Mavin [Care] Limited

Fairlawns 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**

Overall summary

We inspected this service on 20 August 2015 and the inspection was unannounced. Fairlawns Care Home provides personal care for up to 19 older people, some living with dementia. During our inspection there were eight people living in the service.

During a previous inspection on 1 March 2013, we found that the service did not meet requirements in many areas and the service became dormant with the expectation that the provider would make improvements to bring the service within regulation. Fairlawns Care Home reopened in June 2014.

Our next inspection of this service was on 16 April 2015 and the service was rated as good. However, we carried out this inspection because we had been made aware of some concerns regarding this service.

At the time of this inspection there was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are

Summary of findings

'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 previous registered manager had left the service soon after serious concerns had been raised about the service that were being investigated by the local authority safeguarding and quality monitoring teams. A new manager did not start working at the service until five days prior to this inspection on 20 August 2015. The providers did not take action to ensure that there was a person that was competent, suitably qualified, skilled and experienced enough to oversee the day to day running of the service while a manager was being recruited. This was despite there being serious concerns about the safety of the people who were living there.

During this inspection, although the staffing levels were adequate, there was not the necessary mix of skills, competences, qualifications, experience and knowledge to support people safely. Not all of the staff knew what to do if they suspected someone may be being abused or harmed. Recruitment practices had not been robust and did not protect people from staff who were unsuitable to work in care.

Medicines were stored properly and safely, but not all the staff who were administering medicines had been were trained to give medicines safely and no meaningful audits were carried out to protect people from mistakes occurring.

New staff had not received the training they needed to understand how to meet people's needs. Since the new manager had taken up their position, they had hastily arranged some of the necessary training for all the staff during the week before our inspection. However, in some important training areas staff had either not received relevant updates or had not received training at all.

Where people were not able to give informed consent, action had not been taken to protect their rights.

People did have enough to eat and drink to meet their needs, but it was prepared by untrained staff and was often of a poor quality and was therefore potentially hazardous to them. Nor were all the staff trained to assisted or prompt people with meals and fluids if they needed support.

The provider failed to keep the premises in a condition that meant that people's health and welfare was protected or to ensure that risks to their wellbeing were minimised.

Most staff treated people with warmth and compassion, but sometimes addressed them in an inappropriate way, not out of disrespect, but possibly because they had not received training on respecting people's dignity and privacy and had not received redirection by senior staff. People told us that some staff refused to attend to their needs. Some people did not have access to a call bell so were unable to call for help when they needed it.

There had been no arrangements in place to offer people meaningful activities throughout the day. Nor were trips out arranged or arrangements made to bring outside entertainment into the service. Since their appointment the new manager had begun to take steps to address this.

Complaints had not been addressed. We saw no evidence that complaints had been managed as required. However, people told us that they had confidence that the new manager would listen to them.

The previous manager displayed poor leadership skills; they had failed to build a workable relationship with the staff or the provider. When it became obvious that they were not able to fulfil their role effectively, they took no steps to rectify this and we saw no evidence that they asked for support from the providers. The providers left the manager wholly responsible for monitoring the quality and safety of the service, which they had failed to do. The providers failed to realise the manager was not fulfilling their duties and take action to rectify the issue. They also failed in their duty to assess and monitor the quality of the service and manage risks.

We found that there were a number of breaches in the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and you can see what action we have told the provider to take at the back of the full version of the report.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.

Summary of findings

- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The provider failed to recruit staff in a way that ensured that they were suitable to work with vulnerable people.

Not all staff had received training in how to recognise abuse and report any concerns and the provider did not maintain safety because they failed to make sure that there were enough qualified, skilled and experienced staff on duty to meet people's needs.

People's ability to make choices were restricted. Care plans were of a poor quality that did not properly identify people's needs and aspirations.

Some people did not have access to a call bell so were unable to call for help when they needed it.

The service did not manage medicines properly.

The provider failed to keep the premises in a condition that meant that people's health and welfare was protected or to ensure that risks to their wellbeing were minimised.

Is the service effective?

Inadequate

The service was not effective.

Not all staff received the training they required to provide them with the information they needed to carry out their roles and responsibilities.

Not all staff understood how to provide appropriate support to meet people's health, nutritional and social needs.

The Mental Capacity Act and Deprivation of Liberty Safeguards was not effectively understood by the providers or staff. Where people lacked capacity, the correct processes were not put in place so that decisions could be made in the person's best interests.

Is the service caring?

Requires improvement

The service was not always caring.

Staff mainly treated people well and were kind and caring in the ways that they provided care and support, but some staff refused to attend to people's needs when asked.

People were mainly treated with respect and their privacy and dignity were maintained, but not always.

Is the service responsive?

Inadequate

The service was not responsive.

Summary of findings

People's choices and preferences were not always respected and taken into account when staff provided care and support.

The service did not always understand people's interests and did not assist them to take part in any activities that they preferred. However, people were supported to maintain social relationships with people who were important to them.

There was no evidence that processes were in place to deal with any concerns and complaints or to use the outcome of a complaint to make improvements to the service.

Is the service well-led?

Inadequate

The service was not well led.

People and their relatives were not consulted on the quality of the service they received.

The providers failed in their duty to have systems in place to monitor the quality of the service or to protect people's safety and welfare.

People did not have access to meaningful activities and did not get opportunities to go out shopping, for meals out or other community activities.

The provider failed to display or project good visible leadership.

Fairlawns 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

This inspection took place on 20 August 2015 and was unannounced and the inspection was carried out by two inspectors.

Our last inspection of this service was on 16 April 2015 and it was found to be a good service. However, we carried out this inspection because we had been made aware of some concerns regarding this service.

Before we carried out our inspection, we reviewed the information we held on the service. This would have included statutory notifications that had been sent to us in the last year. This is information about important events which the provider is required to send us by law. We would use this information to plan what areas we were going to focus on during our inspection. However, there were very few notifications on file.

During our inspection we observed how the staff interacted with people who used the service and we spoke with six people who used the service.

We also spoke the new manager, two senior care staff and five care staff and with one healthcare professional and a social worker who visited the service during our inspection.

We also looked at five people's care records and four staff records, we would have looked at more but there were no more available. We asked to examine information relating to the management of the service such as health and safety records, staff training records, quality monitoring audits and information about complaints. However, the majority of this information was not available.

Inadequate

Is the service safe?

Our findings

Most of the people we spoke with told us that they felt safe living in the service. Some of the people living in the service were not able to answer questions at this level because they were living with dementia, but we spent time with those people, chatting with them generally. On the whole they were relaxed and did not give the impression of being worried about their safety. However, one person told us, "When I call for help at night the staff don't always come to help me."

We were unable to find evidence that safety checks had been carried out to manage risks to the service, untoward events or emergencies. For example there was no records that fire drills were carried out so that that staff and the people living in the service knew how to respond in the event of a fire. The new manager confirmed that they had not been able to find any health and safety records either.

Risk assessments were in place that were designed to minimise the risk to people in their day to day lives, but the information they contained was minimal and would not protect people from potential risks. For example the risk of falling, risk assessments gave very brief information about support people needed in getting around. There was no guidance for staff on what support people required to reduce the risks they faced.

People did not have access to call bells in their bedroom; there were call buttons on the walls beside people's beds. But the service did not have extension cables so that those people who could not lean over to reach the bell on the wall and people sitting in chairs away from the bed were unable to call for help if they needed it. One person, whose bedroom was away from the main communal rooms and had severe mobility limitations told us, "I have been given a horn to blow when I need help, as I haven't got access to a call bell from my chair, but they don't always hear it."

People told us they did not feel their medicines were always handled safely. One person told us, "One night I was in terrible pain, but the carer brought the painkillers to me in her bare hand. I didn't want to take them after that."

We observed staff supporting people to take their medicines in a patient and caring manner. However, we saw that the medicine records had gaps where staff had failed to sign them after giving people their medicines There was no practice in place for the medicines and their records to be audited by senior staff so that these omissions could be picked up and dealt with.

We did see monthly medicine audits carried out by the previous manager. However, on examination, we saw that all of the audits were identical, with the date being the only difference. None of the audits recorded any necessary changes or poor recordkeeping. Meaning that meaningful audits had not been carried out on staff practices involving medicines. These records we saw covered from December 2014 to July 2015 and had not been picked up by the providers as being invalid.

Where people needed medicines only occasionally (PRN) there were no protocols in place to inform staff when to use them.

Records showed that half of the staff team had not received medicines training and the rest of the staff were overdue update training. One staff member told us, "I was asked to do meds before I had done any training whatsoever," Another said, "Half the staff here haven't done any meds training. It's only in the last week that they've started training people."

The registered person did not always ensure that care was provided in a safe way and had failed to ensure that people received their medicines in a safe way. This is a breach of Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.

Some staff told us that they had not received training in recognising abuse and were not aware of the provider's whistleblowing policy and the procedures they would need to follow if they had concerns about people's safety and wellbeing. This meant that staff did not have the understanding of the types of abuse and of how they would report safeguarding concerns. This left people vulnerable and we could not be confident that action would be taken in people were put in harm's way.

This is a breach of Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2014, Safeguarding people from abuse and improper treatment.

The environmental health and safety officer had recently visited the service and inspected the kitchen and food

Is the service safe?

storage areas. They found many breaches to the food safety and hygiene regulations including inadequately trained staff, poor hand washing practices/facilities, unhygienic conditions and food being stored at unsafe temperatures.

They also found that the layout and design of the kitchen did not allow proper and easy maintenance cleaning or adequate working space for staff to carry out food preparation hygienically. The officer found the space was limited and there was not enough space for the cook to safely take hot food out of the oven. It was found that the provider must provide a kitchen of suitable size to allow food to be prepared, cooked and served safely. The provider had started to make plans for the kitchen to be bought up to standard.

Food preparation facilities are given Food Hygiene Rating Scores (FHRS) rating from zero to five stars, zero being the worst and five being the best. Following the food hygiene inspection the service was awarded one star. Neither the manager nor the providers had identified any of the many concerns and breaches that had been found during the inspection.

The accommodation was not suited to caring for people with limited mobility and needs associated with dementia. A staff member told us that the doors were too narrow and people in wheelchairs were constantly getting bruises from banging their arms against the door. One person told us, “The doors are too narrow for people in wheelchairs. I am constantly banging your arms as I go in and out of my room,”

The environmental health and safety officer had found that the outside areas were unsafe due to uneven pavements, fences falling over, overgrown grass and access doors not being locked. One person had been able to leave the service unsupported by going out of the back garden gate that was not locked. Work was underway to make the garden safe at the time of our inspection.

The registered person had failed to ensure that the premises were suitable for the purpose for which they were designed for. This is a breach of Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2014, Premises and equipment.

The above evidences that the manager and providers had not demonstrated an understanding of keeping people safe by analysing risks to safety or learning by their mistakes. Another example of the service not learning from mistakes was that both staff and the manager told us of an incident where a person, who would not have be able to protect themselves if they were out unaccompanied, had left the building and only returned back to the service with the assistance of the police. Despite knowing that person had left the building and had got out onto the street by using the unlocked back gate, a lock was not fitted to the gate until they had left the building for the second time. A staff member told us, “A resident left the home without anyone knowing through a gate in the garden. Despite knowing about this, nothing was done to secure the garden and a few days later the same person left again. It took four and a half hours, four police officers and two paramedics to get them back.”

The registered person failed to keep people safe by analysing risks to safety or learning by their mistakes. This is a breach of Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014, Good governance.

People we spoke with told us that there were times when they had to wait for support from staff and that at times they spent long periods without seeing any staff, especially at weekends. They also told us that their visitors had to wait a long time at the door before it was answered.

During this inspection the staffing levels did not have the necessary mix of skills, competences, qualifications, experience and knowledge to support people safely.

Prior to our inspection we had been contacted by staff and visitors who told us that only one staff member had been on duty at times to care for the eight people living in the service. That one staff member was also responsible for preparing the main meal of the day. Staff we spoke with acknowledged this as correct and told us that they thought that staffing levels were unsafe at times. One staff member told us, “I am worried that something will happen and someone will get hurt.”

Care staff were asked to prepare rotas. One staff member told us, “I was asked to do the rota, then another member of staff changed it, It’s chaos here.” Another staff member told us, “The shifts here are 7-2, 2-9 and 9-7. I know some people have worked three shifts in a row because there was no cover.”

We saw evidence that within the last week before our inspection the manager had taken control of planning staff cover and had taken steps to recruit new staff. They had also begun using agency staff to maintain staffing levels.

Inadequate

Is the service safe?

The registered person had failed to ensure that sufficient numbers of staff had been made available to keep people safe. This is a breach of Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014, Staffing.

Recruitment practices were not robust and did not protect people from staff who were unsuitable to work with vulnerable people. Half of the care staff were recruited properly and their staff files contained evidence that all necessary checks had been carried out in regards to their suitability to work with vulnerable people. However, the rest of the staff had no recruitment files at all. The new staff we spoke with told us, that they had no formal interview and that no checks had been carried out to ensure that they were of good character and were competent with the right skills and experience to do the jobs they had been employed to carry out.

The manager told us that they had founds gaps in the recruitment records maintained by the previous manager. They told us that when they arrived they found staff who had been recruited without references and Disclosure and Barring Service (DBS) checks to ensure they were suitable. The manager told us they were in the process of setting up interviews for the staff that started work without one, carrying out DBS checks, issuing all staff with new contracts and filling in any gaps in recruitment records they had identified. During our inspection we found that half of the staff working at the service did not have a staff file and there were no documents relating to their recruitment, induction, training or supervision.

One member of staff told us, “I was basically brought in off the street and asked to work without a DBS check or any references being taken,” Another staff member told us that they had heard that the service was struggling to prepare food for people and had spoken to the manager about becoming their chef as they had qualifications in that area. They were taken on and started work the next day. However, within days they were asked to become a member of the care staff team and then almost immediately was given a senior care post. They received no induction and not training for either post. The new manager has since given that person the chef’s post and is arranging relevant training for them.

The registered person had failed to ensure that staff they recruited were suitable to work with vulnerable people and were competent to do their jobs. This is a breach of Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2014, Fit and proper persons employed.

Inadequate

Is the service effective?

Our findings

People did not receive care based on best practice from staff that had the knowledge, skills and the support and supervision they needed to carry out their roles and responsibilities.

On speaking to the manager and checking records it was established that half of the care staff employed had been working without any training. This included the mandatory training subjects, which are considered essential for staff who work with this client group. These include safeguarding vulnerable people, health and safety, fire safety, infection control and food hygiene. This is despite them working alone at times and preparing food.

Two staff we spoke with did not demonstrate an understanding of the experiences of people living with dementia. They described a person with dementia as, "schizophrenic" and stated that this person had "attacked staff" on the evening before the inspection. They both stated that they had not received any training in working with people with dementia or who display behaviours associated with anxiety and distress, and were sure that the other staff hadn't either.

The staff that had been in place when the service was reopened in June 2014 had received all the necessary training required before they started work, but no updates since. None of the newer staff had received any training before the new manager had taken up post. The manager told us that soon after their arrival they found that training had not been offered to staff and had taken steps to arrange training and the update training, but not all the staff had undertaken it. We were unable to validate the staff's training as half of the staff did not have files in place.

Two staff members told us they had not undertaken any form of formal induction when starting to work in the service. One member of staff told us, "I was shown around and helped out by the other staff, but no formal training was provided at all. We have started getting some training now since the new manager has started."

Staff told us that they did have one to one supervision sessions with the previous manager. But we saw that individual staff notes were identical each month with only the date being changed, and were not signed by either the staff or manager. Also, each staff's notes were very similar with only minor changes between each person. There were no one to one notes for the staff who had not been recruited properly. This meant that we could not be confident that staff received meaningful support and appraisal to give them the confidence to carry out their duties and responsibilities.

The registered person had failed to ensure that staff had had the knowledge, skills and the support and supervision they needed to carry out their roles and responsibilities. This is a breach of Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014, Staffing.

People told us they were asked for their consent prior to being given personal care. One person told us, "The staff communicate well with me. The other day I was being washed and the lady asked me if I needed anything else done."

The Care Quality Commission is required by law to monitor the operation of the Deprivation of liberty (DoLS) and The Mental Capacity Act (MCA) which provide legal safeguarding for people who may be unable to make decisions about their care. These safeguards protect the rights of adults by ensuring that if there are restrictions on their freedom and liberty these are assessed by appropriately trained professionals. The records and care plans in place showed that the principles of the MCA code of practice had not always been followed.

Not all the staff had attended MCA and DoLS. Two staff we spoke with confirmed that they had not received any training in MCA, and were unaware of any assessments of capacity in relation to people who used the service. One staff member told us, "We ask what people want, but I'm not aware of any assessments to say who has capacity and who doesn't".

There were capacity assessment in people's care plans, but they were blanket assessments that stated that people were or were not capable of making decisions. No consideration had been given to people whose ability to make decisions fluctuated or to those who were able to make day to day decisions about the care they received and the choices they made.

We saw no evidence that where people lacked capacity, people such as their relatives or GP had been involved in making decisions about their care. Nor that any decision

Inadequate

Is the service effective?

made on behalf of a person was done in their best interest and that the least restrictive option was chosen so that people could still make some decisions for themselves and keep control of their lives.

There were areas in the care plans that were meant to capture people's consent for different areas of their support. For example, to receive care, support with medication and for their private information to be shared with healthcare professionals and others that needed to see it. None of the care plans we looked at had these areas completed.

The registered person had failed to ensure that people were protected by the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). This is a breach of Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2014, Need for consent.

People told us that their meals had improved greatly recently, but still needed improvement. One person told us, "The food is better now, but it was boring, badly cooked and repetitive." Another person told us, "I want to have a choice every day. A while back we had the same dinner two days in a row!"

Until the week before our inspection people did have enough to eat and drink to meet their needs, but it was prepared by untrained staff and was often of a poor quality and potentially hazardous to them.

Before our inspection we had received information from staff and relatives that untrained staff had been preparing meals for people using unsafe practices, such as using out of date food and unsafe food handling in a dirty kitchen. This was also found by the environmental health officer during their visit to the service. Prior to the start of the new manager, Many staff had received none of the training required to safeguard the people from food hazards, infection or cross contamination.

Recognised professional assessment tools, such as the Malnutrition Universal Screening Tool, were used, which should identify people at risk nutritionally. However the assessment carried out were perfunctory and gave very little information about people's nutritional needs. The records only contained comments such as 'Eats normally' or 'Needs help to eat' without any further guidance of what support people needed. In assessments people's weights were recorded as 'normal' or 'average' and people were not routinely weighed so that staff could not monitor people's weight or take action if needed.

The registered person had failed to ensure that people receive food and drink that was adequate to sustain life and good health. This is a breach of Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2014, Meeting nutritional and hydration needs.

A chef had been recruited just before our inspection. They and the manager were working with the providers to supply good quality food in sufficient quantities to allow people to be offered high quality meals of their choice. The chef had rewritten menus in consultation with people who lived in the service and people told us that enjoyed their meals now.

The chef also planned the evening meal for the staff to prepare. However, staff had been preparing food without appropriate training to keep people safe from food related risks and were also supporting people to eat without training to assisted or prompt people with meals and fluids if they needed support.

People's care records showed that they had access to healthcare professionals according to their specific needs. The service had regular contact with a GP surgery that provided support and assisted staff in the delivery of people's healthcare. People were supported to attend hospital and other healthcare professionals.

Requires improvement

Is the service caring?

Our findings

People reported varying levels of satisfaction with the care and support they received. One person said, "Staff are nice, I love it here." However, another person told us, "Generally the staff are caring, but sometimes they demonstrate a lack of knowledge. For example, I have had a severe stroke and am immobile, but the other day one of the carers asked me if I could stand up and move so they could strip the bed. That's offensive to someone who has my condition."

Another person told us that they did not always get the help they needed because they could not reach the call bell to summon assistance and, "….there are two night staff that just refuse to help me when I ask and ignore me when I call out. I told the old manager but they did nothing about it." When asked they told us that they felt the new manager would get things done, but they had not yet been given a call bell extension so that they could reach the bell in bed and from their chair.

People's care records, which contained personal and private details about people were stored on the desk in the staff room which was not kept locked when unoccupied, which meant people's privacy was not protected because they were open to scrutiny by people other than those who were authorised to have access to them.

We observed that most staff treated people with warmth and compassion, but sometimes addressed them in an inappropriate way, not out of disrespect, but possibly because they had not received training on respecting people's dignity and privacy and had not received redirection by senior staff or the manager. People were often called darling, honey, love, gorgeous and babe for example.

These are breaches of Regulation 10 of the HSCA 2008 (Regulated Activities) Regulations 2014, Dignity and respect.

Staff were able to tell us about people's needs and specifically how they liked to be supported and their experiences in life which were important to them. However, this information was not reflected in people's care plans. Nor were people's personal preferences, lifestyles and care choices recorded. There was no evidence that people were involved in writing their care plans or in their review.

Despite the heavy use of endearments instead of people's names, we saw interactions between people and members of staff that were caring and supportive and which demonstrated that staff listened to people. Staff spent time with people chatting and being sociable. We saw genial banter and laughs between people and some staff. The manager told us that they had encouraged staff to stop and talk to people when time allowed, saying that when they first arrived staff were task lead and thought that they were not allowed to stop and chat.

One person had their pet dog with them and they told us how important that was to them. A part of the garden had been fenced off for the dog's use, which could be accessed from the persons own bedroom through French windows. We met the dog who was calm and did not run about the building or jump up at people. Other people who lived in the service were pleased to be greeted by the dog and did not have any concerns about it being in the building. The dog's owner told us that they were very grateful for the support they got to look after their pet, but that it distressed them that they had to leave it in their room when they came out to spend time with others and to eat their meals. This meant that they chose to stay in their bedroom more that they would have chosen to if their dog had been able to spend time with them in the communal areas of the service.

Inadequate

Is the service responsive?

Our findings

People told us that they had little or no input in the running of the service and were not asked their opinion about the way it was run. One person said, "I never get asked what I think about what's going on."

We saw assessments that had been completed before people moved into the service. Care plans were developed from the assessments, however they were perfunctory and did not contain detailed information about people's needs, preferences, hopes or expectations. The care plans that resulted from those assessments were not detailed enough for the carer to understand fully how to deliver care to people in a way that met their needs. The information was given in few words, 'Can tend to their own personal care.' 'Needs help have a bath.' and 'diabetic.' for example. There was no guidance about how people liked to be supported with their bath; not saying how often they would like it, what time of day and if they had any preferences of toiletries to be used. Nor was there guidance on how staff should manage risks to people's heath if they had been identified such as falls, weight loss or life threatening health needs like diabetes.

Areas that were meant to gather information about people's past lives that would help staff to understand their choices and expectations were not completed. There was no evidence that people or their family had any input into the care plans or that they had seen or agreed to their content.

Care plans were reviewed monthly, but all of the review sheets we saw stated that no changes were needed to the care plane every month and there was no evidence that anyone other than the previous manager had been involved with the reviews. Staff, who appeared familiar with the needs of the people they supported, told us that they were not allowed to make changes to the care plans.

People we spoke with told us the home had not provided them with any formal means of engaging in social activities. One person told us, "We never have anything apart from the television. I have heard that we're going to have films and things so I am looking forward to that."

Two care staff told us that the service had not arranged any formal activities for people who used the service, and they were not equipped with any materials which could be used to provide entertainment or leisure activities. One member of care staff told us, "The new manager has just brought in some old jigsaws. Apart from that there is not a thing here for people to do. I have walked out of here in tears I was so disgusted at the lack of stimulation."

No outside entertainers were booked to come into the service and no attempt was made to engage with the local community, by inviting groups to interact with the people who lived there. Local schools or volunteers for example. Staff believed that they would get into trouble if they stopped their task led work to sit and spend time with people. Often there had not been enough staff on duty for staff to stop their chores and build up relationships with them.

The regulated person had failed to involve people in the planning of their care needs in a way that would lead to personalised care that was responsive to their needs. This is a breach of Regulation 9 of the HSCA 2008 (Regulated Activities) Regulations 2014, Person centred care.

The provider had a procedure in place to manage any concerns or complaints that were raised by people or their relatives, however it was not followed. Complaints made to the pervious manager, had not been addressed. There was no complaints record in place and we saw no other evidence that complaints had been managed as required. One person told us of a complaint they had made to the previous manager and said that it was not investigated or dealt with. They have since told the new manager who assured them they will take action.

The registered person had failed to listen to and act on people's concerns and complaints. This is a breach of Regulation 16 of the HSCA 2008 (Regulated Activities) Regulations 2014, Receiving and acting on complaints.

The manager told us, "There were no activities before I came here. It was the cultural norm that staff were not responding to people." They also told us, "The hairdresser was cutting hair in the dining room, now I've moved them into the shower area. The manager confirmed that the home did not currently employ any staff who were specifically employed to provide activities and related support to the home, however they did intend to bring staff in in due course.

The manager also told us they had plans to introduce regular movie nights. They also told us that they had arranged for outside entertainers to come to the service and the first one was booked for the day of our inspection.

Inadequate

Is the service responsive?

Plans were also in place to not only make the garden safe for people to use, but to make it an enjoyable place for them to spend time in with suitable seating areas and raised garden beds to enable people to plant flowers and vegetables.

Inadequate

Is the service well-led?

Our findings

This service was not well led by either the previous manager or the providers. People told us that they thought the service was badly run. One person told us, "Everything is a shambles, nothing gets done and nothing happens." Another person said, "It looks as if things may be on the up, I do hope so. We need some changes here."

Staff told us they did not feel they received clear leadership, although they acknowledged the new manager had only just started and seemed to be trying to improve the way the service was run. One member of staff told us, "It's been chaos here lately. There has been no leadership at all."

The registered manager left the service on 31 July 2015 after serious concerns had been raised about the service. A new manager did not start until five days prior to this inspection on 20 August 2015. The providers had not made arrangements to ensure that there was a person that was competent, suitably qualified, skilled and experienced enough to oversee the day to day running of the service while a manager was being recruited. This was despite there being serious concerns about the safety of the people who were living there.

The previous manager displayed poor leadership skills; they had failed to build a workable relationship with the staff or the provider. When it became obvious that they were not able to fulfil their role effectively, they took no steps to rectify this and we saw no evidence that they asked for support from the providers. The manager was wholly responsible for monitoring the quality and safety of the service and failed to do so.

The providers also failed in their duty to assess and monitor the quality of the service and manage risks.

The previous manager was new to the service when it reopened in June 2014 and the records and files that we have looked at were of poor quality and in some areas appear to have been produced to show that reviews and audits had been carried out that in fact had not been done. Staff supervision notes were found to be the same document with only the date changed to imply that regular supervision meetings had taken place with staff and records had been kept. The same process was used in some of the audits purported to have been carried out, the medicine audits for example.

Other records were not available, such as health and safety records that would have shown if safety checks such as fire drills and essential maintenance checks of the lift and hoists were up to date and regularly scheduled.

The environmental health officer had recently visited the service and found that the kitchen was not adequate for the safe and hygienic preparation of food and that garden was not safe for the people who use the service to use, with uneven paving, fences falling down and access not secured. None of these issues had been identified by either the manager or the providers.

People were not asked their views about the way the service was run. No survey to check what people thought about the quality of service they received had been done since the home was reopened in June 2014. Nor did we see any evidence that people were given the opportunity to attend meetings and give their comments about the running of the home or to voice their concerns.

There were no systems in place to monitor the quality and safety of the service. The manager was expected to carry out regular audits and report concerns to the provider. However, we found no evidence that audits had been carried out effectively or at all. Those audits we did see were ineffective with only dates changed on the sheet, with everything signed as done or no changes needed. People's care record reviews and medicine audits for example.

The manager was not supported by the providers who did not visit the service to carry out provider visits. They did occasionally telephone the service and one provider did the food shopping and delivered it to the service. However, we were told by people and staff that they did not stay long enough to speak with the people who lived there or the staff.

Staff told us they felt unsupported by the directors of the company when the new manager was off sick. One member of staff told us, "They were no help we were just left to get on with it."

The provider did not ask for a shopping list before they shopped and staff told us that sometimes the food was bought when there was very little food left in the premises. During their inspection the environmental health officer noted that there were no client agreed menus in place with the staff member responsible for cooking deciding on that day what to cook based on what ingredients were available to them.

Inadequate

Is the service well-led?

People who used the service and staff told us that the food was often of a poor quality and was unvaried. On occasion the shopping was not done in a timely manner and sometimes there was not enough food available to enable staff to prepare the main meal because the shopping had not arrived. On one occasion this meant that the main meal on two consecutive days was savoury mince because there was no other meat available. The manager and staff were expected to buy items like milk or bread if it had run out and ask for reimbursement. This meant that people were not involved with the planning of the menus and staff were unable to ensure that they were offered a varied and nutritionally sound diet.

These are breaches of Regulation 17 of the HSCA 2008 (Regulated Activities) Regulations 2014, Good Governance.

The manager and provider had not kept us informed about important events which the provider is required to send us. Where concerns had been raised they had not taken appropriate action to liaise with the local authority to ensure the safety and welfare of the people involved. Prior to our inspection we had been given information about some important events affecting the people who used the service by relatives, staff and social services. However, the service failed to send us statutory notifications to inform us about these events.

The registered person failed to keep us informed about incidents in the service. This is a breach of Regulation 18 HSCA 2008 (Registration) Regulations 2014, Notification of other incidents.

The manager that has recently taken up their post at the service told us that they were aware of many of the failings of the service and told us what actions they had taken and planned to take to ensure that the service ensured the safety and wellbeing of the people who use the service. However, because the manager had only been working in the service for a little over a week at the time of our inspection we do not have the evidence to assess whether the action they have planned to take will be put in place or will successfully uplift the quality of the service and protect people from risks.

Despite their good intentions, there was a vast amount of work that needed to be done to bring this service up to regulation and the providers had not offered the manager support, in the way of a deputy manager or extra staffing hours for example. We are not confident that the providers will support the manager in their endeavours financially, physically or emotionally. This is because of the evidence we have that showed that they failed to support the previous manager effectively.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The regulated person had failed to involve people in the planning of their care needs in a way that would lead to personalised care that was responsive to their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The registered person failed to ensure that people were addressed in a respectful way or keep people's personal information safe and private.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The registered person had failed to ensure that people were protected by the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person did not always ensure that care was provided in a safe way and had failed to ensure that people received their medicines in a safe way.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The registered person had failed to ensure that staff had received training in recognising abuse and were aware of the provider's whistleblowing policy and the procedures they would need to follow if they had concerns about people's safety and wellbeing**
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **The registered person had failed to ensure that people received food and drink that was safe to eat and was adequate to sustain life and good health.**
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **The registered person had failed to ensure that the premises were safe and suitable for the purpose for which they were designed for.**
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **The registered person had failed to listen to and act on people's concerns and complaints.**
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Action we have told the provider to take

The registered person failed to have systems and processes in place to allow them to assess the quality of the service they offered to people and to keep them safe by analysing risks to safety, learning by their mistakes or taking action to improve the quality of care provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person had failed to ensure that sufficient numbers of staff had been made available to keep people safe. Also, they had failed to ensure that staff had the knowledge, skills and the support and supervision they needed to carry out their roles and responsibilities.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered person failed to keep us informed about incidents in the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The registered person had failed to ensure that staff they recruited were suitable to work with vulnerable people and were competent to do their jobs.