As U Care Ltd

The Chimes

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 22 and 23 August 2017 and was unannounced.

The Chimes is registered to provide 24-hour care for up to 21 people. The home is situated close to St Annes town centre and is a large corner property with garden and paved areas around the building. There are three floors, two of which have lift access, two lounges and a dining area.
Some bedrooms have en-suite facilities. At the time of our inspection, 17 people lived at the home.

The service did not have a registered manager. 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. At the time of our inspection visit a manager had been recruited by the provider and was managing the home but had not yet registered with CQC.

We last inspected the service on 20 March 2015, when we found the provider was meeting legal requirements. At that time, we rated the service as 'Good'. During this inspection, we found a number of breaches of the Health and Social Care Act 2008, (Regulated Activities) Regulations 2014. These related to person-centred care, need for consent, safe care and treatment, safeguarding service users from abuse and improper treatment, meeting nutritional and hydration needs, good governance and staffing. You can see what action we have told the provider to take at the back of the full version of the report.

The provider had not established systems and processes in order to protect people who used the service against the risks of abuse and improper treatment. Staff had not received training to give them the skills and knowledge to recognise abuse and how to report it.

The provider had not properly assessed the risks to the health and safety of people who lived at the home and done all that was reasonably practicable to mitigate those risks. We found risk assessments were out of date and were not always reflective of people's current circumstances.

Suitable systems were not in place to manage and mitigate the risks associated with fire safety. The provider had not ensured premises and equipment was safe and used in a safe way. The provider's fire risk assessment had not been reviewed and was not suitable. Staff had not received fire safety training. Checks on fire safety equipment had not been undertaken.

The provider had not ensured medicines were managed safely. People were left without prescribed medicines for four days. The provider did not follow best practice guidance for managing medicines.

The provider had not ensured a sufficient number of suitably qualified, competent, skilled and experienced staff were deployed at all times. The provider had not ensured staff received appropriate training and supervision as was necessary to enable them to carry out their role effectively.

The provider was not operating effective systems in order to assess the risk of, prevent, detect and control the spread of infections.

The provider had not ensured care was provided only with the consent of people who used the service. Where people lacked capacity to consent, the provider had not acted in accordance with the Mental Capacity Act 2005. The provider was restricting people and depriving them of their liberty without lawful authority.

The provider had not ensured people received suitable food and hydration in order to sustain good health. Monitoring of people's food and fluid intake was poor. Professional guidance had not been sought for one person who experienced difficulties in swallowing.

Systems were not in place to ensure the care delivered to people met their needs and took account of their preferences. People were not routinely involved in reviewing the care delivered to them.

The provider had not established systems and processes, which were operated effectively in order to assess, monitor and improve the quality of the service. The provider had not carried out audits in key areas, such as care planning and medicines management.

The provider had not maintained an accurate, complete and contemporaneous record in respect of each person who used the service, including a record of the care provided to them. Record keeping was poor, with large gaps in recording. There was no check undertaken on records.

The provider operated sufficient recruitment practices, in order to ensure only suitable people were employed to work with people who may be vulnerable by virtue of their circumstances.

Contact details for advocacy services were available at the home for people who did not have friends or family to act on their behalf.

People we spoke with told us they had developed positive and caring relationships with staff who supported them. We witnessed positive and caring interactions during our inspection. People's privacy and dignity was respected and promoted by the staff team.

The provider had a procedure to manage complaints. People told us they felt confident any concerns they raised would be addressed.

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 have asked the registered provider to take at the back of the full version of the report.

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.

We met with the management team following the inspection. We found the management team receptive to feedback and keen to improve the service. They worked with us in a positive manner and provided all the information we requested.

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.

Medicine protocols were not safe and people did not always receive their medicines correctly, according to their care plan.

Staff had not been trained in safeguarding and were not knowledgeable about how to recognise and report abuse.

Risk management systems were not operated effectively which exposed people to the risk of harm.

There were not enough staff available to meet people's needs, wants and wishes.

Is the service effective?

Inadequate

The service was not effective.

Staff did not have the appropriate training and regular supervision to help them to meet people's needs.

Staff were not aware of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and did not have knowledge of the process to follow.

The home provided a range of food and drinks to help meet people's nutritional needs. However, people's specific needs were not always met consistently.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not routinely involved in making decisions about their care and the support they received

People who lived at the home told us they were treated with dignity, kindness and compassion in their day-to-day care.

Staff had developed positive caring relationships and spoke about those they cared for in a warm, compassionate manner.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not receive care that was person centred and responsive to their needs likes and dislikes.

Activities at the home were very limited. People were not supported to go out into the local community or to undertake activities that were meaningful to them.

People told us they knew how to make a complaint and felt confident any issues they raised would be dealt with.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had not operated effective systems designed to assess, monitor and improve the quality of the service.

The provider had not ensured accurate records were maintained in respect of each service user and the care provided to them.

The provider did not have sufficient plans in place to guide staff in order for people's need to continue to be met in emergencies such as fire, flood or utility loss.

The manager had a visible presence throughout the home. People and staff we spoke with felt the manager was supportive and approachable.

The Chimes

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 team consisted of two adult social care inspectors on the first day of inspection and one adult social care inspector on the second day.

Prior to this inspection visit, we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are submitted to the Care Quality Commission and tell us about important events the provider is required to send us. We spoke with the local authority to gain their feedback about the care people received. The local authority had raised concerns in relation to infection control and food hygiene at the home. We also spoke with the local fire safety officer who provided us with details of the inspection they had undertaken in April 2017. This helped us to gain a balanced overview of what people experienced when receiving a service.

We spent time in communal areas of the home so we could observe how staff interacted with people. We also observed how people were supported during meal times and during individual tasks and activities.

We spoke with a range of people about this home including five people who lived at the home and two visiting relatives. We spoke with the manager, three representatives of the provider company and five staff members during the inspection.

We looked at care records relating to seven people who lived at the home and reviewed four staff files. We reviewed records relating to medicine administration, staff training and support, as well as those related to the management and safety of the home. We also walked around the building to ensure it was clean, hygienic and a safe place for people to live.

Inadequate

Is the service safe?

Our findings

People we spoke with all told us they felt safe at The Chimes. Comments we received from people were positive and included, "Yes, I think it's safe." And, "You press your button and they [staff] are there." Comments we received from relatives included, "Yes I think [relative] is safe."

Although we received some positive feedback about safety at the homes, two relatives expressed some concerns about the service provided. One relative told us their relative had been cared for very well, but recent changes in staffing had given her cause for concern. They told us, "Lots of staff have left and are leaving. Continuity of care is a concern." Another relative told us, "The staff are lovely but they have so much to do. I think they could do with more staff."

We looked at staffing levels within the home and observed care practices, to see whether there were sufficient numbers of staff deployed at all times to meet people's needs safely. Before our inspection, we had received concerns from professionals with regard to staffing levels. The concerns related to there being no staff allocated for cleaning at weekends. This meant care staff had to undertake cleaning at weekends on top of care duties. From speaking with staff, we found this had resulted in cleaning at weekends not being undertaken, because they did not have enough time.

We asked the manager and provider how staffing levels were decided. They confirmed staffing levels were not reviewed in line with people's dependency. On the first day of our inspection, a member of staff had called in sick. The member of staff allocated for cleaning was instead tasked to undertake care duties. This left the home without a member of staff for cleaning on that day. We saw the staff on duty comprised of the manager, one carer and the cleaner. We were told and staffing rotas showed there were usually two carers on duty. When we discussed staffing with the manager, they told us they felt there should be three care staff on duty in order for people's needs to be met safely.

At the time of our inspection, there were 17 people who lived at the home, with varying levels of dependency. Some people, for example, required a member of staff to assist them to mobilise around the home, other people required two staff to assist them, whilst other people were largely independent. During our inspection, there were times when staff were all assisting people in their bedrooms, this left the communal areas of the home unattended. There were people who had been assessed as being at risk of falls who used the communal areas. This meant people were exposed to the risk of falls because staff were not available to assist them wen communal areas were unattended.

When we spoke with staff, they told us they felt there were not always enough staff on duty. Staff we spoke with explained many staff had left and had not yet been replaced. If a staff member was unable to attend the home for their shift, other staff were asked to come in but replacements could not always be found at short notice, such as on the first day of our inspection. Staff and the manager confirmed the home did not use agency staff to make up numbers if they were short.

Staff told us they felt they did not have enough time to complete all the care tasks, which had been

allocated to them. For example, two people were being cared for in bed at the time of our inspection. Staff we spoke with told us these people did not always get the care they needed in terms of repositioning to protect them against the risks of developing pressure sores. Staff told us this was because they were often too busy with caring for other people or undertaking other duties. This was especially the case at weekends. We looked at repositioning records for these two people and found large gaps in recording, as well as inconsistent timings of repositioning. This confirmed what staff had told us.

One member of staff told us, "It feels like we are always on minimum staffing. We are pushed to the limit." They told us staff were expected to meet people's care needs as well as completing additional tasks such as the laundry, tidying bedrooms and providing activities. They told us activities often were not provided because staff were too busy.

When we raised our concerns with the provider, they told us they would allocate a member of domestic staff for two hours cleaning each day at weekends, in addition to care staff. The provider confirmed they would review staffing levels to ensure there were enough staff to meet the needs of people who lived at the home safely.

The above matters show the provider was not meeting legal requirements in relating to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because they had not ensured a sufficient number of suitably qualified, competent, skilled and experienced staff were deployed at all times.

We looked at systems the provider had implemented in order to keep people safe from abuse and improper treatment. We asked staff who were on duty during the inspection whether they had received training in relation to safeguarding people who may be vulnerable by virtue of their circumstances. Staff we spoke with told us they had not. The provider also confirmed this. Of the staff we spoke with, only one was able to confidently describe what forms abuse may take and the action they would take if they thought someone was being abused.

This showed people were exposed to the risk of abuse or improper treatment. This was because staff did not have the necessary skills and knowledge in order to recognise the signs of potential abuse or how to report it. This showed the provider had not established systems and process, which were operated effectively to prevent abuse of service users.

On the first day of our inspection, we saw a person arrived at the front door and was let in to the hallway by a member of staff. We were told the person had come for a job interview. The person, who was not known to staff, was left waiting in the hallway without staff supervision for over an hour. This meant the person had access to the home and 17 potentially vulnerable people, because they were left without staff supervision. This exposed people who lived at the home to the risk of harm and showed a failure to safeguard people who may be vulnerable. We raised our concerns with the manager and provider who confirmed they would address this with staff so that unfamiliar people were not left unsupervised in the home.

The above matters showed the provider was in breach of legal requirements of Regulation 13 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not established systems and processes which were operated effectively in order to protect people who used the service against the risks of abuse and improper treatment.

We looked at how the provider assessed and managed risks for people. We found the provider used a variety of systems to assess and manage risks. For example, we saw documentation which showed risks relating to

moving and handling, nutrition and pressure area care. Risks were assessed by staff. Plans to reduce or remove risks were written by staff and held in people's written plans of care.

Although risk assessments were present , we found risk assessments and plans to mitigate and manage risk were not always completed for every aspect of people's care and were not always reflective of people's current circumstances. For example, we saw one person was being cared for in bed. We reviewed documentation relating to their care and found their written plans of care did not reflect this. This meant the person may not have received the care they needed safely because guidance was not available for staff to follow.

Additionally, we saw notes recorded for this person, which indicated they were being given a blended diet to assist with difficulties in swallowing. There was no guidance in the person's care plan around this and when we spoke with staff, we received conflicting information about the consistency of food provided to this person. The provider confirmed they had not sought specialist advice regarding the person's swallowing difficulties. This meant they were at risk of choking when eating, because the provider had not sought and followed specialist advice or provided guidance for staff to follow.

We looked at care records in relation to a person who sometimes displayed behaviours which may challenge the service. When we looked at the person's written plan of care, there was no information available to guide staff on managing the person's behaviour if they displayed any challenging behaviour. There was no reference to good practice guidelines as to how to effectively manage the behaviour. This presented a risk to people who lived at the home and to staff.

Additionally, we saw a range of liquid toiletries were accessible around the home, in communal areas and in people's bedrooms which were not kept locked. We also found liquid glass cleaner in the top floor bathroom. A number of people who lived at the home were living with varying stages of dementia. We raised this with the manager and provider who confirmed no risk assessments had been carried out in relation to people potentially consuming liquids such as these.

The matters above showed the provider was not meeting legal requirements of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not properly assessed the risks to the health and safety of people who lived at the home and done all that was reasonably practicable to mitigate those risks.

We looked at how environmental risks were addressed and managed at the home. We spoke with the manager and provider who showed us documentation and explained how they managed environmental risks. We looked at documentation relating to fire safety and carried out observations of the building to assess whether safe practices were being employed. We found that suitable systems were not in place to manage and mitigate the risks associated with fire safety.

We reviewed the Fire Risk Assessment for the home, which was implemented in 2013. There was no evidence this document had been reviewed, to ensure it was up to date, suitable and sufficient. This was raised with the provider by the local fire safety officer during their inspection in April 2017 but no action had since been taken. This showed the provider had not ensured risks associated with fire had been properly assessed and managed. Additionally, we were shown a single page document entitled 'Fire Risk Assessment'. This document was a list of residents, their 'mobility' and 'mental state'. This did not provide enough information for staff or the emergency services to enable them to evacuate people in the event of an emergency, ensuring their needs continued to be met safely.

Staff we spoke with and the provider confirmed no fire safety training had been delivered to staff. There were no detailed instructions available at the home to guide staff in the event of an emergency evacuation of the building. The information available to staff instructed them to evacuate the building and to wait for emergency services. There was no information available to staff to guide them on how this should be carried out, for example, for a person who was being cared for in bed. Staff we spoke with were unable to tell us how they would evacuate people safely. There was no clear plan in place. This left people who used the service and staff exposed to risks associated with fire and emergency evacuation of the building.

When we looked around the building, to ensure it was safe and comfortable for people who lived at the home, we found concerns in relation to fire safety. We saw doors had been wedged open, devices used to close doors automatically in the event of a fire were inoperable and the external fire escape had debris on it which presented a slip and trip hazard. This showed the provider had not operated sufficient control measures to ensure fire safety equipment was maintained in good order. This exposed people to the risk of harm from a fire in the home.

The above matters showed the provider was not meeting legal requirements in relation to Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not ensured premises and equipment were safe and used in a safe way.

During our inspection, we observed medicines being administered and checked records relating to the administration of medicines. We found that medicines were not managed properly. When we looked at medicines administration records, we found entries for people where medicines had not been given because they were 'out of stock'. This included medicines for pain relief and anti-psychotic medicines. The impact on people of not receiving these medicines as prescribed could be significant.

We were told by the manager that an order had been placed with the pharmacy and had been due to be delivered to the home the previous week. However, until prompted by the inspectors, no action had been taken by the provider to chase up the delivery, which had left at least two people without their prescribed medicines for four days.

The provider had not undertaken any audit of medicines within the home since December 2016. There had been no investigation into any entries on medicines administration records which showed medicines had not been administered. Additionally, there were no notes recorded in relation to why 'as and when required' medicines were given.

When we looked at how medicines were stored, we found they were not stored in line with best practice guidance. This included the medicines trolley not being secured and drugs which should be subject to additional controls being stored in the medicines trolley.

The above matters showed the provider was not meeting legal requirements in relation to Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because they had not ensured medicines were managed safely.

We looked at the systems and processes in place to assess, monitor and mitigate the risks to people in terms of infection control. Before our inspection, we received concerns from professionals which showed the provider was not operating safe infection control practices. The provider had produced an action plan in response to concerns and had begun to undertake work to improve infection prevention and control within the home. However, during our inspection, we found concerns remained with regard to infection control. For example, we found toilet riser seats in communal toilets and in people's en-suites were visibly dirty.

Additionally, the underside of seats used to assist people into the bath were visibly dirty. The provider showed us infection control audits which had been completed monthly. However, these had not identified the concerns raised during our inspection. We raised our concerns with the manager who told us they would address this as part of their improvements in relation to infection control. This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider was not operating effective systems in order to assess the risk of, prevent, detect and control the spread of infections.

We found the provider had followed safe practices in relation to the recruitment of new staff. We looked at four staff files and noted they contained relevant information. This included a Disclosure and Barring Service (DBS) check and appropriate references to minimise the risks to people of the unsafe recruitment of potential employees. A valid DBS check is a statutory requirement for staff providing a personal care service supporting vulnerable people. Staff we spoke with told us they did not start work until they had received their DBS check. This showed staff were always recruited through an effective recruitment process that helped to ensure only suitable candidates were employed to work with people who may be vulnerable.

Inadequate

Is the service effective?

Our findings

People we spoke with told us they were happy with the care they received and felt staff listened to them. One person told us, "The staff know their jobs here." Another person told us, "Yes, they seem to know what they are doing." A relative we spoke with told us, "They've been really good [with relative], really taken care of her."

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 to receive care and treatment when this is in their best interest and legally authorised under the MCA 2005. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the home was working within the principles of the MCA 2005.

We asked people who lived at the home if they were supported to make choices about their care. People told us they were able to make decisions and choices they wanted to make. They said staff did not restrict the things they were able, and wanted, to do.

We looked at care records to see if people who had mental capacity had consented to their care where they had mental capacity. We found people had signed care plans to give consent to the care they received.

We looked at the care and support provided to people who may not have had the mental capacity to make decisions. Assessments of people's capacity to make decisions had not been undertaken. When we looked at people's care records, we saw consent had been given by other people on their behalf. However, there was no record of any best interests decision making process, in line with the MCA code of practice. For example, two people had bed rails fitted, in order to prevent them from falling out of bed. There was no record to show the decision to use bed rails had been assessed as being in the person's best interests and was the least restrictive measure.

We spoke with staff to assess their knowledge of the MCA. When asked, staff were unable to demonstrate an awareness of the MCA code of practice and confirmed they had not received training about how to support people to make decisions and act in their best interests. This meant people may not have been afforded the protection of the MCA where they lacked capacity to make decisions themselves. The provider confirmed staff had not received training on the MCA or DoLS.

This showed the provider was not meeting legal requirements in relation to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not ensured care was provided only with the consent of people who used the service. Where people lacked capacity to

consent, the provider had not acted in accordance with the Mental Capacity Act 2005.

The home operated a locked door policy, meaning people who lived at the home had to ask staff for assistance if they wished to go outside. When we spoke with staff and the manager, they confirmed there were several people who they would prevent from leaving the premises without supervision. The manager confirmed no applications had been made under DoLS for these restrictions. This was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was restricting people and depriving them of their liberty without lawful authority.

We spoke with staff members, the provider and looked at individual staff training records. The staff members we spoke with said they received induction training on their appointment. They told us their induction consisted of two or three days spent shadowing more experienced staff. They told us no additional formal training was provided at the outset of their employment.

From discussions held with staff, only one had recently undertaken moving and handling training, but had not received any other training. The other staff we spoke with told us they had not received any training whilst working at the home. Staff we spoke with confirmed, no training had been provided to staff in relation to diabetes, dementia, pressure area care or safe swallowing. This training would have enabled staff to meet the needs of people who lived at the home more effectively.

When we discussed this with the provider, they told us staff had access to an online training program which they encouraged staff to use. However, they had not ensured staff had completed this training, nor had they assessed how effective the training was. The manager was new in post and had not yet begun to review staff training. In response to our concerns, the provider told us staff were told they needed to complete the training but this was not monitored closely. The manager confirmed training would be reviewed as a priority following our inspection.

We received mixed feedback from staff regarding supervision sessions. Some staff told us they had received supervision from a more senior person, whilst other staff confirmed they had not. We looked at supervision records for four staff and found two had records of supervision, whilst two did not. We discussed this with the provider who told us they undertook supervision sessions with staff, but due to recent management changes, new staff may not have received supervision sessions. Supervision is a one to one meeting between staff and a more senior person in the organisation, in this case the manager or the provider. These sessions provide the opportunity for a two-way discussion about performance, concerns, training and development and are vital to ensure staff are well supported.

The above matters showed the provider was not meeting legal requirements in relation to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because they had not ensured staff received appropriate training and supervision as was necessary to enable them to carry out their role effectively.

We looked at how the provider ensured people were supported to eat and drink and maintain a balanced diet. We observed the mealtime service at breakfast, lunch and the evening meal during our inspection. We saw tables were well set out with tablecloths, napkins and condiments. Pleasant music played in the dining room during mealtimes. People appeared to enjoy the experience and we received positive feedback about the food provided.

However, we noted from looking at two people's records that they were living with a medical condition which meant they required a specialised diet. There was no information in these people's care plans to

guide staff with regard to foods that were suitable for them. There was also no information available for staff which would alert them, for example, if someone's blood sugar became too low. When we spoke with staff who were responsible for preparing meals during our inspection, they were unable to provide us with information relating to any special meal preparation for people who were diabetic. We witnessed people who were diabetic receiving high sugar puddings during our inspection. This put people at risk of receiving a diet that was not suitable, in order for them to maintain good health, due to their diabetes.

We looked at food and fluid monitoring documents for two people. The manager told us these documents were in place because these people's food and fluid intake needed to be monitored closely to ensure they received sufficient amounts. We saw large gaps in recording and noted fluid totals had not been added up. The manager told us staff had been told about the importance of these documents, but explained no check had been undertaken to ensure they were being completed properly. One of the records we looked at showed the person had received only 415ml of fluid in the previous 24 hours. This meant the person may not have received enough to drink in order to maintain their health. This had not been noticed by staff and no action had been taken to ensure they were sufficiently hydrated until prompted by the inspector.

The above matters showed the provider was not meeting legal requirements in relation to Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not ensured people received suitable food and hydration in order to sustain good health.

Staff had documented involvement from several healthcare agencies to help manage people's healthcare needs. We observed this was generally done in an effective and timely manner. Records we looked at showed involvement from various health professionals such as GPs and specialist practitioners. However, this was not always the case. For example, one person had been experiencing difficulties in swallowing. The provider had not ensured professional guidance had been sought for them, in order that they could meet their nutritional needs effectively.

Requires Improvement

Is the service caring?

Our findings

People we spoke with gave us positive feedback about how caring staff were. For example, one person told us, "Staff are friendly. They treat me well." Another person told us, "They [staff] are good carers. They are nice, it's comforting." A visiting relative told us, "The staff are lovely." Another relative commented, "They've been really good, really taken care of [relative], she's comfortable and she likes it." During our observations, we saw staff were kind, caring, compassionate and respectful during their interactions with people.

We found records contained varying levels of information about people's preferences in relation to their care. However, this information was not consistently used to inform care planning. Additionally, we noted there was no evidence that people or others acting on their behalf, where appropriate, were involved in reviewing the care delivered to people. People who lived at the home and relatives we spoke with told us they could not recall having been involved in reviews, where applicable. This meant systems were not in place to ensure the care delivered to people met their needs and took account of their preferences. This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

With regard to advocacy services, we saw contact details on the notice board in the home. This provided people with the opportunity to contact such services privately if they wished to do so. The manager, confirmed if someone did not have friends or family, they would make them aware of advocacy services during the care planning process. An advocate is in independent person who can act in a person's best interests.

People we spoke with told us they had a good relationship with the staff who supported them. Staff we spoke with confirmed they had got to know people over time. The manager told us they felt it was important for the staff team to build and foster positive relationships with people in their care. We observed staff spoke with people in different ways depending on how the person preferred to be addressed. For example, we observed people enjoying banter with staff, while other preferred to be addressed more softly, to which they responded positively. This showed us staff were aware of how people liked to be communicated with.

We noted people's dignity and privacy were maintained throughout our inspection. Staff knocked on people's doors before entering. People we spoke with confirmed this was usual practice and raised no concerns about privacy or the approach of the staff team.

When we visited people in their rooms, we saw the rooms had been personalised with pictures, ornaments and furnishings. Rooms were tidy which demonstrated staff respected people's belongings.

Requires Improvement

Is the service responsive?

Our findings

People we spoke with told us they felt staff responded well to their general needs, in terms of assisting them with day to day matters. However, people also raised concerns that there was very little for them to do to keep occupied other than watching TV and the occasional singer who came into the home. Relatives we spoke with told us they felt the service did not provide a good enough level of stimulation for people who lived there. One relative told us, "I do wonder whether [relative] is being encouraged to engage. There's very little goes on in terms of activities since [previous manager] left." Another relative commented, "They don't seem to do much with them. The singer hasn't been for a while." A member of staff we spoke with told us, "We're expected to provide activities. I don't know how we're expected to do that when we are under so much pressure to provide care, do the laundry, turn people and do the tea trolley."

We looked at how activities were planned and delivered at The Chimes. People were left in communal areas and bedrooms with the television on and no other stimulation. During our inspection we did not witness any activities taking place at the home.

When we asked staff about activities provision, they told us they were expected to provide activities such as bingo and dominoes as well as completing care tasks. Staff told us this was difficult as the current staffing levels meant they were unable to meet people's care needs and carry out activities at the same time. This meant activities did not take place as expected.

We were told by the manager and provider that a hairdresser and singer visited the home each week. However, the service did not support people to go out of the home, nor were any other outside people or companies engaged to visit the home to provide entertainment.

This showed the provider had not ensured peoples preferences were taken into account in order to provide meaningful and stimulating activities in order to maintain and promote people's social health.

We looked at people's written plans of care and assessments on which they were based. We saw the provider undertook assessments of people's needs. These assessments then formed people's care plans. Although care plans were in place we found these were not updated to ensure they reflected people's circumstances.

For one person, we found conflicting information recorded in their care plan. For example, one person's personal risk assessment stated they needed assistance from one staff member with moving around the home.. This conflicted with a moving and handling assessment, which was completed on the same date for this person which stated they required two care staff to assist them. Daily records for this person also stated they had received a blended diet of fish, which they did not like. We were unable to see any information in the person's care plan with regard to them receiving a soft or blended diet. There was no information to show the service had sought professional guidance for this person with regard to swallowing difficulties. The provider later confirmed they had not yet sought guidance. Additionally, the person was being cared for in bed. The provider had not ensured the person's risk assessments and care plans had been reviewed and

updated to reflect this.

We spoke with a visiting relative, they raised concerns about their loved one not receiving the personal care they required, for example, bathing and washing. We looked at the person's care records and daily notes. We saw there had been no entry recorded to say the person had received a bath, shower or bed bath for a month. The manager told us personal care would have taken place but had not been recorded.

The above matters showed the provider was not meeting legal requirements in relation to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not ensured the care delivered to people met their needs and reflected their preferences.

There was a complaints policy. People we spoke with stated they would not have any reservations in making a complaint. They told us they felt able to raise concerns with any member of staff or the manager, who they described as approachable. No one we spoke with had raised any concerns but felt confident the manager would address any issues. This showed the provider had a procedure to manage complaints.

Inadequate

Is the service well-led?

Our findings

People we spoke with and staff were positive about the manager and how well-led the home was. Comments we received from people included, "[Manager] is really nice." And, "[Manager] is very nice, approachable." Relatives we spoke with told us there had been a lot of managerial changes in recent months, but thought the new manager was approachable. Staff we spoke with told us they liked the manager who they described as supportive.

The home had been without a registered manager since February 2017. The provider had identified an employee to take on the role of registered manager but had recently taken the decision not to continue in the role. The provider had recruited a new manager to replace them, who had been in post only two weeks by the time of our inspection. The home had also experienced a high turnover of staff in recent months and were recruiting to fill several care staff vacancies.

The provider had a range of audits and checks in place as part of their quality assurance for monitoring the home. These included the fire safety checks, emergency lighting, water temperature and infection control. Checks on any lifting equipment was undertaken and certificated by an external company. However, no checks had been undertaken on care planning and no audit of medicines had been undertaken since December 2016. We found the provider's quality assurance systems were not operated effectively and had not identified the concerns and breaches of legal requirements set out in this report. Additionally, where checks had been completed, they were always reliable. For example, the most recent infection control audit had not identified the concerns raised by the infection prevention and control team when they inspected the service.

Additionally, the provider's policies and procedures had not been reviewed and updated since June 2012, which meant they did not reflect important changes in guidance and legislation, such as with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards, for example.

Similarly, when we looked at fire safety documentation, we asked the provider how they undertook fire safety checks. They were unable to explain how the checks had been carried out. This showed the provider had not established systems and processes which were operated effectively in order to assess, monitor and improve the quality of the service.

We found records relating to people's care, such as daily activities, bathing records and food and fluid monitoring, were not consistently completed. The manager said they had spoken to staff about the quality of paperwork and the need for improvements but no checks had been undertaken to ensure improvements had been made. The provider is required by law to keep an accurate, complete and contemporaneous record in respect of each person who uses the service, including a record of the care provided to them.

The provider had not ensured they met their legal responsibilities. For example, in relation to overseeing staff training, ensuring medicines were in stock and ensuring improvements to record keeping had been made. This showed oversight of the service was poor.

The above matters were in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider told us they had used satisfaction questionnaires to gather people's views. However, when asked, they were unable to provide any results of recent surveys. They told us the questionnaires are available in the reception area at the home for people to take if they wished to fill one in. The provider told us they spent time at the home to ensure they gained people's views and experiences of the service through one to one conversations. These discussions were not recorded and the provider was unable to evidence changes they had made as a result of these discussions.

There was a business continuity plan in place. A business continuity plan is a response planning document and shows how the management team would return to 'business as usual' should an incident or accident take place. However, the business continuity plan had not been reviewed since 2013 and held out of date information, for example staff who no longer worked at the home. The plan did not provide guidance for staff to follow or state how the business would continue to function in the event of a flood or utility loss, for example.

The manager understood their responsibilities and was proactive in introducing changes within the home. This included informing CQC of specific events the provider is required to notify us about and working with other agencies to maintain people's welfare.

We met with the management team following the inspection. We found the management team receptive to feedback and keen to improve the service. They worked with us in a positive manner and provided all the information we requested.

The provider had ensured the rating from the previous inspection was on display in a prominent position at the home.

The home's liability insurance was valid and in date.

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 implemented systems were to ensure the care delivered to people met their needs and took account of their preferences. The provider had not ensured the care delivered to people met their needs and reflected their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent because the provider had not ensured care was provided only with the consent of people who used the service. Where people lacked capacity to consent, the provider had not acted in accordance with the Mental Capacity Act 2005.

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 properly assessed the risks to the health and safety of people who lived at the home and done all that was reasonably practicable to mitigate those risks. the provider had not ensured premises and equipment were safe and used in a safe way. The provider had not ensured medicines were managed properly and safely. The provider was not operating effective systems in order to assess the risk of, prevent, detect and control the spread of infections.

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 not established systems and processes which were operated effectively in order to protect people who used the service against the risks of abuse and improper treatment. The provider was restricting people and depriving them of their liberty without lawful authority.

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 had not ensured people received suitable food and hydration in order to sustain good health.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured a sufficient number of suitably qualified, competent, skilled and experienced staff were deployed at all times. The provider had not ensured staff received appropriate training and supervision as was necessary to enable them to carry out their role effectively.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's systems to assess, monitor and improve the quality and safety of services provided were not operated effectively. The provider's systems and processes to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk were not operated effectively. The provider had not maintained securely and accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

The enforcement action we took:

We served a Warning Notice against to provider for breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Good governance)