Matt Matharu

Parkview Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 25 and 26 November 2015. Following these two days of inspection we requested the provider send us an urgent action plan in response to concerns that we identified. We visited again on 7 December 2015 to check the action they said they had taken. This was unannounced. We last inspected the service on 28 April 2015.

We completed an unannounced comprehensive inspection of this service on 2 and 5 February 2015 and found the provider was failing to meet legal requirements. Specifically the provider had breached Regulations 12, 13, 15 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

During our February 2015 inspection we concluded people were not being protected against the risks of receiving care that was inappropriate or unsafe. People were not fully protected against the risks associated with medicines because the provider did not manage medicines appropriately. The provider did not have effective systems in place to protect people from the risks of exposure to a health care associated infection. People's rights against inappropriate restriction of liberty were not in place to make the required assessments and applications, in line with Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) legislation. People were not fully protected against the risks associated with unsafe or unsuitable premises.

We undertook an unannounced focused inspection on 28 April 2015 as part of our on-going enforcement activity and to check whether the provider now met legal requirements. However we found continuing breaches of legal requirements. Specifically these related to Regulations 12, 13, 15 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. In summary people were not fully protected against the risks associated with medicines because the provider did not manage medicines appropriately. The provider did not have effective systems in place to protect people from the risks of exposure to a health care associated infection. People's rights against inappropriate restriction of liberty were not protected because appropriate measures were not in place to make the required assessments and applications, in line with MCA and DoLS legislation. People were not fully protected against the risks associated with unsafe or unsuitable premises.

Parkview Residential Home provides care and accommodation for up to 26 people. On 25 November 2015 there were 17 people using the service.

The home had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Safeguarding concerns had not been raised in relation to incidents where one person was sleeping in a

room where the roof was leaking above their head. Nor was an incident of inappropriate touch between people raised as a concern. The registered manager, despite attending training, did not acknowledge these events as safeguarding incidents and therefore no alerts had been made, meaning people remained in potentially harmful situations.

Risk assessments for the building, equipment and people were ineffective and did not identify risk or control measures to keep people safe.

The building was in a poor state of repair. There were no risk assessments or effective monitoring of the leaking roofs. People were using a bathroom with a draughty window that did not close properly. The registered manager told us people preferred to use this bathroom however the other bathroom was not useable due to the bath hoist being broken.

There was no ongoing maintenance schedule to evidence a rolling programme of repairs for the building or equipment. External exit routes were found to be padlocked which would prevent people leaving in the case of an emergency evacuation; fire doors were compromised and compartments breached.

Care plans contained inaccurate information about people's care, and the registered manager confirmed the contradictions but did not act to rectify them.

Do Not Attempt Cardio Pulmonary Resuscitation orders were in place for some people but the registered manager had not questioned the content of these which was in breach of the Mental Capacity Act (2005) code of practice.

Staff did not understand the MCA (2005) code of practice. Capacity summary sheets were in place but were not decision specific. Relatives were giving consent when they had no Lasting Power of Attorney in place to give them the authority to do so.

We saw two people asleep during mealtimes; one person's head was on a cup of tea, the other in a bowl of cornflakes. There were no staff available in the dining area to respond to people's needs.

Staff were task focused and there were not enough of them to meet people's needs as detailed in care plans. For example, one person required two-to-one support for transfers; another person needed to be observed whenever mobile and another person was to be observed if presenting with challenging behaviour. This would need four staff but there was only three care staff working at any given time which meant the remaining people were left without supervision or support.

We saw accidents had occurred where people had fallen or hit their head on the dining table. They were attended to by staff who were not trained in first aid nor was medical support sought for people.

There were not enough seats in the dining area for everyone to sit and have a meal together if they chose to do so.

The registered manager failed to recognise, investigate and respond to complaints and in the process failed to follow the provider's own policy in relation to complaint management.

There was no effective quality assurance process in place. The registered manager did not complete any audits nor did they respond to actions identified on audits completed by the quality manager. There was no system or process to assess quality and drive continuous improvement.

Medicines were managed appropriately.

Staff received supervision and appraisal however some training had not been delivered, such as nutrition and hydration, dignity and respect and first aid.

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.

You can see what action we told the provider to take at the back of the full version of the report.

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 effective. The Mental Capacity Act (2005) code of practice was not followed or understood.

People had Do Not Attempt Cardiovascular Pulmonary Resuscitation (DNACPR) orders in place which contained incorrect information which had not been challenged by the registered manager.

Staff were supervised and had an annual appraisal. Some training was up to date, however not all staff had been trained in nutrition and hydration or first aid.

Is the service effective?

Inadequate

The service was not effective. The Mental Capacity Act (2005) code of practice was not followed or understood.

People had Do Not Attempt Cardiovascular Pulmonary Resuscitation (DNACPR) orders in place which contained incorrect information which had not been challenged by the registered manager.

Staff were supervised and had an annual appraisal. Some training was up to date, however not all staff had been trained in nutrition and hydration or first aid.

Is the service caring?

Inadequate

The service was not caring. One person told us, "It's like living in prison."

Staff approach was task oriented and staff were not visibly taking the time to interact and engage with people in a caring manner.

Staff were not trained in equality and diversity.

Is the service responsive?

Inadequate

The service was not responsive. Care plans contained contradictory information about people's care needs. The registered manager confirmed the contradictions but did not act

to amend them.

Complaints weren't fully investigated or recorded and the registered manager did not adhere to the provider's policy for managing complaints.

Activities were limited and did not specifically cater to the needs of people living with dementia.

Is the service well-led?

Inadequate

The service was not well led. The registered manager could not demonstrate effective management and leadership in completing audits to drive improvement within the service.

Team meetings were not held regularly so care staff did not have a forum to share concerns, learning and ideas for developing the service.

Parkview Residential 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.

We undertook an unannounced comprehensive inspection on 25, 26 November 2015 and 7 December 2015. The inspection team consisted of two adult social care inspectors and two specialist advisors. One of the specialist advisors had a nursing background; the other was a qualified electrician. Cleveland Fire Service completed a fire safety audit on 25 November 2015. Environmental health officers completed a food hygiene audit on 7 December 2015 and began a buildings inspection.

Before the inspection we reviewed the information we held about the service, including notifications we had received from the provider. Notifications are changes, events or incidents that the provider is legally obliged to send us with the required timescale. We also contacted the local authority safeguarding team, commissioners for the service and the local Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We carried out observations using the Short Observational Framework for inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us. We undertook meal time observations and observations of how staff interacted with people as they went about their work.

We were supported by the registered manager on the first two days of inspection but on the final day they were not available.

We spoke with six people who lived there, two visitors, the registered manager, the deputy manager, the director, the area manager and the quality manager. We also spoke with three senior care staff, three care staff, the activities coordinator and the cook.

We looked at care records for five people and pathway tracked their records. We looked at the medicines records for all people using the service and records relating to the management of the premises.

We also viewed four staff files and four bank staff files, including recruitment, training and supervision and looked at records relating to the quality assurance and improvement of the service.

Inadequate

Is the service safe?

Our findings

We saw records where people had received injury following a fall and the registered manager had not followed the provider's own accident reporting policy as people had not received the relevant medical support. We saw information was recorded which indicated people had been placed at potential risk from other people. The registered manager had not made any safeguarding alerts in relation to incidents. Hartlepool Borough Council safeguarding policy was available in the incident file and clearly showed the incidents met the threshold for a safeguarding alert.

We asked the registered manager about safeguarding referrals and notifications, they said, "I know I haven't done safeguarding."

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments for people referred staff to follow the steps indicated in the care plan otherwise people would be at risk. However care plans did not routinely identify risk, hazards or control measures. We raised our concerns with the provider and registered manager and they reviewed some risk assessments. We were shown a risk assessment for one person who we identified as being at risk due to falling asleep at the dining room table during meals. The risk assessment identified the risk as the person causing injury due to banging their head on the table. The action required included 'pull the table away to ensure [the person] cannot hit the table should they fall asleep.' This left the person at risk of falling to the floor which may cause more serious injury.

We asked about processes for the safe keeping of people's personal money. The registered manager said, "The money and receipts are kept in the safe." We asked about the risk assessment for the safe, they said, "There's no risk assessment for the safe or who has access." We asked who had access and they said all the seniors, the deputy and themselves. This was a failure to follow their own policy as it stated that only the registered manager should have access.

We observed staff were carrying hot food up two flights of stairs but there was no risk assessment in place to manage the risks associated with this.

Cleveland Fire Service issued a notification of deficiency following their audit on 25 November 2015. This included concerns around external exit routes being padlocked, fire doors being compromised and breaches of compartments which would support the spread of fire and smoke in the event of a fire.

Risk assessments for work being completed in the premises were not routinely completed. Where they were in place they had been completed by the workmen who were unable, due to their role to identify any potential risk or impact on people. For example, some people preferred to spend their time in their rooms and no regard had been given to how work might impact on them if the workmen needed access to their rooms. Nor was regard paid to the impact of any disruption the works may have to people's peace and

quiet.

Not all staff had evacuation chair training and we saw that staff rotas had not been managed to ensure that two evacuation chair trained staff were on shift at all times. On reviewing the fire evacuation policy we noted it said, 'One staff member to be situated at the front door to prevent residents leaving the building or people entering the building.' If one staff member was at the front door and two were supporting people using the evacuation chair there were insufficient staff to support other people as, at times, there were only three staff on duty.

Accidents and incidents were recorded but we saw no information on how staff should distinguish between an accident and incident which had led to confused reporting. There were four incidents from February 2015 however we saw no evidence of analysis to identify lessons learnt. The analysis for accidents included the number of accidents correlated to the time of day however this information was not analysed to identify specific triggers or behaviour patterns that may lead to an accident. During September there were 27 accidents and in November one person had experienced 17 accidents. The last six monthly analysis of accidents and incidents was completed in April 2015.The registered manager acknowledged that they hadn't completed it since.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had one shower and two bathrooms. The registered manager told us one bath was not used because people preferred not to use it. We later found that the bath could not be used because it contained a bath hoist that was out of use. The window above the other bath did not close properly so this room was draughty.

The home had two conservatories which were available for people to use; one had no lighting and windows which did not close so was very cold but was still available for people to use. The second conservatory had a leak but was still made available for people to use if they chose to do so. One person told us they would use the conservatory. We raised this as a concern and asked the provider for an immediate action plan. The provider put the conservatory which was cold as it had limited heating 'out of bounds' for people, but on 7 December 2015 we saw people were still using the conservatory with the leak. The provider said they had mitigated the risk by monitoring the leak. We found small containers on the floor of the conservatory to collect any potential water.

We were advised via Healthwatch prior to our inspection that the passenger lift had been out of order during their visit on 22 October 2015. We asked the registered manager about this but they were unable to give a clear account of the timeline for this, the reason for the lift being out of order and the contingency that had been put in place to mitigate risk of people being unable to use the lift. On careful analysis of records we found the lift had been out of use for approximately three weeks. The registered manager had failed to notify the Commission of this. This matter is being managed outside of the inspection process.

We saw buckets and open rafters and holes in the main roof of the building and noted there had been a leak which had spread into a person's room. During the inspection we asked the registered manager for a schedule of works for planned and emergency maintenance but they were unable to provide this. Environmental Health stated the roof had been an area of concern during their inspection of August 2014. As part of the immediate action plan requested from the provider we were informed that all the issues would be made safe by 4 December 2015. We visited the service on 7 December 2015 and noted a building firm had recommended renewal of the lead valley and the replacement of damaged tiles.

We noted that the dining room didn't have sufficient number of seats and tables to accommodate the number of people living at the home. A care worker said, "Some people prefer to have their meals in their rooms."

We concluded there were insufficient bathing and toilet facilities and dining facilities to meet the needs of the potential number of people using the service as it is registered for 26 people. The building and equipment had not been adequately maintained.

This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not enough care staff to ensure people's care needs as detailed in care plans could be met. One person required two-to-one support for transfers, another person needed to be observed whenever they were mobile and another person needed to be observed if presenting with challenging behaviour. This would need four staff but only three were on the rota at any given time meaning there were insufficient staff to meet everyone's needs and people were left unsupported.

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

We saw the medicine file containing each person's Medicine Administration Records (MARs) was kept in an unlocked cupboard in a communal hallway next to the medicine trolley. We raised this with the quality manager who said, "It should be in the trolley." On the subsequent days of the inspection we saw the file was left on top of the medicine trolley where it was accessible to any people, staff or visitors within the building.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were administered as prescribed. As and when required medicines had specific protocols for staff to follow. Medicine care plans were in place which included reasons for the medicine and possible side effects however they did not include personalised information on how people liked to take their medicine.

All staff had safeguarding training. One staff member said, "I would tell the manager or go to a higher authority like the police."

The registered manager had followed appropriate recruitment practices including references and DBS checks.

Inadequate

Is the service effective?

Our findings

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), and to report on what we find. MCA is a law that protects and supports people who do not have the ability to make their own decisions and to ensure decisions are made in their 'best interests.' It also ensures unlawful restrictions are not placed on people in care homes and hospitals.

Capacity summary sheets were in place but they did not follow the principles of the Mental Capacity Act (2005) code of practice as they were not decision specific. We asked the registered manager about these. They said, "I was meant to take those out after the first inspection." We asked why they hadn't been removed as that inspection was in February 2015. They said, "I don't know."

One person had a consent form for a vaccination which had been signed by a relative. There was no evidence that this person had a formal Lasting Power of Attorney (LPA) for health and welfare giving them a legal right to act in the person's best interest.

Another person had a deprivation of liberty care plan which stated staff needed to liaise with the person's relevant person's representative (RPR). However there was no evidence of this person's formal status as RPR within the care record.

This person had a Do Not Attempt Cardio Pulmonary Resuscitation order in place (DNACPR) stating they had capacity and had requested not to be resuscitated. It stated the LPA had been consulted. The information contained in the person's care record indicated the LPA was for property rather than health and welfare. We asked the registered manager and they said, "The DNACPR was done with the [relative] who has lasting power of attorney. The LPA is just for health." We showed the registered manager the information in the file which related to LPA for property only. They did not comment. The DNACPR stated the decision had been made following the Best interests process of the Mental Capacity Act. We saw no evidence of this. A capacity assessment had been completed for DoLS which stated the person did not have capacity. We asked the registered manager whether the person had capacity to make a decision around the DNACPR. At no point did the registered manager question the lack of involvement from the person in the production of the new DNACPR.

Following the inspection on 25 and 26 November 2015 the provider was asked to produce an action plan in response to concerns raised over consent and DNACPR. The action plan stated that the provider had contacted the safeguarding authority over the person mentioned above however there was no reference to audit of every person's DNACPR.

We later found a DNACPR for another person which stated they had capacity to request not to be resuscitated. When asked whether the person had capacity to make this decision staff were unclear.

We saw a DoLS request for one person with the reason being recorded as RPR does not visit. This person

already had a DoLS authorisation in place and, whilst it is relevant to contact the authorising authority that the RPR was not actively involved in the person's life, a request for a DoLS authorisation is not the appropriate method to do this.

One person had a care plan in place which stated they were not to leave the building without staff being with them. We asked if this person had an authorised DoLS in place. Staff did not know and could not initially find any paperwork relating to this. We asked the deputy manager about this and they said, "It's because they fall a lot so it's for their safety." Without an authorised DoLS this would constitute a deprivation of the person's liberty. The area manager said, "I understand this." It was later confirmed that the person had capacity and therefore did not have a DoLS in place.

The registered manager was unable to evidence a working knowledge of the Mental Capacity Act code of practice (2005) and DoLS which meant the rights of people were being unlawfully restricted.

One person had a behaviour care plan which stated, 'If walking stick is used as a weapon staff will intervene and in best interests their walking stick will be removed for a short period of time to ensure everyone's safety is maintained. Should [person] wish to mobilise in this time, a staff member will remain to assist.' This placed the person at risk of falls as well as being a restriction of the person's liberty as they would be unable to walk without their mobility aid. In addition, there was insufficient staffing to enable a member of staff to remain with this person.

This was a breach of regulation 11 and 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how people's nutritional needs were being met. The chef said, "No one had been assessed as needing a special diet." However we saw care records which stated several people had diabetes which was diet controlled. The chef was asked how people's dietary needs were met, they said, "I only put sugar on one side of the apple crumble." People said, "There's not much choice on the food menu but I'm easily pleased." Another person said, "The food is cooked nicely but there's not much choice." On one day we saw that people had chicken, chips and gravy for lunch and for tea they had meat pie, chips and gravy. We did not observe anyone being offered an alternate meal.

Training records showed that 70% of staff had not received nutrition and hydration training even though care staff were preparing the evening meal for people.

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

People were not always supported to access health care services when required. For example, People who had fallen should have received medical support but had not received this. This contravened the provider's own policy.

Care records included information on people having been seen by the doctor, district nurse and chiropody for routine appointments. For some people referrals had been made to occupational health.

Referrals' had been made to the falls team and for one person we saw they had also had input from physiotherapy and then been discharged. However, the registered manager, on a subsequent referral to the falls team, told them they the person was already having physiotherapy when in fact they had been discharged the month previously. There was no explanation of this offered by the registered manager.

Staff meetings had not been held since July 2015. The registered manager said, "Individual staff surveys were held in their individual files and the information was collated however there were no issues." We saw no evidence of this in staff files.

Staff were receiving bi-monthly supervision and an annual appraisal. An induction check list was in place for permanent, bank and agency staff. All staff files we looked at included a completed induction checklist.

We viewed a training matrix for 20 staff. Of these 55% of staff were not first aid trained. All staff had received training in MCA and DoLs and safeguarding. Also, 95% of staff were trained in fire safety and 90% of staff in moving and handling.

The activities coordinator said, "I believe I'm being trained toward being a carer. I've done fire training and moving and handling."

Inadequate

Is the service caring?

Our findings

People's comments about the service were not favourable. One person said, "I stay upstairs in my cell." Another said, "It's like being in prison."

One person asked if we could get them a cup of tea as they "didn't want to pester the staff." Another person said, "I don't like it here, I want to get out."

We observed several mealtimes and saw that tables were set with plastic-coated table cloths, condiments were not always available and people had to ask for them.

At breakfast time we saw two people asleep at the table. One person's head was on a cup of tea, the other in a bowl of cornflakes. There were no staff present to support either person. When we asked the registered manager to assist, they went into the dining room and said, "This is the norm." They then woke both people and encouraged one person to eat their cornflakes.

During the lunch time meal there were 10 people in the dining area. Two staff brought meals out for people but they did not stay in the dining room as seven people were having their meal in their rooms. Plates of food were placed in front of people but there was no engagement from staff other than one staff member who asked a person to use their fork and then left.

There were no staff in the dining room at meal times, other than the activities co-ordinator who was standing watching people but not engaging with them. We observed one person, who had a history of falling asleep at the table, was left with hot food and drink and cutlery with no staff to observe therefore was at risk of serious injury. We noted the activities coordinator had not received appropriate training in areas such as first aid.

We raised our concerns about staff interactions with the registered manager. We asked for an action plan in relation to staffing and were advised that 'An analysis of care hours shows sufficient hours were in place, however they are not utilised to the best effect. We have reviewed staffing and introduced extra care hours during meal times and busy periods.'

On the final day of inspection staffing levels had been increased and we saw one staff member was sitting with one person at lunch time. They said, "Are you going to eat your pudding," and then turned away from the person to speak to another staff member who was engaging people in the lounge with an activity of naming films.

We saw one person asleep in the lounge who was bent over so their head was over their knees. The person looked uncomfortable and at risk of falling forward. We asked staff if they needed to make the person more comfortable. One staff member said, "He always sleeps like that."

The training matrix showed that 90% of staff did not have equality and diversity training; the registered

manager said it was booked but we saw no evidence of proposed dates for the training to be delivered.

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed staff knocking on doors but they were not seen to wait for a response before entering.

One person said, "If I have any difficulties I only have to buzz and they'll come and help me." Another said they thought the staff "were always in a hurry".

Residents' meetings were not held. The registered manager said, "I have individual chats with people." This covered menus, food, complaints and the fire procedure. We saw no evidence that any changes had been made in response to comments made by people.

Information was on display around the home in relation to advocacy services however we did not see any evidence that anyone had been offered the services of an advocate.

Inadequate

Is the service responsive?

Our findings

Each person had a care plan file with a standardised index. People did not always need all the care plans identified on the index, however there was no indication of which were needed and which weren't.

Care plans were evaluated on a monthly basis however we did not see any evidence that care plans had been re-written or updated in response to any evaluation. Annual care management reviews had been held and were documented.

We asked the registered manager how many people needed two to one support. They said, "There's no two-to-one support, no mobility needs for two staff," but care plans contradicted this. For example one person needed two staff to support with moving and handling and the use of a hoist as detailed in their care plan.

Care plans contained inaccurate information about people's care, for example it was recorded one person needed support shaving. We asked the registered manager whether the person had consented to being shaved by staff but they said, "We don't shave her she does it herself."

Another person's care plan around their mental health said to 'ensure [person] feels safe and secure in their surroundings' but there was no information on how to do this. It went on to say staff were to, 'observe for a change in mood and offer reassurance.' Again there was no information on known changes in the person's behaviour and what it might mean for the person or how to offer reassurance.

Care plans did not include personalised information about how the person liked or needed to be supported. There was no information on how to meet people's cultural, spiritual or religious need.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the registered manager if they had information available for people on how to complain. They initially said, "No, we don't." We later found information was displayed on the backs of bedroom doors. The registered manager then said, "The complaints procedure's in wardrobes, its laminated."

There was a complaints file in place however there was no log or analysis. There were two complaints in the file in relation to interaction at mealtimes and recording of food and fluid intake and the provision of personal care. On reviewing other documents we found several concerns had been raised by relatives however these had not been logged. The registered manager, "But they were concerns not complaints." They went on to say, "It wasn't a written complaint, do we still need to record it."

The registered manager was unable to explain the difference between a concern and a complaint and why they wouldn't record a verbal complaint. We noted a relative had raised concerns in relation to the maintenance of the building and the impact it had on one person's room as it related to a leak in the bathroom and they were concerned that the person would slip. The concerns also included: a bedroom

window, that had not been replaced within the promised timeframe, had tape around it and did not open; and the response to a leak in the ceiling/roof space. There was no record of these concerns being raised, even though the relative told us they had complained. The registered manager said "I've told them to speak to [name of the landlord] about it." As a registered manager it was their responsibility to effectively manage complaints about the accommodation and the care provided.

The registered manager failed to recognise, acknowledge, investigate and respond to complaints and concerns. They also failed to follow own policy in relation to complaint management.

This was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was an activities coordinator in post who worked four hours a day four days a week. There was information about activities on display but it did not relate to a specific programme of activities that was offered for people. People told us, "We play cards and ball games." We observed people involved in an alphabet game, although one person commented, "We did this yesterday." The activities coordinator said, "We play a game of trying to get a ball in a bucket, sometimes I let people use three balls and they throw them at them. They think it's funny and I like to see people laugh." People told us they liked the activities coordinator. One person said, "[Staff member] makes sure I get out once a week." We noted the activities coordinator had no training in dementia support or providing activities for people.

Inadequate

Is the service well-led?

Our findings

Staff meetings did not happen on a regular or routine basis therefore staff had limited opportunity to be involved in the development of the service.

We asked if there was any action plan for the premises. The registered manager said, "I don't have one, [buildings manager] may have one, I haven't." They added, "I know what's happening but I don't have a plan, it all comes down to time and money." The registered manager was unable to tell us timeframes for building works or what action was to be taken by the maintenance team or external contractors.

We asked the registered manager about their role and what it involved. They said, "It's to protect everyone. I check everything's done, t's crossed and i's dotted, check audits and put audits in place." We saw no evidence that any audits had been completed by the registered manager. We asked about care plan audits. The registered manager said, "[Names of senior care staff] will do them, I'll check them." We asked what this involved and they said, "We've gone through [name of person] care plan to see if they agree with them." We asked what they did as a registered manager to quality check the content. They said, "There's no process at the moment," they added, "I don't do any audits at the minute." We asked who wrote the care plans. They said, "All seniors do care plans." We asked the registered manager if the senior care staff had been trained in care planning and they said, "No, it's to be arranged."

We saw the quality manager had completed an audit of people's personal monies which was managed by the staff. We asked the registered manager why there was no information on whether any of the identified actions had been completed. They said, "They [the quality manager] never told me there were actions to do." When we asked if they had looked at the file since the audits were done, they said, "No."

We asked whether there was the opportunity to meet with other managers in the provider group to discuss learning and feedback from the Commission on previous inspections. They said, "We've only just had the inspection so no." We explained that the Commission had conducted inspections across locations since February 2015. They said, "It's never happened." When we asked if they had discussed previous reports in their one-to-one meetings with their manager, they said, "No." We asked if they had an action plan to raise the standards with the home. They said, "There was an action plan after the first inspection." We asked if there was anything from the second inspection (which took place in April 2015). They said, "The windows have been done." When we asked if there was anything else to be done, they said, "I don't know." We asked if there was anything they did to monitor or improve the service. They said, "I just go to the managers' meeting with [sister home]." We asked if they attended any provider groups and they said, "I look at code of practice for MCA, regulations, care planning handbook. I'd speak to PCT about medicine." PCT is the primary care trust.

The registered manager said, "I need more support for audits and action plans."

There was no effective quality assurance process in place for the service; the registered manager had failed to action on the finance audits which had been completed by the quality manager. There was no process in

place to audit the quality, content and appropriateness of care plans. This meant there was no system or process to assess quality and drive continuous improvement.

We asked the registered manager about any other responsibilities of being a registered manager. They shook their head. We prompted with regard to notifications needing to be made to the Commission. They said, "DoLS, deaths, serious injury, outbreaks of diarrhoea and vomiting. I know I haven't done safeguarding." We asked about events that interrupted the service such as for the lift being out of service and there was no response. We asked why notifications for allegations of abuse and events that had interrupted the service hadn't been received. They said, "I don't know." It is the responsibility of the registered manager to ensure statutory notifications are submitted to the Commission.

Staff said they felt supported, however we noted that the registered manager did not take part in the supervision of care staff, this was delegated to senior care staff who were supervised by the deputy manager.

Satisfaction questionnaires were sent to relatives, we asked for the process and procedure but the registered manager was unable to explain this to us and did not have a written procedure for obtaining feedback. We noted that only one questionnaire had been received per month. We asked about the frequency and recording and the registered manager confirmed she didn't have anything written down. There was no evidence of analysis of information or any lessons learnt. This meant the process was ineffective and any feedback that was given wasn't responded to or acted upon.

We asked about the management of staff hours in relation to the meeting the needs of the people living in the service. This had been completed using a generic number of hours per person. The area manager said, "I don't know why that tool's being used, it should be specific to the person's needs." The registered manager had not identified that there were insufficient staff on shift at any given time to enable the fire evacuation procedure and fire safety care plans to be followed appropriately.

The registered manager had not followed the organisation's own policies in relation to accident reporting or the safekeeping of people's personal finances.

We asked the provider for an action plan due to the level of concern identified. This included information on the assessment of risk. Some additional risk assessments had been completed by the third day of inspection and had been completed with input from a registered manager from a sister home. The risk assessments did not fully identify all the hazards or control measures that were in place. We asked if the senior managers or provider had oversight of risk and signed risk assessments off. We were told no.

The registered manager who had oversight of this home during the period of this and previous inspections demonstrated a failure to respond to the concerns raised previously. They had not developed an action plan to ensure compliance with the fundamental standards and regulations and therefore had not led the service to improve.

This was a breach of regulation 7 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 9 HSCA RA Regulations 2014 Person-centred care The registered manager did not ensure people received appropriate person centred care and treatment that met their needs. Regulation 9(1)

The enforcement action we took:

We took enforcement action which resulted in the cancellation of the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider did not always ensure the privacy of people using the service. Regulation 10 (1).

The enforcement action we took:

We took enforcement action which resulted in the cancellation of the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered manager's did not ensure care and treatment was provided with the consent of the relevant person. Regulation 11(1)

The enforcement action we took:

We took enforcement action which resulted in the cancellation of the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe

way. Risks to the health and safety of people were not assessed nor were risks mitigated.

The registered manager did not ensure that staff had the necessary training, competence and skills to care for people safely.

The provider had failed to ensure the premises and equipment were safe for their intended purpose and were used in a safe way.

Regulation 12(1); 12(2)(a); 12(2)(b); 12(2)(c); 12(2)(d); 12(2)(e)

The enforcement action we took:

We took enforcement action which resulted in the cancellation of the providers registration.

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 manager failed to implement safeguarding policy and procedures. They failed to establish and operate effective systems and processes to prevent abuse of people. They failed to recognise and investigate, immediately upon becoming aware of, any allegation or evidence of abuse. Regulation 13(1); 13(2); 13(3);13(7)

The enforcement action we took:

We took enforcement action which resulted in the cancellation of the providers registration.

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 manager failed to ensure people received suitable and nutritious food adequate to sustain good health. The registered manager failed to ensure people received the necessary support to eat and drink. Regulation 14(4)(a); 14(4)(d)

The enforcement action we took:

We took enforcement action which resulted in the cancellation of the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment There were inadequate facilities and amenities provided for the number of people using the service. The registered manager failed to ensure the premises and equipment were properly maintained. Regulations 15(1)(c); 15(1)(e)

The enforcement action we took:

We took enforcement action which resulted in the cancellation of the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered manager failed to investigate complaints and take action in response to failures identified by the complainant. The registered manager failed to establish and operate an accessible system for identifying, receiving, recording, handling and responding to complaints. Regulation 16(1); 16(2)

The enforcement action we took:

We took enforcement action which resulted in the cancellation of the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure audit and governance systems were effective. The registered manager failed to assess, monitor and improve the quality and safety of the service. They failed to assess, monitor and mitigate the risks relating to health, safety and welfare and to maintain securely an accurate, complete and contemporaneous record in respect of people. They failed to seek and act on feedback and to continually evaluate and improve the service. Regulation 17(1); 17(2)(a)(b)(c)(e)(f)

The enforcement action we took:

We took enforcement action which resulted in the cancellation of the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 7 HSCA RA Regulations 2014 Requirements relating to registered managers The registered manager failed to demonstrate the necessary competence, skills and experience to manage the carrying on of the regulated activity.

The enforcement action we took:

We took enforcement action which resulted in the cancellation of the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered manager failed to ensure sufficient numbers of suitably qualified, competent, skilled staff be deployed to meet people's needs. The registered manager failed to continuously review staffing levels and skill mix to respond the needs and circumstances of people. Regulation 18(1)

The enforcement action we took:

We took enforcement action which resulted in the cancellation of the providers registration