us, "There's never enough staff anywhere". Some staff expressed concern at the amount of people with complex needs and how to keep them all safe at the same time for example, "There's enough staff on paper but the types of residents here, we don't have enough to cope with the special needs."

● Many incidents were unwitnessed and these events in communal areas could only be established by reviewing CCTV footage. There had also been a high number of unexplained bruises within the service that could not be accounted for. People with complex needs were not being appropriately supported because there were either, not enough staff or they were not effectively deployed to ensure to the avoidance of these injuries or witness how they had taken place.

● The provider was using a significant amount of agency staff. This was having an impact on permanent staff who told us, "There is enough time to get the care done if it all goes smoothly but if you're working with new agency staff, you can spend more time with them than with the residents". One relative told us, "I do sometimes think there are too many agencies here and you can't always get the same ones. It's nursing rather than caring here. There's one to ones which takes off the staff".

● We observed that the staff rotas demonstrated that the numbers of staff were limited. During the inspection we observed there was little time available for staff to provide any social interaction with people and this contributed to a task-focused culture. At times people were observed to be walking without a purpose and trying to seek assistance from staff which did not come promptly. Staff appeared rushed and under pressure to meet basic needs for people.

The insufficient level or ineffective deployment of staffing to meet the needs of people was a breach of Regulation 18 Staffing of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● The registered manager did not always fully understand their responsibilities in relation to safeguarding. They sometimes needed guidance from other agencies on how to safeguard people or what to report to agencies.

● A significant number of staff did not have up to date safeguarding training. However, staff we spoke to

were able to tell us how they would identify safeguarding concerns and recognise the types and signs of possible abuse. One member of staff explained to us, "I would always report abuse to the manager and I know they would do something".

Recruitment

● Procedures were in place to prevent the employment of unsuitable staff. These included a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent the employment of staff who may be unsuitable to work with people who use care services. Identity checks and character references were obtained and candidates attended an interview to assess their suitability for the role. Applicants were asked to complete details of their full employment history. For registered nurses, records of professional registration documents were kept.

Using medicines safely

● We looked at the ordering, administration, storage and disposal of medicines within the service. Medicine administration records were completed appropriately. Staff received training in medicines management and annual competency assessments to check their practice. We looked at how medicines given on an 'as needed' basis (PRN) were managed. PRN protocols were in place for all medicines taken this way; they outlined how, when and why they should be taken and included maximum doses over a 24-hour period.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

One relative told us, "[Person's] well looked after, [person] gets checked on". However, our observations and findings demonstrated that the provider did not consistently achieve good outcomes for people and the delivery of care was not based on best practice guidelines.

Staff support: induction, training, skills and experience

- A significant number of staff had out of date or no training in subjects including: dementia awareness, safeguarding, health and safety, first aid training and risk assessment. This had an impact on the quality of support that people received for example, people living with dementia were not receiving person-centred care that met their needs.
- No staff had received training from the service in physical intervention and how to manage physical violence. Staff were regularly engaging in physical intervention and this lack of training placed staff and people at risk. One member of staff told us that they were concerned about this and felt, "We have to have that in place". Another staff member told us they "Felt helpless" during physically violent episodes. Staff were not providing effective support for people with mental health needs. Some staff did not recognise poor practice in relation to moving and handling.
- Agency staff did not always have appropriate training to provide support to people for example, training in dementia and behaviour that may challenge others. We observed the records for two agency staff working during the inspection who did not have training in either of these subjects. The registered manager told us they would work with head office to ensure that they only use agency staff with the appropriate training in future.

The provider had failed to provide sufficient training as is necessary to enable staff to carry out the duties they are employed to perform. This was a breach of Regulation 18 Staffing of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

- Staff received supervision to support them in their work. We received mixed feedback about how effective supervision was for staff. One staff member told us, "I get supervision, yes. I have it with one of the nurses. It's fine; I can say what's on my mind". Other staff members told us supervision did not benefit them and that they found their line manager unapproachable.
- There were numerous incidents where staff had been affected by aggressive behaviours of people. Records demonstrated a lack of support for staff after these incidents. Though one staff member told us they had a debriefing session after an incident, this was not routine practice.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
● Some people in the service shared rooms but they lacked capacity to make this decision. The provider had not carried out mental capacity assessments or a best interest decision about this.
● Some people in the service lacked capacity but the service had not carried out mental capacity assessments to establish how much support the person needed to make decisions about their care. For one person it was documented in their care plan that they were 'unable to consent with my care package' but there were no mental capacity assessments in place to support the decision for them to receive care. Mental capacity assessments that were in place lacked detail.
● One DoLS had recommended that the provider update the person's care plan to make it more person centred and to include the person's past interests and hobbies. However, this recommendation had not been followed and the life history part of their care plan was blank.
● We spoke with staff about their understanding of issues around consent and mental capacity. Some staff members understood the principles of the MCA. However, other staff we spoke to told us they had not completed any recent training in the care of people with dementia or in the MCA. Their knowledge in this area was not sufficient given the care setting and the complex needs of those people living at the home.

The failure to provide care and support in accordance with the Mental Capacity Act (2005) was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. After the inspection, we were informed that some mental capacity assessments had been completed but they continued to lack detail and there was limited involvement of the person or their relatives.

● We noted that for one person the appropriate people had been involved in carrying out a best interest decision including: an advocate, family and staff from the home.
● Five people received their medicines covertly, that is without their knowledge or consent. They had been subject to mental capacity assessments and best interests' decision in line with current legislation.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were not appropriately assessed, as described in the 'Safe' domain.
● The service was described as specialising in care for people living with dementia, Alzheimer's disease, and mental illnesses on the provider's website. However, the registered manager and provider were not able to tell us of any best practice guidance or national guidance that they were following at the time of the inspection. Staff were also not able to tell us about best practice guidance.
● The provider told us they were in the process of investing in the environment to make it more dementia friendly and this needed further development.

Supporting people to eat and drink enough to maintain a balanced diet
● We received mixed feedback about how nutritional needs were met in the service. We received some feedback from staff that food was not always prepared at the correct consistency for people. We brought these concerns to the attention of the provider and registered manager who told us they would investigate

these concerns immediately. The registered manager addressed this concern with staff after the inspection. The local authority and CCG also expressed concerns to us that risks of choking were not always well managed within the service. We also received information of concern from the clinical commissioning group that people's needs were not always met in relation to appropriate levels of hydration. However, we found the provider had taken action to address these concerns.

● Staff we spoke with during the inspection were knowledgeable about people's differing dietary requirements and necessary consistencies of food. We did not observe anyone to be given the wrong consistency of food during the inspection. Staff were aware of the importance of healthy eating, special diets and of maintaining a balanced diet. Care plans reflected this; for example, one person was at heightened risk of choking due to difficulty with swallowing. The person had been referred to and seen by a Speech and Language Therapist and provided with thickener to add to drinks. The staff we spoke with were aware of the importance of adhering to the use of these and the need for close supervision during mealtimes.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● We noted from our examination of care plans, that people had been referred to external healthcare professionals. For example, referrals had been made on behalf of people to agencies such as dieticians, Community Mental Health Teams and NHS Tissue Viability Nurses. We noted however that although these referrals were made, there was not always sufficient follow up from staff to ensure people received input from external professionals regularly and in a timely manner.

Adapting service, design, decoration to meet people's needs

● There was appropriate signage to facilities such as toilets and bathrooms; communal areas such as corridors were decorated in such a way as to differentiate between areas of the home, which would be useful to people living with dementia. However, the service could have been further improved to be more stimulating for people living with dementia. The provider and registered manager had noted this and had plans to make the service more dementia friendly.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

We received mixed feedback about the nature of support people received. One person told us, "They're a good bunch here" and another person told us "Sometimes [staff] are kind". One relative told us, "I visit almost daily and I feel welcomed". Some staff told us that due to staffing pressures people were not always treated with dignity and respect.

Ensuring people are well treated and supported; equality and diversity

- We noted staff were sometimes respectful and kind to people living at the home. We observed some compassionate and caring interactions between staff and people.
- There was not a calm atmosphere in the home. Call bells were constantly ringing and a number of people were calling out in distress during our visit to the home. At times some staff appeared unengaged and were not interacting with people whilst supporting them. At other times staff were engaged for example, providing reassurance to people.
- Some staff appeared to know people well including their personal history and hobbies but others did not and cared for people in a task focused way. We observed some carers to kneel and speak to people at their level appropriately.

Respecting and promoting people's privacy, dignity and independence

- People were not always treated with dignity and respect. Some people were slumped in chairs and staff did not always attempt or know how to reposition people comfortably. This did not demonstrate a caring approach from staff as people were left seated in positions that not only appeared uncomfortable but did not support good posture and could cause pain.
- One person was sat with their stomach exposed because their clothes had become displaced. A person's relative told us they were upset that their family member's clothes go missing and they were wearing another person's shirt during the inspection. Staff were under pressure, often trying to do multiple tasks at once which affected their ability to consistently provide support in a caring way. One staff member was observed to be rushing and said to one person, "Give us a chance [person], I'll be back in a minute". The task focused approach from staff was having an impact on people's dignity.
- When we spoke to staff about the care being provided, they often spoke to us in terms of tasks being completed rather than the experience or choices of people living in the home.
- We saw limited evidence of people being encouraged to maintain their independence. Records did not demonstrate that the service was promoting people's independence.

A failure to always treat people with dignity and respect was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. After the inspection, the registered manager

told us they would carry out more observations within the home to monitor and ensure people were being treated with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care

● Care records did not demonstrate that people, families or their representatives were involved in care planning. We received inconsistent feedback from relatives about how they were involved. One relative told us, "We know the Manager, we can always ask her things. We have meetings every month". Another relative told us they had not been regularly involved in care planning and when they were involved they found the care plan required changes.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

Services were not planned or delivered in ways that met people's needs. Some regulations were not met.

We received inconsistent feedback about whether the service was meeting people's needs. One person told us, "There'd be lots of things I'd change. More things to do to keep you moving along".

Planning personalised care to meet people's needs, preferences, interests and give them choice and control; End of life care and support

- We observed some staff to be task-focused during the inspection. Some staff we spoke with were knowledgeable about the people they were caring for and could explain to us people's individual needs and requirements. Other staff were not knowledgeable about people's needs.
- Some care records included appropriate information about people's health needs. However, some care records lacked detail and lacked person centred information about people's personal histories. One care plan had no personal history information at all and they had started living in the home in March 2016. Some care plans included brief information of likes and dislikes for example, 'I like to be alone in my bedroom mostly. I do not like noisy environment' or foods that people enjoy. Daily records were not person-centred and provided very little insight into the person's daily life for example, 'resident observed, no issues'.
- Care records included basic information on how staff should support people to understand information for example, 'I would like staff to speak to me clearly, I would like them to tell me what you are going to do and when'. However, we did not observe that staff knew how to interact with people in a skilled way according to their complex needs.
- The last relative survey raised concern that people did not receive enough mental engagement and physical exercise. During the inspection two of the activities provided were hairdressing and nails. Though this is an important activity of daily life, it does not provide the same social, emotional and psychological stimulation that a person-centred activity would for a person. People appeared unengaged and unstimulated for significant periods of time. One person we spoke to was sat in front of a television. They were not watching the programme and told us they found the television irritating. During our visit an external entertainer visited the home. They performed songs in a very loud manner using an amplifier and encouraged people to join in. Whilst some people appeared to enjoy it, we were concerned that loud noises was a trigger to anxiety and subsequent incidents of challenging behaviours. One staff member told us they didn't have enough time to build a picture of people and what activities they may enjoy. This meant activities were not always planned and delivered based on individualised needs and preferences. One relative told us that their family member enjoyed gardening but their overall experience was that this did not take place regularly and they felt they always had to ask staff to take their relative out.
- We observed that people were offered a choice of two cooked meals however for one person who received a different diet they only received one choice and during the inspection they did not like what was available. Therefore, they were not able to have a hot meal like other people and only able to have a sandwich.

The failure to provide care that met people's needs and preferences was a breach of Regulation 9 of the

Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

● End of life care records included basic information such as, 'I would like staff to make sure that I am comfortable and free from any pain'. These records did not include specific information about people's preferences as they approach the end of their life.

Improving care quality in response to complaints or concerns

● The provider had not received any formal complaints since the last inspection. However, the provider was not consistently documenting informal concerns raised by people or relatives. Therefore, we could not be assured that these were acted upon. We noted that some significant concerns had been received through questionnaires but actions taken as a result were not documented. Many people in the service were not able to express their views, therefore it is important that feedback from relatives and visitors is sought and acted upon. We recommend that the service seek advice from a reputable source on the management of concerns and complaints.

● We noted the complaints procedure was available for all to view in communal areas. It contained information about how and to whom people and representatives should make a formal complaint. There were also contact details for external agencies, such as the Local Government Ombudsman. The staff we spoke with were clear about their responsibilities in this area.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

We received inconsistent feedback from people, relatives and staff about the management of the home. One relative told us, "There is a marked lack of morale boosting on the part of the senior management and it would help the residents and their loved ones for a slightly higher profile of senior management". Another relative told us, "You won't get any complaint from me. It's very transparent here. They always let me know about [person]". One staff member told us, "I think the home is well run yes and the owner is around a lot". Another staff member told us, "The staff here feel very undervalued and under-appreciated".

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility

- The provider told us that they made decisions about admitting people to the home in conjunction with the registered manager. He told us he would ask the registered manager "Would anyone else take them [registered manager]?' [Registered manager] says no and I say well if you think you can cope then take them'". Following the inspection, the provider told us that after a preadmission assessment which confirms if the home can meet a person's needs and once the equipment needed is in place, the provider says 'that if you think this resident is going to have better outcome here than where the resident is at the moment, then go ahead'.
- One staff member told us, "I don't think enough consideration is given to the people coming in and the (impact on) staff". This tied with our observations that the provider and registered manager had not given due attention to the number of residents with complex needs and how they could live and interact with one another safely.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The registered manager and staff were not always clear about their roles and how the focus on tasks had an impact on the quality of the service being provided as previously outlined in the other sections of the report.
- The provider and registered manager were not clear on their regulatory requirements and did not act quickly enough to address concerns found during the inspection.
- The provider and registered manager were not sufficiently monitoring the service to robustly manage and act upon the risks to people. The majority of audits were carried out sporadically and addressed different areas of the service which meant there wasn't consistent oversight of the whole service and concerns we found during the inspection had not been identified by the management. These audits were ineffective and appropriate actions were rarely identified to drive improvement in the service.
- The provider initially told us that going forward that they were going to audit the service in terms of the

Commission's key lines of enquiry in the safe and well-led domains twice per year and the other domains annually. This was not sufficient to robustly monitor the service and further demonstrated a lack of understanding of robust governance. Following the inspection, the provider told us they would significantly increase the monitoring and governance of the service to twice weekly but a robust governance system needed to be embedded and sustained. The registered manager told us incidents and accidents would be reviewed and analysed on a daily basis. After the inspection, the provider informed us that a quality assurance manager had carried out an audit of the service and that the provider had commissioned further external audits to take place twice annually.

The failure to monitor the quality of the service and maintain accurate records was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

● The provider had undertaken monthly medicines management audits. These covered both the management of MARs and the wider aspects of medicines management, including the ordering, storing and disposal of medicines. Areas of concern identified were managed in a timely fashion, such as absent photographs on MARs. The provider was also subject to audit from the provider's dispensing pharmacist. The latest of these, carried out on 31 October 2018, revealed no major issues.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● We received mixed feedback about the culture of the service. These included concerns about bullying, a lack of team work and a focus on completing tasks. One relative told us, "The Manager is not good no. Efficient yes, tick box mentality". Comments from staff included, "On the whole we all get along, there's a mass of us that are strong but there's a couple [who are not]" and "There's a massive bullying problem, it's constant and it's miserable". Another staff member told us, "I like my job sometimes. Sometimes I love it sometimes I hate it. I think my unhappiness comes from not a good team. In general the staff is good but you get some who rely on other people if I can say that."

● We received inconsistent feedback about how welcoming the service was for new staff. One new member of staff told us, "[Staff] always talk to me and they always say hello". However, another member of staff told us, "We can't keep good carers because we've got continuous bullying".

● A staff feedback survey included responses that demonstrated concerns about a lack of teamwork. This feedback had not been acted upon by the provider and registered manager. We recommend the provider seeks and acts upon feedback from staff, people and relatives.

● Some staff expressed fear or reluctance about speaking out about their concerns which demonstrated that the service was not always open and transparent. The provider and registered manager were deeply disheartened to hear of the concerns about the culture within the service. It is concerning that the provider and registered manager were not already aware of these concerns. However, they put measures in place to address the culture immediately, including team building days. They were hopeful that the new staff deployment which included an extra registered nurse on during the day would also alleviate pressure on staff and have a positive effect on the whole service.

● We received mixed feedback about how approachable the registered manager was. One staff member told us that when they had approached the provider or registered manager for help in the past, they had received support. Another staff member told us that the registered manager was not approachable with personal concerns that may be affecting them in the workplace, "I don't feel like I can really engage with [registered manager] even on a professional level".

Working in partnership with others

● Representatives from a local church occasionally came to the service and some activities were provided

by external people. The service did not have any links to organisations in the local community.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to meet the needs and preferences of people using the service. Regulation 9 (a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to treat people with dignity and respect at all times. Regulation 10 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to act in accordance with the Mental Capacity Act (2005). Regulation 11 (1)(3)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to assess risks to people and to do all that is reasonably practicable to mitigate those risks. Regulation 12 (2)(a)(b)

The enforcement action we took:

We imposed urgent conditions on the provider's registration requiring them to audit the service and provide CQC with monthly reports.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to assess risks to people and to do all that is reasonably practicable to mitigate those risks. Regulation 12 (2)(a)(b)

The enforcement action we took:

We imposed urgent conditions on the provider's registration requiring them to audit the service and provide CQC with monthly reports.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There was insufficient numbers of suitably qualified, competent, skilled and experienced persons employed to provide care and support. There was a failure to provide appropriate support, training and professional development to staff to enable them to carry out the duties they are employed to perform. Regulation 18 (1)(2)(a)

The enforcement action we took:

We imposed urgent conditions on the provider's registration requiring them to audit the service and provide CQC with monthly reports.