Field House Residential Care Limited

Field House Rest 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

The Field House Rest Home provides accommodation and personal care for up to 54 people. On the day of our inspection there were 44 people living at the home.

We undertook a comprehensive inspection of this service on 2 May 2017. At that inspection the service was rated as good overall, and requires improvement in the caring section. We found the service was not consistently caring and required improvement. People were supported by staff in a task focussed way and the specialist needs for people living with dementia needed improvement. We found on this inspection that improvement had not been made.

After this inspection we received concerns in relation to how people were safely cared for and how their care was managed. As a result we undertook an unannounced comprehensive inspection to look into those concerns on the 30 and 31August 2017. The inspection was carried out by two inspectors.

At the time of our inspection there was no registered manager in place. The previous registered manager had de registered with us in March 2017. There had been another manager who had since left and at the time of the inspection there was an interim manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered providers and registered managers 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.

We found people living at the home were not consistently protected from abuse by other people living at the home. Staff we spoke with were aware of how to recognise signs of abuse, and systems were in place to guide them in reporting these, however these were not always actioned and investigated to ensure people were protected. Staff were not always confident to support people who became upset. We saw there was not always sufficient staff effectively deployed to ensure people remained safe. People had not always had their risks identified, and their identified risks assessed and mitigated. Staff were not always aware of the safe way to support people. People were not always supported to live in a safe environment and protected against the risk of infection. The management team had started to take action with some of the areas that needed improving. People told us they had their medicines as prescribed.

People were not always assessed when needed to ensure they were able to consent to their care. People may have been deprived of their liberty without a best interests assessment being completed. Staff told us they did not always have up to date knowledge and training to support people. Staff respected people's rights to make their own decisions and choices about their support. People had food and drink they enjoyed to maintain a healthy diet. People said they had access to health professionals when they needed to. Relatives were confident their family member was supported to maintain their well-being.

People said they were supported by kind staff. Relatives told us they were happy with the care their family

member received. However we saw staff were not always able to spend the time they needed to meet people's needs. People were not always provided with choice in their day to day lives, such as if they wanted more food or choice of condiments or sauces People living with dementia were not always provided with the specialist help, and adaptations to their environment to improve their well-being. People living at the home were able to see their friends and relatives as they wanted. We saw staff treated people with dignity. They knew people well, and worked with people to maintain their independence.

People were not always supported in a way that took into account their personal choices and wishes. They were not always able to get up and eat their breakfast, or have baths when they wanted to. They knew how to raise complaints and were confident to raise them. There was had a complaints process in place to ensure people were listened to and action could be taken if required, however we found not all complaints were recorded for transparency.

People told us they did not always have interesting things to do, and relatives told us there could be more access to pastimes their relative enjoyed. The management team had identified people needed more interesting things to do. They were looking at recruiting additional staff to provide more support in this area. People and their relatives had not attended regular meetings recently and were not aware of what was happening at the home.

The provider had not taken actions to ensure people were supported safely and in an environment where they were not placed at risk. There was a culture of complacency where known risks were not reduced or monitored. Staff didn't feel supported and were not confident to discuss concerns with the provider. The provider had systems in place to monitor the quality of care and treatment people living at the home received. These were not always effective at identifying improvements such as ensuring the environment was safe. Where improvements had been identified there was a plan in place however actions were not completed or sustained.

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

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

People were not protected from abuse by other people living at the home. People were not provided with a safe environment, or protected from the risk of infection by the management team's policies and procedures. People did not consistently have risks identified and assessed, or their identified risks mitigated. People were not always supported by sufficient staff, deployed effectively to ensure they remained safe.

People were supported with their medicines by staff who had been trained.

Is the service effective?

Requires Improvement

The service was not consistently effective

People were not always supported to make decisions about their care when they needed. The provider had not ensured people were assessed when they needed to be so they were able to consent to their care. People were not consistently supported by staff that had up to date training and the skills to meet their needs.

People did not always receive their meals in a timely way which impacted on their appetite. They were not always offered they food they liked or given sufficient choice. People were confident staff had contacted health care professionals when they needed to.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff could not always attend to people who were not able to voice their needs. However, people had good relationships with staff who were caring. People were not consistently empowered to make choices, and they did not always have their confidentiality maintained. Staff protected people's dignity at all times. They encouraged people to remain as independent as possible.

Is the service responsive?

Requires Improvement

The service was responsive

People did not consistently have their needs met, and the service was not always responsive to their changing needs and preferences. People did not always have interesting things to do with their time and did not benefit from regular meetings to share their views and updates about the service. People who lived at the home and relatives knew how to raise concerns.

Is the service well-led?

Inadequate

The service was not well-led

The provider had not ensured improvements were identified and implemented in a timely way. People did not always benefit from management systems which identified where improvements needed to be made. The provider had systems in place to monitor the quality of the service and some improvements had been identified; however, we found the systems were not robust enough to identify all areas requiring improvement.

Field House Rest Home

Detailed findings

Background to this inspection

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

This inspection took place on 30 and 31 August 2017 and was unannounced. The inspection team consisted of two inspectors.

The local authority shared information with us about the services provided at the home. The local authorities are responsible for monitoring the quality and funding for some of the people who use the service.

We looked at the information we held about the service and the provider. We looked at statutory notifications that the provider had sent us. Statutory notifications are reports that the provider is required by law to send to us, to inform us about incidents that have happened at the service, such as an accident or a serious injury.

We undertook a responsive, comprehensive inspection as a result of seven safe guarding reports and other information of concern raised by other stakeholders within a two week period. Therefore we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with seven people who lived at the home, and three relatives. We looked at how staff supported people throughout the day. We used different methods to gather experiences of what it was like to live at the home. We observed care to help us understand the experience of people who could not talk with us.

We spoke with the interim manager, operations director and 10 staff. We also spoke with two district nurses, a Community Psychiatric Nurse and Commissioning Infection Prevention Lead Nurse for the Clinical Commissioning Group. We looked at four records about people's care. We also looked at complaint files,

incident reports involving people who lived at the home. We looked at quality checks on aspects of the service which the provider had completed.

Inadequate

Is the service safe?

Our findings

We found people were not protected from abuse. We saw nine incidents recorded from 26 August 2017 until the 30 August 2017 where people or staff had been physically or verbally abused by other people living at the home. These records reported three different people physically abusing other people and staff. For example, one person bent another person's fingers back. A further person kicked another person. One person we spoke to told us they tried to avoid another person because they were concerned about their behaviour. They said, "We know to keep out of [person's] way." Another person told us they preferred to stay in their room because they did not like the communal areas.

During our inspection one inspector had to intervene on one occasion to prevent an altercation between two people living at the home because they were at risk of harming each other. There were no staff available in the communal the time to support these people. People and their relatives told us and staff confirmed there were not consistently sufficient staff to meet people's needs. Staff were not always deployed effectively to protect people from the risk of abuse.

The provider had not ensured there was an overview of people's developing needs to ensure people were protected from abuse. Staff we spoke with told us some people's well-being had changed since they had lived at the home and they now sometimes presented behaviours that staff had difficulty managing. Staff also told us there were also other people who had come to live at the home more recently who also sometimes had behaviours that could lead to incidents of abuse with other people and staff at the home. This escalation of abuse had not been managed to ensure people were safe.

Safe guarding incidents were not consistently reported to the local authority or CQC to ensure they were investigated and action taken to keep people were safe. We saw two incidents recorded on the 26 and 28 of August 2017 which had not been investigated or reported. The interim manager had identified one of them but not investigated or reported at the time of our inspection. These incidents were when one person living at the home injured another person living at the home. The provider had not ensured staff were sufficiently skilled to identify and report possible incidents of abuse consistently.

We discussed with the interim manager how previous incidents of abuse were being managed. For example, the interim manager told us they had increased the number of checks for one person. The staff informed us the half hourly checks were in place because there had been repeated incidents of physical and verbal abuse and to ensure they had not left the building. There was no risk assessment in place, or an effective strategy to manage this person's behaviours and protect other people living at the home from abuse. These checks had failed to ensure people were protected from abuse or that the person had not left the building. There had been three incidents of abuse by this person towards other people and staff since the additional measures had been in place. We also saw this person had left the building on 26 August 2017. We spoke with a psychiatric community nurse who had visited this person. They told us the records completed had not provided sufficient information to enable them to review the person's care and offer alternative ways to support this person. Staff we spoke with told us they lacked skills and confidence to support people when they were presenting some behaviour.

We were also made aware prior to the inspection of five separate reports from district nurses about unexplained bruises, skin tears and poor care prior to our inspection. These had been reported through the Local Authority Safeguarding Team and were under current investigation with this team.

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). We checked whether the service was working within the principles of the MCA.

Staff were not clear about who was subject to a DoLS authorisation. When questioned further they were not sure what an authorised DoLS meant for the individuals concerned. Whilst the interim manager had reapplied for expired applications they were unclear if previous requirements for authorised DoLS had been met. They also said said they would put a system in place to ensure any requirements from the best interests assessment would be completed and recorded.

The interim manager understood the legal requirements for restricting people's freedom and ensuring people had as few restrictions as possible. The interim manager was unable to determine how many new applications would be required because of the lack of information available to them. People were restricted through locked doors at the home. They told us there were potentially 21 other DoLS applications that needed to be completed to ensure people had their rights protected. They had been unable to complete these because of the lack of information available in people's care plans to support these applications. They were unable to give us a time when these would be completed. People were potentially being deprived of their liberty without an assessment being completed in their best interests.

This was a breach in Regulation 13 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to protect people from abuse.

People did not have their identified risks assessed and monitored to ensure their risks were mitigated. For example, staff told us about one person who was at high risk of choking and ingesting small objects. We saw on the first day of our inspection there were objects left out by staff such as plastic gloves and cotton wipes in communal areas. One member of staff explained that this person had put gloves and serviettes in their mouth since living at the home. A relative told us a personal item belonging to their family member had been chewed, but not ingested a few days prior to our inspection. Staff told us this incident involved the person at risk. There was no risk assessment in place and the communal areas were not monitored to ensure there were no items available to put this person at risk. We spoke with the interim manager and they completed a risk assessment, and reminded staff about this concern and we saw there was some improvement on the second day.

People at risk of falling did not consistently have their risks assessed and mitigated. For example, we saw one person who had fallen recently and injured themselves. There was no risk assessment or clear guidance for staff to follow to reduce the risk of further falls. Staff we spoke with were unclear if the person needed two people or one person to support with mobilising. We saw the person mobilising on their own with and without a walking aid and examples of staff providing one and two person support to the person during our inspection. This meant the person was a potential risk of further falls through unclear guidance to staff.

The management team had identified improvements to one bathroom but had not taken steps to ensure people's safety. The bath had been removed because improvements were being made. This left exposed pipes which presented a risk of tripping and injury to people using the bathroom. This bathroom was used people living at the home who had been identified as not understanding risks to their safety. In addition

staff told us the bathroom had been in this condition for at least six weeks. We spoke with the interim manager and they took immediate steps to mitigate the risk.

We found the environment in some areas of the home was not consistently suitable for people to use safely. For example, there were windows on the first floor in communal areas where restrictors were not in place. The facilities for cleaning soiled equipment were provided in a public bathroom which was used and unlocked, which meant there was an infection control risk. The interim manager took urgent action and put locks and restrictors in place straight away. The provider had not ensured people had a suitable environment as the risks had not been identified.

People told us staff sometimes took a long time to answer their calls for assistance. One person said, "Staff do come, but I wait a long time at night." Relatives told us there was not always sufficient staff to meet people's needs. One relative said, "Seems like there is lots of staff in the week, however the weekends are not so good." Staff we spoke with said that regularly there were not enough staff to ensure people's needs were met and people were supported in a safe way. For example, one member of staff told us some people living at the home went in other people's rooms which at times lead to confrontations between people. They went on to say they had insufficient time to ensure people were monitored and remained safe. We spoke to the interim manager and they explained they were recruiting new staff, and reorganising the rota to improve staffing levels.

However from our observations we saw there was insufficient staff at times through the day, and staff were not deployed effectively. For example, on the first day of our inspection there were additional staff on duty, however we saw an incident where one person put salt on their breakfast and in their tea because there were no staff supporting them. Also a member of staff confirmed some people were being supported with their personal care at 11 am, not at their request. The management team agreed to review their staffing levels and staff deployment to ensure people were safe and had their needs met. Staffing levels and the deployment of staff had not demonstrated people received care that kept them safe.

People were not consistently assessed for their own specialist mobilising equipment (slings). Staff told us they used one specific sling for all the people who needed support with mobilising this way, and it was not fit for purpose for everyone. They told us this was because they were unclear about what slings to use for people, and they did not have appropriate slings available. This also increased the risk of cross contamination for people using the sling and was an infection control risk because staff told us the sling was not washed between different people using it. The interim manager told us she had made a referral to the occupational therapist to assess people at the home because she had found there were no records of who required which type of sling. The management team said they would review all the slings in the home and ensure they had correct sling for each person requiring one.

We found people were not kept safe from the risk of infection. We saw soiled laundry in plastic bags was kept in corridor areas where people were able to move freely without supervision on both days of our inspection. We spoke to the interim manager who said the soiled laundry would be stored in a more secure area straight away. We saw a member of care staff cleaning a bin in their uniform without an apron on. They were washing the soiled cloth in the bowl which had a cup in it that people used for tea. We spoke to the member of staff and they were aware this was not good practice. The senior member of staff took action to ensure the staff member changed their uniform before supporting people to meet their needs.

We spoke with Commissioning Infection Prevention Lead Nurse for the Clinical Commissioning Group, who was visiting the home on the second day of our inspection. They explained the home needed to make improvements to managing their infection control. They said there was no effective monitoring of the

cleanliness of the environment, and no overview of what training staff had received about infection control. They told us they would work with the interim manager to support improvements. The interim manager was recruiting a head of housekeeping who would be the home's infection control lead and complete regular infection control audits to ensure people were protected from infection. Infection control regimes were not effective to ensure people were not at risk.

This was a breach in Regulation 12 (1) The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured people were supported in a safe way.

Staff we spoke with told us the appropriate pre-employment checks had been completed. These checks helped the provider make sure that suitable staff were employed and people who lived at the home were not placed at risk through their recruitment processes.

We looked at how people were supported with their medicines. We saw there was an electronic system in place which supported staff to administer medicines in a safe way. Records shown indicated people had their medicines when they needed them and the interim manager had ensured that regular checks were in place to support this. Relatives we spoke with said their family member had their medicines as prescribed. One relative told us, "Medication is efficient, I have no issues." We saw staff explain to people as they administered their medicines, what they were taking and sought their consent before they administered them. Staff were trained to be able to administer medicines. They were aware of what to look for as possible side effects of the medicines people were prescribed. There was suitable storage and disposal of medicines in place.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The provider had not ensured people were able to consent to their care. Staff told us they were unclear about who had capacity to make decisions and they had not been involved in discussions about who needed additional support. Staff explained some people living at the home were able to make day to day decisions and they always tried to encourage their choice. However they were not confident at understanding the MCA and the impact to people living at the home. We were unable to confirm when staff had completed this training because systems were not in place to demonstrate this at the time of our inspection visit. The interim manager told us that people's care plans were not consistently up to date to reflect people's ability to make decisions. They said they were unable to determine from the records who had capacity and were in the process of reviewing people's needs to ensure people were supported with compliance to the MCA.

Breach in regulation 11(3) The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured people were able to consent to their care.

People we spoke with told us they were happy with the food provided. Relatives we spoke with said the food appeared good and their family member ate well. People explained there was one choice at lunchtime meal, however if they did not like the main choice they could have something else. One person said, "Most of us have the main choice." We saw one person ask for something different, however by the time this was made for them they had eaten their pudding and no longer wanted it. Another person told us, staff used to prepare a specific food the way they preferred, but staff no longer did this and they did not like the way the food was now prepared. However they said, "I have to put up with it." We saw accompanying foods such as gravy and cream were put on every body's plate without asking if people wanted them with their meal.

We spoke with kitchen staff and they showed us how people's nutritional requirements were met. The interim manager acknowledged that it was not always clear who had special dietary needs and how they needed to meet them. They were arranging for a white board to clearly indicate to all kitchen staff special dietary needs. We saw staff provided support for people when they needed it with their meals. We saw people being offered regular drinks and food when they wanted them. Food and fluid charts were in place where concerns were identified. The interim manager had identified these were not always completed and was looking to monitor them more effectively.

Two staff we spoke with said their induction had not supported them to effectively meet people's needs. One said they had not completed shadowing experienced staff, and the other said they had not received all the training they needed. Other staff we spoke with said they did not complete regular training consistently.

They also said they lacked knowledge about how to support people living with dementia and challenging behaviours. One staff member told us they did not always know what to do when people were shouting at them. The interim manager explained they were reviewing the training needs for all the staff and would be implementing a training matrix to ensure staff training was effectively monitored.

Staff we spoke with said they lacked effective communication with the management team. They said it was difficult to share concerns with the management team. All the staff we spoke with said they felt unsupported and were not clear on what was happening with the changes in the management team.

People told us they had access to their GP, dentist and optician when they needed to. Relatives said their family member was supported to see health and welfare professionals as required. One relative said about staff, "Communication is very good, they organised the dentist and hair dresser." We spoke with two district nurses who regularly visited people living at the home. They explained communication with staff could be improved. The records needed to support the district nurses treatment were not consistently completed or correct. Staff we spoke with told us it was important to monitor the health of each person; however they did not always have time to achieve this. The district nurses said staff would benefit from additional pressure area training to improve their identification of sore skin.

Requires Improvement

Is the service caring?

Our findings

When we inspected in May 2017 we found the service was not consistently caring and required improvement. The inspection found people were supported by staff in a task focussed way and the specialist needs for people living with dementia required improvement. We found on this inspection that no improvement had been made.

In some areas of the home we saw people continued to be left alone for periods of time and staff only interacted with them when they needed assistance with something, such as a drink or food. We saw three people in one lounge were unable to reach any call bells to summon assistance. We asked them what they would do if they needed something, one person said, "We get by, we have to shout." Another person told us if they wanted a drink they, "Had to wait or call out."

All staff we spoke with understood that people living at the home would benefit more fully if they had more time to spend with them. They were clear about their role to provide care was about people and not just the care task. However staff told us this was not consistently happening and they had not had the opportunity to sit and spend time with people regularly because of the volume of other work. Staff explained if they had more time to sit and chat with people throughout the day it would improve people's well-being and assist in supporting people when they became upset. They said some people living at the home had high dependency and there was not enough staff to meet their social needs.

The provider had not ensured staff had the skills to support people with dementia to express their views. Staff told us they lacked the skills and knowledge to communicate with some people when they were upset, to understand them and improve their well-being. One member of staff said that additional training would help them to understand and support people. Another member of staff told us, "We let people down," because they were unable to consistently respond to people's needs.

The provider had not ensured people were involved in making decisions about their care. We received mixed responses from people and relatives about the support offered to them to share their views about their care. People we spoke with said they accepted how they were supported at the home. One person told us, "We do speak to staff, but they can't change things, it's not up to them." Staff told us they did not always have time to encourage people to make their day to day decisions about their care, for example when they wanted their breakfast and baths. They did not always have time to provide the support they knew people needed. They said spending time with people was important for their well-being, however this was difficult for them to achieve because they were busy completing other tasks.

We saw occasions also where staff were kind to people when they were upset and they tried their best to reassure them. One member of staff explained how they supported one person when they were upset, they found if a different member of staff intervened sometimes distracted the person and improved their well-being. However we saw and staff told us, because of the number of the people who were upset staff did not have sufficient time to spend with people to reassure them. People who could vocalise their concerns received the attention of staff and others who were quiet lacked interaction from staff. We spoke with the

interim manager and they were reviewing staffing levels and deployment. They understood changes were needed and were recruiting to ensure they had sufficient staff.

We found that people's personal information and personal files were not consistently stored securely. We spoke with the interim manager and they were aware of the need to maintain confidentiality and store information securely, however we saw on many occasions this was not happening. The interim manager said they would look at ways to improve this so they were consistently maintaining confidentiality.

People we spoke with told us staff were caring. One person said, "Staff are ok." Another person told us, "Some carers are better than others." We saw staff supporting people living at the home in a caring way. Relatives told us they were happy with their family members care. One relative said about staff, "Staff are approachable." Another relative told us, "Staff do care, they are kind." Relatives explained they felt involved and included in the care for their family member. They said they felt welcome to visit the home at any time.

Staff explained they encouraged people to be as independent as possible. One member of staff gave the example of how they encouraged one person to visit the communal lounges to give them an opportunity to interact with other people. They explained this improved the person's well-being.

People were not consistently empowered to make choices. For example, during the meal time experience people were not always offered condiments and people were not given the opportunity to decide to if they wanted more food.

People were supported by staff who took into account and maintained people's dignity. We saw staff were discreet when discussing people's personal care needs. We saw one staff member discreetly prompt one person to change an item of clothing that had become soiled to maintain this person's dignity. Staff told us they promoted people's dignity and gave examples about people's privacy such as closing doors during personal care and knocking before entering rooms.

Requires Improvement

Is the service responsive?

Our findings

We found people had not consistently had their individual needs met. We saw on both days of our inspection people had not had their breakfasts in a timely way. For example, one person approached an inspector and asked for something to eat because they were hungry at 12.10pm.The inspector spoke to staff and they provided this person breakfast. We found four people had received their breakfast after 12 noon. When we asked the interim manager about this they had not been told by staff and the lunch meal remained planned for 13:00. Following our discussion the interim manager gave instruction to the kitchen staff to give people a later meal for those affected. We saw in the provider records that both the regional director and the operations manager had previously noted people did not always receive their breakfasts in a timely way. The management team had not taken people's preferences about meal times into consideration to adapt the service to meet people's needs.

Staff we spoke with told us people were not consistently having baths when they wanted them. For example, staff told us two people who wanted a daily bath were not receiving them. Records showed one person had not had a bath over the last month, and the other had received a bath once a week. We saw people appeared clean and staff confirmed people were receiving support with their personal care. People had not complained and accepted staff were unable to support their choice. Staff told us when they were short of staff there was no time to bath people, and there was only one bathroom suitable in the home for some people requiring additional support. We spoke to the interim manager and they had a plan in place to update bathrooms and to ensure bathroom equipment was suitable to meet people's needs.

People were not supported to have their individual continence needs met. We saw people's individual continence needs had not been assessed and they did not have individual continence aids. Staff told us people shared a stock of continence aids which were kept in communal areas. We spoke with the interim manager and they had arranged for continence assessments to be completed for those who needed them.

Staff were not given effective guidance about how to meet people's individual needs. The interim manager told us care records had not been consistently reviewed for the last four months. Relatives we spoke with could not remember being involved with any care plan reviews. We saw four care plans which had not been reviewed in all areas since April 2017. Care plans did not consistently contain guidance to staff to support people's needs. For example, staff told us about one person who was frequently upset. We looked in this person's care plan which had no guidance to staff about how to improve this person's well-being.

People we spoke with said they did not have interesting things to do to pass the time. One person told us they were happy, "I have the television and the daily paper." Another person said, "All I do is eat and sleep," they told us they didn't do anything else. A further person said, "There is not much to do, I try and keep busy. I would like to go out in the garden."

Relatives told us they would like more interesting things for people to do. One relative explained activities were held in the main lounge and told us, "Unless you got up there you can miss them," they also said, "I would like to be able to walk with [family member] in the garden, we haven't been out yet."

Staff told us people did not have enough to occupy their time. The activities co-ordinator frequently had to stop supporting people with their social needs to support them with their care needs. The interim manager told us there was one member of staff dedicated to providing activities for people living at the home. The activities co-ordinator worked four days a week and they were aware this was not sufficient.

On the second day of our inspection there had been some entertainment booked in the afternoon. We saw people participated in the entertainment and enjoyed the moment. People who had been upset calmed down and their well-being improved. The Community Psychiatric Nurse we spoke with said people at the home would benefit from more social interactions particularly related to dementia. They explained people's health and well-being would improve if they were occupied with things to do that were specific to their needs.

Staff told us they did not have regular meetings at the start of their shift. They received information on a sheet updating them about people's care needs. Staff explained that messages had not always got to the relevant staff and this could impact on people's care. For example, one member of staff told us they were not always up to date when people had falls or incidents which meant people did not always have their needs met. The interim manager agreed that communication needed improvement and was reviewing how important information could be effectively communicated.

This was a breach in Regulation 9 (1) The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured people's personal needs and preferences were met.

People we spoke with said they did not have regular meetings with staff to keep them up to date with home developments and provide an opportunity to raise concerns. One person told us, "There has been no residents' meetings for a long time, there has been lots of changes it's hard to keep up." We spoke with the interim manager and they were unable to confirm if there had been any recent meetings. They confirmed these would be completed as soon as possible.

People we spoke with said they would speak to staff or the management team about any concerns. One person told us, "I am very happy here, no complaints." Relatives told us they were happy to raise any concerns with the management team, or staff. One relative said, "I would go straight to the office if I had any concerns." We saw there was a complaints procedure in place, and there were two recent complaints recorded at the time of our inspection. We saw they had been investigated and responded to in line with the provider's policy. We looked at the emails detailing the provider visits and we saw one complaint that had been raised by a relative and resolved by the regional director. However this was not logged in the complaints folder to ensure transparency and consistent approach.

Inadequate

Is the service well-led?

Our findings

At our last inspection in May 2017 we found the service was well-led. There had been a new manager in post who had now left the service. The service was supported by the Operations Director and the Regional Director. Three weeks prior to our inspection the provider had appointed an interim manager. Despite these actions we found at this inspection the governance and leadership had deteriorated and was now inadequate in well-led.

We found there were ineffective systems in place to identify environmental risks. For example, the Operations Director had taken action to improve one bathroom which was leaking. However the management team had failed to identify this action had put people at risk as they continued to use the bathroom. This had not been identified as a risk until the inspector raised the concern. Other examples, was soiled laundry stored in communal walk ways which put people at risk of infection, sluice kept in a bathroom with the door open and facilities to lock this away. The provider had failed to complete regular checks to identify environmental risks and mitigate them.

The management team had no overview of accidents and incidents to ensure lessons were learnt and improvements to people's safety were made. We found there was an increased number of incident reports about people abusing other people at the service. We found accident forms had not always been completed for the interim manager to investigate and take the appropriate action. We were told of two incidents that had occurred a few days before our inspection, yet we were not shown incident forms completed. The interim manager was in the process of implementing a system to overview accidents and incidents. People were not protected from the risk of accidents and incidents because systems were not in place to ensure the provider monitored and implemented learning from them.

The interim manager told us approximately 30 people at the home lived with dementia. At our last inspection we recommended the provider sought advice and guidance from a reputable source on current best practice, in relation to the specialist needs of people living with dementia. We saw no evidence that this advice had been followed through. For example, we saw no signage about the home to assist with orientating people living with dementia to improve their confidence and well-being. Staff we spoke with had not completed dementia specific training to ensure they understood best practice ideas. When the community psychiatric nurse spoke with us they explained they had made suggestions to staff about improved ways to manage behavioural concerns. However they had not seen these used by staff.

We found staff deployment was ineffective to ensure people's needs were met. One the second day of our inspection we were told they were one member of staff short during the morning shift. We saw some staff were upset because they had not had enough time to support people effectively. Staff deployment had not effectively ensured all the people were supported to have their needs met in a timely way.

The provider had not ensured staff received the right training, support and supervision to carry out their roles and understand their responsibilities. For example, staff we spoke to knew there was a risk to one person if they left small items in the communal areas of the home. However on the first day of the inspection

we found the provider had not supported staff to remain vigilant and had not ensured these risks were monitored. Staff told us they felt unsupported and not valued by the management team. Staff explained there had been changes in the management team and they were unclear who was their manager at the time of the inspection. Staff said the management team had not always been approachable and had not felt confident to raise concerns with them. People were not supported by staff who felt confident to raise concerns with the management team.

Staff told us there were no regular staff meetings for them to voice their opinion. They had not had the opportunity to voice concerns and receive up to date information about what was happening at the home. Staff we spoke with were unsure who they needed to raise concerns with. Staff we spoke with said they were hopeful the interim manager would stay and there would be improvement with the communication at the home between staff and the management team.

The interim manager had told us there was no overview of training to ensure staff had up to date knowledge and skills. Staff told us they were not up to date with their training and required additional training to meet the needs of people living at the home. One member of staff told us they often felt overwhelmed when supporting some people because they lacked the specialist knowledge to feel confident. Records of people's care needs and risk assessments were not kept reviewed and up to date. Staff did not have the guidance through care plans, risk assessments, training, and meetings to share best practice to effectively support people. The interim manager was implementing a training matrix to enable the management team to monitor staff training needs effectively. People were not assured to be supported by skilled staff who could meet their needs.

We saw there had been audits and provider visits completed to monitor the quality of care provided. However we found these were not always effective. The checks had not identified all the concerns we found at our inspection. This was because the audit did not focus on the experiences or care people received. Records indicated the provider was aware of some of the concerns we found. The interim manager had completed an action plan detailing where improvements were needed. For example, improvements to bathing arrangements and sufficient specialist equipment. These improvements had been identified however they had not been completed or established at the time of our inspection

This was a breach in Regulation 17 (1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have effective arrangements in place to monitor and improve the quality and safety and welfare of people using the service.

The provider had failed to display the ratings from our inspection in May 2017 at the home. The provider is required to display performance assessments both at the home and on their web site. We saw the ratings were displayed on the web site but not at the home. The interim manager took immediate action and displayed ratings from our last inspection before we left the premises.

The interim manager was unable to show what systems were in place to enable the provider to gain feedback from people and their families at the home. People we spoke with said there had not been regular meetings between the management team and people living at the home for a period of time. They were not sure what was happening at the home. One person told us, "Overall it's ok, but could be better. It was better last year."

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 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured people's personal needs and preferences were met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured people were able to consent to their care.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured people were supported in a safe way.

The enforcement action we took:

Notice of decision

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 provider had failed to protect people from abuse.

The enforcement action we took:

Notice of Decision

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective arrangements in place to monitor and improve the quality and safety and welfare of people using the service.

The enforcement action we took:

Notice of decision.