Loyal Care Centre Limited

Rowlandson House

Inspection report

1-2 Rowlandson Terrace
Sunderland
Tyne And Wear
SR2 7SU

Date of inspection visit:
25 September 2018
04 October 2018
09 October 2018

Date of publication:
10 December 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 25 September, 4 and 9 October 2018. The inspection was unannounced.

At our last inspection in June 2018 we rated each key question of safe, effective, caring, responsive and well led as requires improvement. We found breaches of regulations 11, 12 and 17. These breaches concerned issues of consent, safe care and treatment and good governance. We asked the provider to send us an action plan. They told us they would have completed all the required actions by 16 August 2018. We also met with the provider to discuss with them how they intended to improve each key question to a rating of at least 'good'.

Following receipt of concerning information we undertook an unannounced focused inspection on 25 September 2018 and 4 October 2018 to look at the key questions of safe and well-led. This inspection was also done to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection in June 2018 inspection had been made. Due to the concerns identified during our focussed inspection we returned to the service on 9 October 2018 to complete a comprehensive inspection and look at the additional key questions of effective, caring and responsive. We found continued breaches of regulations 11, 12 and 17 and further regulatory breaches of regulations 13, 14 and 19.

Rowlandson House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The home provided accommodation across three floors for up to 27 people who require assistance with their personal care. The home does not provide nursing care. The registered manager told us 21 people were using the service at the time of our inspection. Most people using the service were living with dementia.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service had a registered manager in post. Due to staff shortages the registered manager had supported people as a member of the staff team. This took her away from her management

duties.

People were at risk of the maladministration of medicines as there were no stock checks carried out in the service. This resulted in inspectors finding people's medicines missing. Clear guidance to support staff in their application of topical medicines was not in place.

Records required updating and contradictions in people's records needed to be addressed to give staff clear information about people's care needs.

The service had failed to follow the requirements of the Mental Capacity Act 2005 and the Mental Capacity Act Code of Practice. This put people at risk of not being involved in decisions which affected them.

Fire evacuation procedures and equipment needed to be reviewed to enable staff to support people to evacuate people at their nearest exit.

The risks of cross infection were not reduced. The laundry was in a dirty state. Arrangements were put in place during our inspection to secure radiator covers to the wall to reduce the risk to people of accidental burning.

The small lift and the number of hoists available to staff made the movement and handling of people challenging. The operations manager told us they were planning to invest in the home.

Personal emergency evacuation plans were in place. However, we found the plans required support from more staff than was on duty to support people to evacuate. The registered manager showed us their dependency tool and they were providing more hours than required. We made a recommendation about this.

Improvements were required to ensure staff were meeting people's nutrition and hydration needs. Electronic fluid charts failed to provide accurate information about people's intake. Advice from dieticians had been sought and incorporated into people's care plans. People did not have the support they needed to eat in a safe manner.

Staff had received training and were supported using supervision meetings with their line manager. They presented as kind and caring during our inspection. They protected people's privacy by knocking on doors. They knew people's likes and dislikes and provided explanations to people about meal times.

The provider had a complaints policy in place. The operations manager showed us a complaint they had responded to via email. Complaints had not been documented in line with the policy. We made a recommendation about this.

People were not supported with stimulating activities to keep them active. Only those people who were able to occupy themselves with, for example, knitting had things to do.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

Arrangements were not in place to ensure the proper and safe management of people's medicines.

Improvements were required to the building to keep people safe.

Insufficient checks were carried out on staff before they began working in the service.

Following safeguarding incidents, people's records had not been updated to guide staff on how to keep people safe.

Is the service effective?

Inadequate

The service did not meet the requirements of the Mental Capacity Act 2005.

People were given hot and well-presented food. People were not always supported to eat in ways which met their needs and staff did not always document people's fluid intake.

There was insufficient equipment in the service to meet people's moving and handling needs.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff provided kind care against a backdrop of poor information and a lack of equipment to help them safely carry out their duties.

Staff knew people's likes and dislikes.

Confidential information was accessible and not stored in locked facilities.

Is the service responsive?

Requires Improvement

The service was not always responsive

Care records lacked information about specific needs.

Although a complaint had been responded to, the provider was not maintaining records to demonstrate they were meeting the requirements of their policy.

People were not provided with stimulating activities.

Is the service well-led?

Inadequate

The service was not well led.

An investigation into serious concerns in the home had failed to include all the relevant information to enable a comprehensive overview of the issues.

Quality assurance procedures in the home failed to identify issues we found during our inspection.

The registered manager had needed to spend time delivering care to people which had removed them from their management duties.

Rowlandson House

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.

The inspection was prompted in part by whistleblowing information of concern received by CQC in September 2018.

This inspection took place on 25 September and, 4 and 9 October 2018 and was unannounced.

Inspection site visit activity started on 25 September 2018 and ended on 9 October 2018. It included a review of people's care records and records used by the provider to monitor the service. We spoke to people who used the service, their relatives and to staff. We carried out observations during our inspection visits and looked at the environment.

The inspection team consisted of two adult social care inspectors and two adult social care assistant inspectors.

Before the inspection we reviewed information available to us about this service. We reviewed safeguarding alerts; share your experience forms and notifications that had been sent to us. A notification is information about important events which the provider is required to send us by law. We also reviewed whistle-blowing information where people tell their worries about the service. We spoke with the local authority commissioning team and the fire service.

On our inspection days we spoke with four people who used the service and one of their relatives. We spoke with ten staff including the operations manager, the registered manager, senior care staff, care staff, maintenance person and the cook.

We reviewed seven people's care records, three people's medicine records in detail and six staff records. We also looked at records relating to the management of the service such as quality audits, surveys and policies.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Our findings

Concerns which were raised with us prior to the inspection included the maladministration of medicines. We reviewed people's medicines and found the service had not kept an account of the medicine Lorazepam which was prescribed as an 'as required' medicine to be administered if people became agitated. On checking the medicine administration records (MARs) we found there were missing tablets which could not be accounted for. Without stock checks in place people were at risk of receiving inappropriate doses of medicines.

People had been prescribed 'as and when required' medicines. Guidance provided to staff on when to administer these medicines did not provide sufficient information to assist staff determine when a person may need this medication. For instance, a protocol for one person for Codeine Phosphate stated, 'take one or two tablets four times a day for general pain. The guidance did not specify when to give increased amounts, what to do it they were not effective at resolving the problem or alternative approaches that could be tried prior to offering medication.

People were prescribed topical medicines. These are creams applied to the skin. The pharmacist had provided a list of people's medicines including topical medicines. We found arrangements were not in place to ensure people received their topical medicines in a safe manner. For example, staff were not given guidance about when and where to apply the medicines. Opening dates had not been added to tubes and boxes. For one person who had been diagnosed with skin integrity issues, proper arrangements to manage their condition with topical medicines were not in place. The manager agreed to put a skin care regime in place.

We found staff had handwritten on the MARs where people had been prescribed new medicines. The National Institute for Clinical Excellence (NICE) in their guidance on Managing Medicines in Care Homes requires new records to be checked for accuracy and signed by a second trained and skilled member of staff before it is first used. These new entries on people's MARs had not been checked and signed for by two staff members.

Regular temperature checks of the fridge and cupboard had not been completed so it could not be confirmed that medicines were stored at the correct temperature. There was no sink in the clinic room, which meant staff could neither wash their hands or equipment such as medicine pots before they started to administer the medicines.

The provider had a fire risk assessment in place to look at fire risks in the home and put in place control measures. The home is on three floors and the registered manager explained that the largest rooms were on the top floor. These were used for people who needed equipment to assist their mobility. There was only one evacuation chair in the building. Using this one chair staff would need to access the chair and return to people on the first and second floors to evacuate them. The operational manager told inspectors the second set of stairs was not used. There was no evacuation chair on these stairs although it led to a fire exit.

We reviewed the Personal Emergency Evacuation Plans (PEEPs) and found there was insufficient staff on duty to support the evacuation of people from the building. Seven people needed two staff to assist them to evacuate and the remaining 15 people needed one carer. Five people were identified as needing to use wheelchairs but there was no guidance on how the individuals were to be supported into these or evacuated from the various floors. In the event of a fire the lift could not be used and therefore the hoist could not be used on the floor it had been left. On one person's PEEPs there was the mention of an evacuation chair and on another person's PEEPs the use of a 'stair chair.' We were unclear what a 'stair chair' was but did not see a stair chair lift and only saw one evacuation chair, which was on the third floor. We discussed this with the staff and registered manager and found no consideration had been given to how many staff would need to be available to complete a full evacuation in the event of a fire, that the hoist might be elsewhere, that there was only one evacuation chair and the lift unusable so what alterative aides could be used such as an evacuation sled. We found insufficient fire safety measures were in place. We spoke with the local fire officer who agreed to look into our concerns.

Radiator covers were not securely attached to the wall. People had access to hot radiators which placed them at risk of burns. The operations manager made arrangements for the radiators to be secured. Emergency pull cords were inaccessible to people if they fell in the bathrooms and toilets. The operations manager said they were introducing a new call system.

Infection control measures were not always in place. Laundry facilities were housed in a cellar which was dirty throughout; surfaces in the laundry had not been cleaned and there was a build-up of grime on the tops of the two washing machines and tumble dryers. Pipes in the cellar were covered with dust and there was a build-up of flock which increased the risk of a fire spreading more rapidly. The only sink for any hand-washing in the laundry was dirty. People's clothes and bedding were transported into the laundry in red cotton bags and placed on the floor. There was no flooring in place or work spaces to ensure people clothes were kept clean and the risk of cross contamination was reduced. One person said, "The laundry could be improved. All my clothes were coming back with stains on them. I complained and my clothes are now washed separately, which is somewhat better than before." We pointed out the condition of the laundry to the operations manager who told us people's laundry was taken into the building after it was washed and dried.

Accidents and incidents were recorded on an electronic system. We asked the registered manager how they reviewed accident trends. They told us they reviewed them on the system, but were unable to demonstrate when they had carried out these checks.

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

We reviewed six staff files and found the provider had not always carried out the necessary pre-employment staff checks. Application forms did not provide space for people to record the start and finish dates for their full employment history. Staff had not completed the forms regarding their qualifications and evidence of qualifications had not been obtained. There were no health check assessments in place to ensure the

provider could make any reasonable adjustments required to employ a person. We found that for three people the same referee was used who was a friend. During our inspection the operations manager made amendments to the application form.

This was a breach of 19 Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were trained in safeguarding. The provider had an electronic records system for recording any safeguarding concerns. The Commission had been notified of two safeguarding incidents. We checked these incidents and found following the outcome of the incidents records had not been updated to guide staff on how to protect people. One person chose to live their life in a manner which posed a risk to others. Staff had not been given guidance on how to protect the person and other people who used the service.

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

Arrangements were in place to carry out tests on equipment in the home. We saw there was one hoist in the building to be used between three floors. This necessitated staff putting the hoist into the lift each time they needed to use it on a different floor

The registered manager demonstrated how they had updated the dependency tool to calculate the numbers of staff hours required in the service. They showed us there were more staff hours than was required by the tool. One relative said, "We find staff are always very busy and if someone needs a hand in the lounge we tend to try and find someone. Often that is not possible."

We recommend the provider considers staffing levels and their deployment in the service.

Risk assessments were documented in a file. We saw for example there was a risk assessment for staff use of ladders in the home. In the same file we found a personal risk assessment for one person living in the home. On the electronic system personal risks for people had been identified and actions were in place to mitigate risks.

Water checks showed the water temperatures in people bedroom sinks and bathrooms did not rise above 31 degrees and the lowest temperature was 18 degrees. Actions had not been taken to ensure people were not washing and bathing in tepid water.

We asked the registered manager if they had learnt any lessons and suggested recent recruitment issues. They were unable to give us any examples.

The operations manager told us the service had access to advice regarding staff disciplinary issues and discussed with us recent scenario where they were considering staff disciplinary action.

People's human rights were respected. Family life was promoted and relatives were welcomed into the service. Discussions had taken place with people and their relatives regarding their end of life preferences. This meant the service had considered people's right to life.

Inadequate

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. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At our last inspection we found the service was not complaint with the MCA. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that DoLS applications had been made and authorised by the relevant local authorities. However, we found the service did not follow the two-stage mental capacity test as prescribed in the Mental Capacity Act Code of Practice published in 2005. People had capacity assessments in place which stated they had impairments which may affect their decision making but decision specific assessments were not carried out. We found a consultant for one person had described an impairment to make decisions, however, their records documented they had capacity to make decisions. Without this two-stage test taking place people were at risk of being denied the right to make a decision.

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

Fluids were provided to people throughout our inspection visits. Electronic records for people's food and fluid charts, when checked by the inspectors, defaulted to recordings on 8 October 2018. The registered manager provided the inspectors with a weekly report. The printed fluid balance report did not identify the name of each person. Consequently, we were unable to have oversight of the names of the people and what they had consumed. Targets were set for people's fluid intake. The registered manager told us the targets were unrealistic for some people. No safe targets had been identified. Staff had also documented people had drank excessive amounts of tea in one go which inflated their daily target. There was no oversight or reviews of people's fluid intake. We observed staff providing drinks to people during a lunchtime and found no one's fluid intake had been documented.

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

Meals were well presented to people and were hot. One person said, "The food is good but I'm easily pleased, as long as it is edible I'll like it. There is no menu to look at but you do get a choice. I don't know what the choice is today." Some care plans stated people needed 'full assistance' when eating, yet only one member of staff was present during the morning dining experience who left the room intermittently to offer other people their breakfast. The service used an electronic version of the Malnutrition Universal Screening Tool (MUST) to measure if people were at risk of malnutrition. We found the service did not follow the guidance provided in the tool. For example, people who were at risk of malnutrition were not always weighed weekly.

The service had made referrals to other professionals to ask for their advice in meeting peoples' care needs. Advice from the Speech and Language Therapy team (SALT) and dieticians had been incorporated into people's care plans. We asked the cook how they found out about people's dietary requirements. They told us staff told them about people's needs. On the kitchen wall were various pieces of handwritten notes about people's diets. Kitchen staff and the registered manager were unable to find the list of people's likes and dislikes to demonstrate they had considered any reasonable requirements of a person's food and hydration arising from their personal preferences, or their religious or cultural background.

Menus were not available in an accessible form which enabled people to choose their meal. The registered manager showed us two photographs of work in progress to create pictorial menus. The cook told us they were not following the menus as they were trying to use the food in the freezer so they could defrost it. There was no menu in place for the week. We asked the registered manager how people chose their meals. They told us staff asked people on the morning but were unable to show us any records of people being encouraged to eat by choosing their own meals.

During the inspection we carried out a Short Observation Framework for Inspection (SOFI) and saw one person was given their main meal which included a slice of pork. They repeatedly lifted the full slice of pork to their mouth but were unable to eat in. In the person's care plans it stated they were at risk of choking and needed their food to be cut up. No plate guard was made available to assist the person as they picked their peas off the table and put them back on their plate. One person was provided with a drink to their left-hand side when they were right handed and unable to see the tumbler. Another person who was at risk of losing weight was given their meal and provided no encouragement to eat. Their plate of uneaten food was removed from them at a later point. During our SOFI observations no one was given a meal choice.

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

Rowlandson House is a large, three-storey, terraced building. The premises required some refurbishment to address areas, such as, worn carpets on the stairs. Two people had large adapted chairs but these did not fit into the lift so the individuals need to be transported from their bedrooms in ordinary wheelchairs. We found no information to confirm that the people could safely use ordinary wheelchairs.

The service had one hoist which needed to be transported to all three floors as people reside on each floor that need this equipment. The lift was very small and staff told us they found they were unable to fit in the lift with the hoist so sent this up separately then walked up the stairs. The operations manager told us it was possible for a staff member to get into the lift with the hoist. Once upstairs, staff then assisted people into wheelchairs and took people down in the lift. Staff needed to return to get the hoist to enable the person to transfer into their chair. We found the complications of obtaining the hoist could encourage staff to take short cuts and use inappropriate moving and handling techniques. We found there were insufficient hoists in the service.

The operations manager told us they had identified the issues and were in the process of taking steps to replace the lift. They provided at our request an action plan for improvements to the premises.

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

Arrangements were in place to support staff through an induction period. The service used a training booklet from a care company to ensure staff were skilled in their work. Certificates were provided by the training company once they had reviewed each stage of the staff member's training. Staff confirmed they had received training. The registered manager used a staff matrix to monitor staff supervision and told us due to recent events in the service the matrix needed to be brought up to date. The registered manager provided us with a pile of supervision notes yet to be filed in staff files. We found staff supervision was taking place.

Handover documents to pass information between shifts could be extracted from the electronic recording system. Handover meetings between shifts were held each day.

Hospital passports are documents which provide information to medical staff about a person's background and their needs when they transfer to medical services. These were held in people's individual files in the reception area.

Requires Improvement

Our findings

Whilst we observed staff to be caring when they engaged with people living in the home, we found deficits in the home which showed the provider was not ensuring the service was caring overall. The caring nature of the staff was undermined by the lack of provision to meet people's needs such as fire evacuation. We found people's well-being was compromised by the standards and practices in the home. For example, a lack of activities failed to provide a stimulus, and a lack of support with meals and the lack of the recording of fluids failed to show the service was caring overall.

Staff supported people's independence by encouraging them to walk with their walking frames. However, we found some people's frames were too small for them and people were bent over their frames as they walked. We spoke with the registered manager who told us one person had recently been admitted to the home with a low frame and they had contacted the occupational therapist to make the necessary adjustments.

Staff told us relatives had bought wallpaper for people's bedrooms to ensure their environment was improved. One relative said, "The family bought a new carpet and wardrobes for [person's name] bedroom, as the carpet was shabby and the furniture was very dark, so quite depressing. The owner decorated the room, which was a help." We were provided with a spare room to work in and found the bed was made up. The duvet cover had holes along the bottom and the duvet edges were frayed and worn. We found the use of such bedding did not demonstrate a respectful approach to people. We pointed this out to the registered manager who acknowledged our concerns.

People's privacy was respected. Staff knocked on people's doors before entering their rooms. Where people had alarms on their doors night staff switched off the alarm before entering to check on the person so the alarm would not disturb them.

Staff showed kindness towards people. They used humour and banter to encourage people to join in conversations. We saw staff carrying out observations and offering to help people. One person said, "I have no problem with the staff." Another person said, "Staff are brilliant and nothing is too much bother for them." Staff knew people's likes and dislikes.

We observed staff supporting people and using explanations about what was happening. For example, staff provided explanations and reassurances to people when using the hoist. When verbal altercations occurred, staff intervened quickly and were able to support people with explanations and distraction techniques to

avoid further escalation.

Confidential information was not secured. We found personal information in an unlocked cupboard and district nursing notes were in an unlocked drawer. Electronic records were password protected and each staff member had their own log on details.

Opportunities for people and their relatives to be involved in the service was lacking. There were no regular residents and relative's meetings. One person supported the service by raising funds through knitting Christmas decorations.

An advocate is a person who helps a person speak up or represent their views to other professionals. People using the service had previously had advocates involved. Advocacy information was not on display in the home.

Requires Improvement

Our findings

The service had electronic care plans in place which covered a variety of issues including personal care, nutrition and hydration and mobility. Assessment tools were used to measure risks of malnutrition and skin integrity. These were reviewed on a regular basis and a senior carer during our inspection came into the service to update the care plans. However, we found people's care plans were not always accurate. This meant staff were not always given clear guidance about how to meet the specific needs of individual people. For example, one person's emotional needs were assessed 'very high risk' with a history of suicide attempts and tendencies, yet we could find no documented discussions or referrals for the person to have choice over receiving GP or mental health service input. One person did not like footplates on their wheelchair and would remove these. The service had failed however to request occupational therapy input or risk assess this appropriately to minimise the risk of physical injury. We found inconsistent information about people in their care plans. For example, information relating to people's capacity was not specific in relation to decision making. Following the investigation into safeguarding incidents people's care plans had not been updated to tell staff how to protect people.

Staff completed daily notes throughout the day. However, we found there were areas of care missing from the notes. Fluid intake had been missed off at lunchtime. Topical medicines were not documented in line with information provided by the pharmacist.

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

The provider had a complaints procedure in place. One relative told us they had made a formal complaint about the condition of the carpet in the lounge. This was not documented in a manner which showed a complaints procedure had been followed. The operations manager provided us with an email response to a complainant about the carpet and provided us with information to demonstrate it was being replaced.

We recommend the provider record complaints in line with their policy requirements.

Following our last inspection, we recommended the provider review current guidance on meaningful activities for people living with a dementia. This was because we found the service did not offer a planned programme of activities and no community links had been established. During our inspection we found a handwritten list of activities which documented people's preferred activities. We found people were not provided with stimulating activities. The registered manager told us they had given up their office for a

person who liked to listen to music. One person told us, "From the money I get it is difficult to get out and visit people. I can only go out with staff or relatives. I have no relatives so I don't go out very far, mainly over the road to the shop." People said, "There is nothing to do at all and even the TV is on the blink, so we can't watch that" and "It's a long day here, as there is nothing to do." Another person said, "There is never anything to do unless I do my knitting." One relative said, "I have never seen any activities going on since [person's name] has been here and we visit regularly." We pointed out the television issues to the registered manager and the operations manager. Both said the TV repair man had just been to the service to put a person's TV in their bedroom. They explained there was a problem with aerial connections in the home.

The registered manager told us people preferred not to do group activities and that no group activities took place. They said people preferred individual activities. Staff told us people were supported individually on shopping trips and visits to the pub.

The Accessible Information Standard was introduced by NHS England in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. Information was not available to people in formats which supported their understanding.

At the time of our inspection there was no one in receipt of end of life care. For people who did not wish to be resuscitated in the event of their heart stopping documents known as 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) were on file. Staff had documented where they had tried to discuss people's end of life wishes with them and people had declined to do this.

Inadequate

Our findings

During our last inspection we found a breach of regulation 17– Good governance. During this inspection we found there was a lack of improvement made in the service. Despite the previous breach of regulation 17 and the provider having had an action plan in place to improve, we found they had failed to monitor and improve the quality of the service and assess, monitor and mitigate risks to people.

Following the allegations of misuse of medicines made by a whistle-blower, the registered manager had asked a pharmacist to consider discrepancies in medication administration for one person. This was despite the whistle-blower concerns that another person was being administered someone else's Lorazepam.

We found the registered manager's investigation into the concerns around maladministration of medication did not look at whether there were discrepancies in medicine counts for the six people who received Lorazepam and merely concentrated on the person we had initially discussed with them to highlight the issue. Without further consideration, the extent of the missing medicines could not be ascertained and the possibility of medicines being wrongly administered understood. This meant governance arrangements in the home were lacking in transparency and openness.

We found the quality assurance procedures were not effective. For instance, the tool the provider had supplied for monitoring health and safety did not identify the issues with the PEEPs and ensure sufficient staff were in place to evacuate the building. The provider's procedures also failed to address the sufficiency of equipment, the implementation of the Mental Capacity Act 2005, people's nutrition and hydration needs and the legal requirements for staff files.

Accurate and contemporaneous records for each person were not always in place. For example, the electronic system for recording fluid charts was not able to provide adequate oversight of people's fluid intake. Fluid charts were not being accurately completed by staff. On 9 October 2018 we found people were given fluids on the lunch time. These fluids were not documented on each person's daily records. There was no review of people's fluid intake.

We asked the registered manager for surveys they had conducted to measure the quality of the service. They told us they had a file in the reception area which contained the surveys for people to complete and said they had only received a small number of comments. We asked the operations manager for the file but they were unable to locate it. We asked the registered manager if surveys had been used to gain the views of people who used the service. They told us they were not used. There were no involvement sessions in the

home used to monitor how people viewed the service.

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

We found the culture of the home included the registered manager meeting people's daily needs and working with staff to cover staff absences. This took the registered manager away from management duties and had created time pressures resulting in the home and its records being disorganised with little opportunity for oversight and the measurement of quality of the service. We found the home to be disorganised with piles of unfiled records. The registered manager told us this was due to her recent workload. The operations manager said they had tried to employ an administrator but it had not worked out.

The registered manager had held meetings with different staff groups to engage them in the service and provide them with advice and support. Staff told us they felt supported by the registered manager and said she "always listens." The registered manager was aware of workforce equality issues and described to us actions they had taken to prevent discrimination and cause offence to staff.

The home had worked in partnership with a number of agencies, including the local authority, safeguarding teams and multidisciplinary teams. There was no evidence of people having regular access to community facilities and events.

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 11 HSCA RA Regulations 2014 Need for consent The provided failed to comply with the requirements of the Mental Capacity Act 2005 and the Mental Capacity Act Code of Practice 2005.

The enforcement action we took:

We served an urgent notice of decision that placed conditions on the provider that required additional action was taken to ensure the service users' needs were met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to do all that was reasonably practicable to mitigate any risks. 12(2)(b) The provider failed to ensure that persons providing care or treatment to service users had the qualifications, competence, skills and experience to do so safely. 12(2)(c) The provider failed to ensure that the premises were safe to use for their intended purpose.12(2)(d) The provider failed to ensure the proper and safe management of medicines 12(2)(g) The provider failed to assess the risk of, and preventing, detecting and controlling the spread of, infections.12(2)(h)

The enforcement action we took:

We served an urgent notice of decision that placed conditions on the provider to prevent admissions and require additional action was taken to ensure the service users' needs were met.

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 failed to ensure people were protected from potential abuse.

The enforcement action we took:

We served an urgent notice of decision that placed conditions on the provider that required additional action was taken to ensure the service users' needs were met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider failed to demonstrate they had me any reasonable requirements of a service user for food and hydration arising from the service user's preferences or their religious or cultural background. 14(4)(c) The provider failed to provide the necessary support for service users to eat or drink.

The enforcement action we took:

We served an urgent notice of decision that placed conditions on the provider that required additional action was taken to ensure the service users' needs were met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to assess, monitor and improve the quality and safety of the service provided. 12(2)(a). The provider failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users.12(2)(b). The provider failed to maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided; 12(2)(c).

The enforcement action we took:

We served an urgent notice of decision that placed conditions on the provider to prevent admissions and require additional action was taken to ensure the service users' needs were met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed

The provider was unable to demonstrate they maintained recruitment records under schedule 3 of the Health and Social Care Act 2008 19(3)(a)

The enforcement action we took:

We served an urgent notice of decision that placed conditions on the provider that required additional action was taken to ensure the service users' needs were met.