Valley View Residential Homes Ltd

Valley View Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This was an unannounced inspection which took place over three days, 8, 10 and 17 February 2017. The service was last inspected in December 2015. Seven breaches of regulation were found at that time. These related to person centred care; consent; safe care and treatment; safeguarding service users from abuse and improper treatment; meeting nutritional and hydration needs; staffing and governance. Requirement notices were issued to the provider.

Valley View is registered to provide accommodation for people who need personal care. It provides a service primarily for older people, including people with dementia. There were 35 people living there at the time of this inspection.

There was a registered manager who had been in post since 2010. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager had not always notified the CQC of all incidents as required. Six safeguarding alerts had been raised with the local authority but notifications had not been submitted as required to the CQC where possible harm occurred.

People, staff, external professionals and our observations told us that staff were not always able to respond quickly and consistently to people's need for support. People's care plans were not always updated promptly with any changes to their support needs.

Routine checks of the service's safety had not always been completed consistently nor had they identified the issues we found at inspection. Records of people's care did not demonstrate that people were receiving the support they required. People's personal care and support records were not being used to consistently support people's wellbeing.

People's medicines were not safely managed. There had been a number of concerns raised about gaps in recording and failing to have adequate supplies of medicines.

Most people, relatives, staff and external professionals we spoke with told us there were not enough staff to meet people's needs. Sufficient staff were not in place to support people throughout the day and night and to maintain accurate records. We had previously recommended the provider use a suitable staffing calculation tool and this had not been acted upon.

Staff were not properly trained and supported to meet people's needs. Staff were overdue essential training. Staff were not receiving regular supervision or appraisal of their future development needs.

The service did not always records best interests decisions in line with the principles of the Mental Capacity Act. We have made a recommendation to improve how this is recorded in future.

People were not always supported to maintain a suitable food and fluid intake, recording of intake was inconsistent and not in line with people's needs. Due to limited staffing people told us they missed meals or were not supported to avoid malnutrition or de-hydration.

Staff were aware of people's choices and how they preferred to be cared for. Where decisions had to be made about people's care, they and their families were not always involved and consulted as part of the process. It was not always recorded how people's consent had been agreed.

Staff were caring and valued the people they worked with. However staff told us they did not have 'time to care' due to limited staffing in place to meet people's needs. Staff told us they missed breaks to support people and each other, but had negative feelings about how well they supported people as individuals.

The service supported people to access appropriate external healthcare services so the staff could keep them safe and well. External healthcare professionals expressed concerns about the services capacity to manage people's needs.

The service did not have any regular and consistent activity or stimulation for people using the service. Staff told us they did not have time or resources to support people to take part in interest's or activity to prevent isolation or boredom. We have made a recommendation to improve the activities on offer to people.

The action plan submitted by the provider after our last inspection had not been acted upon robustly. The service had failed to make the changes required to improve the service and had failed to identify or act on a number of the issues we found at inspection. The registered manager was not seen as effective or visible in the service.

We found breaches of regulation in safe care and treatment around checks of the service and managing people's medicines. In nutrition and hydration ensuring people ate and drank enough. For the governance and leadership of the service and ensuring staffing arrangements and support to staff were robust. Please see details in the main body of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The service did not have enough suitably skilled and supported staff to meet people's increasingly complex needs.

The service did not take prompt action following incidents to ensure people were safe and they learnt from these events.

The service did not use a dependency tool to calculate staffing numbers. Staff, people, relatives and external professionals told us there was not enough staff.

People's medicines were not always managed appropriately.

Staff knew how to keep people safe and prevent harm from occurring.

Is the service effective?

Requires Improvement

The service was not effective.

Staff received day to day support from senior staff. Formal supervision and appraisal processes were not in place to enable staff to receive feedback on their performance and identify further training needs.

People told us they were not supported to eat and drink where this was needed. Records of people's food and fluids were not completed correctly or regularly evaluated to ensure effective monitoring.

Arrangements were in place to request health and social care services to help keep people well. External professionals' advice was sought when needed but not always incorporated into care plans.

Staff demonstrated they had an awareness and knowledge of the Mental Capacity Act 2005. The service did not always record where people, or their representatives, had been involved or given their consent to their care.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always supported by a staff team who had the time to support people in a personalised way. Staff told us they did not always have time to offer choices and involve people as much as they would wish to.

People were treated with respect. Staff understood how to provide care in a dignified manner and respected people's right to privacy.

Is the service responsive?

Requires Improvement

The service was not responsive.

Care plans were not always personalised to the individual or kept updated as people's needs changed over time. Care records did not always show how people or their representatives had been involved in their creation or review.

Staff knew people as individuals and respected their choices. The service did not offer enough activity or stimulation to people.

People and their relatives could raise any concerns and felt confident these would be addressed promptly.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had not notified us of all incidents that occurred as required.

The action plan submitted after our last inspection had not been completed to the required standard. Areas of concern in the service had not been picked up by the registered managers audit process.

The registered manager was not seen by staff and some people as visible or knowledgeable about the needs of people using the service.

Valley View Residential 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 checked 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. We checked if improvements to meet legal requirements had been made following our last inspection in December 2015.

This inspection took place on 8, 10 and 17 February 2017 and day one was unannounced. This meant the provider and staff did not know we were coming. This inspection was carried out to check that improvements to meet legal requirements had been made after our comprehensive inspection of December 2015. This was because the service was not meeting legal requirements at the time of our last inspection. The visit was undertaken by an adult social care inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed information we held about the home, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We also asked the provider to complete a provider information return [PIR] which helped us to prepare for the inspection. This is a document that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make.

During the visit we spoke with seven staff including the registered manager and seven people who used the service. We spoke with 10 relatives or visitors during our visit. We spoke with six external professionals who regularly visited the service during and after our visit.

Five care records were reviewed as were six medicines records and the staff training matrix. Other records reviewed included safeguarding alerts and deprivation of liberty safeguards applications. We also reviewed

complaints records, Four staff recruitment, training and supervision files and staff meeting minutes. Other records reviewed included internal audits and the maintenance records for the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

The internal and external communal areas were viewed as were the kitchen and the dining areas of the houses, offices, activities rooms and with their permission, some people's bedrooms.

Inadequate

Is the service safe?

Our findings

At our last inspection we found issues relating to safe care and treatment and safeguarding people from abuse and improper treatment. We issued requirement notices to the provider. We also recommended that the registered manager sourced and regularly used a recognised tool to calculate safe staffing numbers.

Staff told us they had attended the providers safeguarding adults training and could tell us what potential signs of abuse might be in people with a dementia related condition. Records at the service showed there had been two recent safeguarding alerts where people had not had their medicines as prescribed. One person missed a diuretic medicine (medications designed to increase the amount of water and salt expelled from the body as urine) for two days, another person a diabetes medicine (to help manage their blood sugar levels) for five days. Both these incidents occurred in January but the registered manager had not promptly concluded any investigation into the cause of these incidents. This meant action had been taken slowly to find the root cause of these missed medicines and the risk remained. This placed people at further risk of medicines errors by staff.

Staff told us how they made sure people remained safe, for instance, by ensuring that people who needed supervision or support were assisted by a staff member when they went to the bathroom. Staff also told us that at times they were not always able to support people promptly due to low staffing numbers. They told us that as a number of people needed two staff to support them, this meant the communal areas were left unstaffed. This was confirmed by our own observations and feedback from external professionals who told us that people who needed supervision had been left unobserved for periods of time. People told us that staff responded to their requests, but that at times this may be delayed if there were a number of people needing assistance. One person told us, "The staff usually answers reasonable quickly, though it depends who else calls and needs help as well".

We saw that in people's files there were risk assessments and care plans designed to keep people safe and reduce the risk of harm where this was identified. We also found some people had been identified as at risk their care needs, but revised care plans were not in place to support them. For example, one person's care plan stated in three places that they could leave the service unsupported. However this was not accurate and the person had been assessed as at risk crossing the road and this was reflected in review notes over a period of three months. The revised care plan and risk assessment had not been completed in a timely fashion and different staff we spoke with were managing the situation differently. When we brought this to the registered manager's attention they took immediate action to update the records. The service had not taken prompt action to ensure that risk were assessed and managed consistently placing people at risk.

We looked around the service to ensure it was safe, as well as check audit records of the service. We found that following re-decoration some radiator guards had not been re-attached to the walls and were loose which posed a hazard to people. When we brought this to the staff's attention they took action. We checked the health and safety checks that had been carried out in relation to the environment and found that this issue had not been identified with this process. These checks had been carried out regularly over the past 12 months with the exception of January 2017. The registered manager told us they were not carried out then

due to other work commitments. We also found that the services emergency evacuation plan was one year overdue its review. We highlighted this to the registered manager in our feedback. By failing to carry out regular checks of the environment and safety this meant people using the service were placed at risk of avoidable harm.

We also found that routine temperature checks were not being completed of the room in which medicines were stored. We brought this to staff attention who took immediate action.

We looked at two people's daily care records; both were at risk of pressure areas and had a care plan to change their positioning regularly to reduce this risk. We saw that both people's records lacked a clear goal of how often their position should be changed. Staff we spoke with told us they aimed to change people's position every two hours. Records from the previous two weeks did not confirm this to be the case. Records demonstrated these checks varied from 2 to 5 hour intervals, one record had blanks for a period of 12 hours overnight. External healthcare professionals we spoke with told us they were supporting the service with 10 people who had pressure areas and they were concerned at the level of support being offered by the service to prevent these conditions from occurring. By not making regular positional changes people were placed at risk of damage to their skin integrity.

Two people's records around personal care were reviewed in detail. One person had not been supported with oral healthcare for two weeks as staff advised they did not have teeth or wear dentures. Their care plans did not detail how often they should be supported with their oral healthcare. Oral healthcare should continue for people for the prevention of gum disease, NICE guidelines for oral health for adults in care homes. We brought this to staff's attention who agreed to take immediate action. Another person had not had support with their oral healthcare for two weeks; a GP had also asked they be referred to the dentist on the 2 February 2017 due to concerns about dietary intake and oral health. This was not actioned until we brought this to staff's attention on inspection 15 days later. This meant that people did not receive the support they needed around oral health.

Bathing records for one person we reviewed showed they had a bath or shower only five times over an eight week period. Their care plan did not detail how often they should be supported to bathe or shower. Another person's records showed they had a bath or shower only seven times in nine weeks. Again their care plan did not detail how often they should be supported to bathe or shower. Staff we spoke with told us they provided personal care when changing people's continence pads, but that due to staffing issues people were not always able to have regular baths or showers as requested by people.

An external healthcare professional highlighted to us that one person who had been recently discharged from hospital had not passed urine for 39 hours. Care records kept by staff noted this lack of urine output, but no action had been taken to seek medical advice for this concern. The external healthcare professional was concerned that if they had not identified this and taken action that staff had not picked this up. Action was taken after this had been identified by the external healthcare professional to staff. Staff did not respond promptly to this persons change in needs or seek medical attention placing this person at a risk to their wellbeing.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Almost all the staff we spoke with told us that they did not think there was enough staff to meet people's needs. Staff told us that they were task focussed and had no time to spend with people. When we asked staff why records of care had gaps they told us this was due to not having time to complete records. Staff told us

that some morning's people did not have breakfast as they chose to remain in their rooms and staff did not have time to support them. This was supported by records which showed a number of people did not receive breakfasts. Staff told us they regularly did not have time to take their work breaks throughout the day. External healthcare professionals we spoke with expressed their concerns that staff did not have the capacity to support the numbers and complexity of people using the service. They told us that people who needed support were left unsupervised, that care records showed that staff were not delivering the levels of care required by people. For example, food and fluid support, positional changes and personal care. We saw in recent staff meeting records that staffing levels had been identified as an issue by senior staff. Staff told us they raised this as an issue with the registered manager but that nothing changed. The registered manager told us they had raised staffing levels with the provider, but that funding was not in place for this to change.

Whilst touring the building we saw one person who was in a corridor and in a state of undress. From talking to staff and external professionals we were advised this was a common issue for this person. Staff told us they tried to ensure they were observing this person to support their dignity and privacy, but due to low staffing levels they were not in a position to support this person consistently. This meant they were not always able to support them in maintaining their dignity.

At our last inspection in 2015 we recommended the provider use a recognised staffing calculation tool for the service, based upon people's care and support needs to determine safe levels of staffing. When we discussed this with the registered manager they told us they had looked at a number of such tools, but none were in use at the inspection. The registered manager was using a dependency tool which assessed people's behaviours, but not their care and support needs. Staff told us that they did not have time to keep adequate records to demonstrate that care was provided in line with care plans. We saw that care plans were not being updated as people's needs changed over time placing them at risk of receiving unsafe care.

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

We looked at four staff recruitment files. Before staff were confirmed in post the provider ensured an application form had been completed with provision for staff to provide a detailed employment history. Other checks were carried out, including the receipt of employment references and a Disclosure and Barring Service (DBS) check. A DBS check provides information to employers about an employee's criminal record and confirms if staff have been barred from working with vulnerable adults and children. This helps support safe recruitment decisions. Appropriate documentation and checks were in place for all four staff and they had not been confirmed in post before all the DBS and references had been received. Staff we spoke with confirmed they had been through the full application and approval process.

We spoke with staff about how the service was kept clean; we saw a rota for the service included cleaning the home throughout the day, as well as regular deep cleans. People and relatives told us they felt the service was mostly clean and odour free and we found this to be the case during the inspection. We did find some marked furnishings, and when we drew this to staff's attention this was rectified.

Requires Improvement

Is the service effective?

Our findings

At our last inspection we found issues relating to staffing, seeking consent and meeting nutritional and hydration needs. We issued requirement notices to the provider.

We looked at how staff were trained to see if improvements had been made since our last inspection. External healthcare professionals we spoke with raised concerns that that staff needed additional support, training and advice to meet people's needs. Information we received from the provider showed that staff training was not up to date. Staff records of training were reviewed at inspection demonstrated that staff had not attended training specific to the needs of people using the service. For example the records told us that no staff had recent training in dementia care, malnutrition care and assistance with eating. The registered manager confirmed to us that staff training was not up to date in those areas.

At our last inspection we found that staff were not receiving regular supervision and annual appraisal of their training and development needs. At this inspection we looked at four staff members' supervision and appraisal records to check whether improvements had been made. We found that staff were still not being supervised and appraised regularly. One staff member had one supervision record for 2016 and one for 2015, with no appraisal since they started in 2013. Another had one supervision record in 2016, and three in 2015 with no appraisal since starting in 2014. This meant staff did not have the regular supervision and appraisal needed to keep their knowledge up to date or ensure they had the skills and training to meet people's needs. Staff we spoke with told us they got day to day support from the deputy manager, but confirmed that formal supervision and appraisal was not occurring. Most staff told us they did not feel supported by the registered manager.

These were breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and be the least restrictive possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager showed us their records of applications made and authorisations. There were a number of people subject to DoLS at the service and the correct authorisations were in place, as well as having a review and renewal process to keep these up to date. The registered manager had also sent us required notifications.

We found examples of where best interests' decisions were required on how best to support people who lacked capacity but saw these had not been completed in line with best practice guidance. Staff we spoke

with were familiar with the principles of the MCA, but agreed they did not always follow these principles in practice when making decisions on behalf of people. We saw consent forms had been signed by family members, who did not have the legal authority to do so and the best interest's decision making process should have been used instead to record this agreement. Care plans or records did not have evidence of where people, or their representatives, had been involved in discussions about, or had consented to their care plan. This meant care was provided to people which had not been consented to.

We recommend the registered person ensures that records of best interests decisions are kept in line with the requirements of the MCA codes of practice.

At our last inspection we found that people were not always supported to eat and drink enough to maintain their wellbeing. Feedback from people was that this remained an issue. One person told us, "The food is sometimes good, other times not and a bit unsure. On the whole it's ok and you get a choice. Supper doesn't always happen sometimes you get something and sometimes you don't. There is not usually a trolley either that comes around. I don't think we get enough to drink. I would like more tea". Another person told us, "The food is good, I enjoy it. I feel we could have more drinks offered. I understand they are busy though". Relatives also told us they had concerns about peoples eating and drinking. One relative told us, "I don't feel that my family member gets offered enough drinks. I do worry about that sometimes".

People had MUST assessments (Malnutrition Universal Screening Tool) in place where required to protect them from malnutrition and dehydration. We looked at people's food and fluid monitoring charts to check to see how much people ate and drank over the day. These were in place where people were assessed as being at risk of malnutrition and dehydration. There was no target intake in place for people in the records we reviewed. The services records told us fluid intake varied for one person between 800mls to 1200mls daily over a two week period. Another person had no target intake and over the previous two weeks fluids varied between 650mls and 1125mls according to records. Some people had been prescribed fortified drinks to help increase their calorie intake. Records of their use were not kept alongside fluid intake records and we could not be sure that people received these as their doctor had intended. For example we saw one person was left with their fortified drink in their room and it was recorded as taken before they had actually drunk it. This meant people remained at risk of de-hydration as effective monitoring was not in place.

Records of people's food intake were also inconsistent and could not evidence that people were supported to eat to maintain their wellbeing. One person's records showed us they had only eaten between half and a quarter of the food offered over a period of a week, they often missed breakfast with no explanation in records. When we brought this to staff's attention they weighed the person and found they had lost weight in the previous week and extra support was put in place and a dietician referral made. Staff told us that they did not always have time to support people with meals, particularly in the mornings when supporting people out of bed and to dress and wash. Staff also told us they did not always record all the drinks and meals or snacks that people consumed, as again they did not have the time to complete these records. This meant that people were at risk of malnutrition as there was not enough support in place for this to happen and effective monitoring systems were not in place to ensure people received the required nutritional intake.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us how they were aware of health care issues that may affect some of the people living there, such as pressure areas. They described how they kept a close eye on people's skin integrity when providing personal care, and reported any concerns to the district nurses. We saw that local district nursing teams

were providing support to the service with a number of healthcare issues, particularly those with poor skin integrity. These external healthcare professionals felt the service was struggling to meet people's care due to adequate staffing numbers not being in place to meet people's complex needs. One told us that staff were not able to respond to people's needs promptly. These professionals were concerned at the link between people's inconsistent care and skin integrity issues. They told us they had spoken to the registered manager and deputy manager about their concerns around staffing numbers in the service but that nothing had changed. External healthcare professionals told us they felt staff were caring, but lacked in numbers to meet people's needs.

Requires Improvement

Is the service caring?

Our findings

People gave us mixed feedback about the caring nature of the service. One person told us "Staff are excellent, they really are. I cannot speak highly enough of them. I do think they need more staff sometimes as I feel the staff are overworked, they are always on the go". Another told us, "90% of the time you cannot fault the staff, they never bring me a cuppa in the morning though, and it's the little things that matter". Relatives we spoke with also had mixed comments about care at the service. One relative told us, "Some staff are better than others to be honest. They do need more staff though, especially at weekends". Another told us, "Staff are sometimes good, sometimes not".

Staff we spoke with told us they did not always feel they had time to spend with people; they reported to us they were 'task focussed'. One staff member told us, "I like working here; I like the residents and the rest of the team. But we don't have time to take our own breaks and cover the floor so have to rush through the day". All the staff we spoke to told us they did not have 'time to care' and expressed negative feelings about this situation. Staff we spoke with knew people's needs and personalities well. We observed that staff did not have time to interact with people during the day as staff had to respond to peoples care needs.

The registered manager told us they arranged regular meetings with people and relatives to seek their feedback on the service. They told us these were poorly attended and were as a result of limited use in reviewing and developing the service. The registered manager had not considered developing other methods of seeking people's involvement in reviewing or developing the service. People and relatives we spoke with told us that if they had any issues they would raise them, but did not feel invited or consulted about how the service was developed.

Some people who used the service faced challenges around communicating their decisions. Care plans and records did not always detail to staff how to support people to communicate their views and feelings.

The registered manager had information about local advocacy services in their office. Staff told us they could make referrals if required, either for specialist mental capacity advocacy or for general advocacy support. We saw in one person's care records where advocacy had been considered due to a familial disagreement to ensure the person had their own support.

All people we spoke to told us they felt their privacy and dignity was always respected by staff. All people we spoke to advised if they needed any help with personal care, bathing, or other assistance they felt respected and told us curtains were always pulled across, or doors closed for privacy and dignity. This was observed when members of staff answered call buzzers. Staff would always knock first and ask for permission before entering if the door was closed. Staff would say to the person. "Hello I am here, can I come in? "How are you doing today?"

We saw people had information in their care plans about their preferences for care at the end of their lives. Staff told us they were experienced in providing end of life care (EOL). Staff said they linked in with local GP's and NHS nurses to administer medical support such as pain relief and in making advance care plans. They

also told us they worked closely with people and their families to ensure their end of life wishes were met. External healthcare professionals told us they supported the service with people requiring EOL care.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we found issues relating to person centred care. We issued a requirement notice to the provider.

We looked at the care plans staff used to direct and review people's care. People's needs were assessed before they moved to the service. These plans were then added to as people were assessed over the initial period and were then subject to ongoing monthly review. We saw that care plans had been re-written since our last inspection, however we still found care plans had not been updated following more recent changes in people's needs. One person's care plan did not reflect their need for staff support when accessing the community. Another did not show that they now needed two staff to support them to mobilise when this had changed three months previously. Talking to staff we found that staff mostly understood what peoples current support needs were, but this was not reflected in people's care plans. It was also unclear from records we reviewed how much the person, or their relatives, had been involved in any reviews of care plans. People and relatives we spoke with had differing views of their involvement in their care planning. Some told us they had been consulted, others told us they had not. This meant people were at increased risk of receiving care that was not based on their current needs or that reflected their preferences.

We looked at how the service ensured people had their interest supported by the service or what activities were on offer. People told us there were some one off activities, but not on a day to day basis. One person told us, "There is nothing really. Some bingo or even dominos would be nice". Another person told us, "I would love to go out somewhere anywhere really, that would be nice. There is just no stimulation". Relatives also told us there was a lack of stimulation for people. One relative told us, "There are no activities that I have seen for my family member. People just seem to sit in the lounge and sleep that is all they do. Sometimes there is not even the TV on there is nothing. I also feel that there should be one person in the lounge but this doesn't always happen". Another relative told us, "There are no activities at all. I really feel my family member would like it but they don't do much. Even some music would be good but they don't even do that".

This was supported by our own observations and through talking to staff. The activities co-ordinator post was vacant and due to staffing levels was not being covered by any other staff, there was no activities schedule in place for the service and we did not observe any activity whilst inspecting. Staff we spoke with told us they did not have the time or resources to provide activities in the communal areas or to people who were cared for in their bedrooms. The registered manager told us there had been recent entertainers in the service, and seasonal activities took place. People were at risk of social isolation and lack of stimulation.

We recommend the registered person ensures that people are supported to participate in meaningful activity in line with the NICE quality standard for Mental wellbeing of older people in care homes.

We looked at the systems for recording and dealing with complaints. People were given information about how to make a complaint when they came to live at the service. People and relatives we spoke to told us they knew who to complain to and felt able to raise any concerns. Most said they would speak to a member

of staff and the manager if they had any concerns. We saw there had been five complaints made in 2016 and these had all been responded to promptly by the registered manager. Records kept showed how each was responded to and how the service investigated the complaint.

Inadequate

Is the service well-led?

Our findings

At our last inspection we found issues relating to good governance and leadership. We issued a requirement notice to the provider.

We talked to staff about the registered manager's leadership of the service. Staff we spoke with told us the service was struggling due to a lack of staff, especially in the mornings. Staff told us they lacked confidence in the registered manager to make changes to the service and staffing. One staff member told us, "I have concerns about the Manager really as they do not know their residents at all. I feel they are not proactive at all and they don't really deal with problems very well". Another staff member told us that the issue of staffing levels had been raised before and the registered manager spoke with the owners and there was no change to staffing levels. They told us, "The manager is lovely but they do not get to make any decisions really as they just have to do whatever the owners want them to do".

Comments from people using the service also reflected this. One person told us, "I don't know lot about the manager really. I never see her". Other comments from people and relatives about the registered manager included, "I didn't know there was a manager, I have never seen her"; "I know the staff very well and they are great, but I don't really know who the manager is to be honest" and "I know who the manager is, they don't seem to mix a lot with people though".

The registered manager's monthly checks around the service for medicines, safety, care planning etc. had not been completed since December 2016. This meant the usual checks had not occurred in the preceding month. When we brought this to the registered manager's attention they told us that they had lacked the capacity due to workload to complete these routine checks of service quality the previous month. The issues of staff not receiving supervision and appraisal as well as other issues and breaches of regulations we found at this inspection had not been highlighted by the registered manager's quality assurance process. This meant that these systems had been ineffective in driving improvements within the service.

Records of staff meetings we looked at showed that staff had raised the issue of staffing levels in the service in September 2016. No action had been taken to review staffing levels after this. The action plan submitted by the provider after our last inspection had not been acted upon robustly by the registered manager as there remained a number of areas where improvements had not been completed to meet the regulations. Records showed that staff had not been afforded by the provider the opportunity to feedback on the service, to seek their views and suggestions on how the service might improve.

We looked at records called 'Managers daily report' and found a number of issues had been highlighted prior to our inspection which we subsequently found during this inspection. For example on the 11 February 2017 '[Name] no positional turns since 6pm last night'. Another record for the same day said '[Name] monitoring charts say clean and dry, was covered in dry faeces', another says 'dirty clothes and pad left on floor' on this same day a number of gaps in care records were identified as well as comments about contradictory recording by staff. From these reports and from talking to staff we saw that no clear actions had arisen from these issues highlighted in the reports. These reports had been signed by the registered

manager but not taken robust action to prevent these issues arising again.

There had been a number of safeguarding alerts raised with the local authority. We asked the registered manager for feedback on the outcome of their investigations into the causes of these alerts. This was to check that the service was taking any immediate action and any learning from such incidents to prevent possible reoccurrence. We found that remedial actions were not always implemented to prevent recurrence. There were ineffective systems in place to learn from events and drive improvement.

The service had failed to provide suitable mental stimulation and activity for people and to prevent their social isolation.

The breaches in regulation and recommendations made demonstrated that the management and leadership of the service had not been robust. Issues found at inspection had not been identified by the registered manager and where they had been identified suitable action had not been taken to improve the service.

The registered person had not responded robustly to the last inspections findings, failed to take on board our recommendations and not taken action on issues and concerns raised by staff and external professionals. This has led to the continuing breaches of regulation identified at this inspection.

These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed there had been six safeguarding alerts raised by the service with the local authority where harm may have occurred to people. However these had not been raised to the CQC as required via a statutory notification. This meant the CQC was not promptly informed of concerns that had been raised about the service.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Before inspection we checked the provider's public website, to check if the last inspection rating was displayed. We were unable to find either a copy or a link to the last report; the Care Quality Commission was listed as the 'Quality Care Commission'. We also checked when we visited the service to ensure the last report was visibly displayed in the service. We were unable to find and staff were unable to show us where the last rating was on display in any communal areas of the service. When we asked the registered manager why their rating was not on display they were not aware this was a requirement.

This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person had failed to notify the Commission of any abuse or allegation of abuse in relation to a service user. Registration Regulation 18 (2) (e)

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 had failed to assess the risks to the health and safety of service users doing all that is reasonably practicable to mitigate any such risks. The registered person had failed to ensure that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. The registered person had failed to ensure where medicines are supplied by the service provider, ensuring that there are sufficient quantities of these to ensure the safety of service users and to meet their needs; and the proper and safe management of medicines. Reg 12 (2) (a) (b) (c) (f) and (g)

Regulated activity	Regulation
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 receipt by a service user of suitable and nutritious food and hydration which is adequate to sustain life and good health.

Reg 14 (4) (a)

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	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had failed to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. The registered person had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. The registered person had failed to maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided; The registered person had failed to evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e). Reg 17 (2) (a) (b) (c) and (f)

The enforcement action we took:

not yet confimred

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 sufficient numbers of suitably qualified, competent, skilled and experienced persons be deployed in order to meet the needs of people.

The registered person had failed to ensure staff receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

Reg 18 (1) (2) (a)

The enforcement action we took:

not yet confirmed