Haven House Care Limited

Haven House Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection was carried out on 6 February 2017. Haven House Residential Care Home provides accommodation and care for people who have a long term mental health condition. The service is registered to accommodate up to 19 people. On the day of our inspection 15 people lived at the service with one person due to return from hospital.

There was no registered manager at the service. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There were not always enough staff deployed in the service to consistently meet people's needs. People were left on their own for long periods of time without the support of staff. Not all of the care staff on duty provided care to people; staff were undertaking kitchen, domestic and activity duties which left one member of care staff to provide the care for 15 people.

Risk assessments for people were missing and other assessments were not always detailed. There was not enough information to guide staff about how to reduce the risks to people. Incidents and accidents were not always followed up and lacked detail and actions to reduce the risk of repeated incidents. Staff were not following good infection control procedures. The premises and equipment was not well maintained. People's medicines were managed in a safe way.

Personal evacuation plans were not in place for every person who lived at the service. In the event of an emergency, such as the building being flooded or a fire, there was no service contingency plan to detail what staff needed to do to protect people and make them safe.

Although staff and the provider had knowledge of safeguarding adult's procedures and there was a safeguarding adult's policy in place. People who had capacity were having their liberties restricted. There were people who told us that they did not always feel safe. Recruitment practices were not always safe as relevant checks had not always been completed before staff started work.

People's rights were not always met under the Mental Capacity Act 2005 (MCA), and the Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty they have been authorised by the local authority as being required to protect them from harm. Assessments had not been completed specific to the decision that needed to be made around people's capacity. DoLS applications had not been submitted to the local authority where it may have been appropriate.

People were not always receiving care from staff that were competent, skilled and experienced. There was a risk that people were receiving care from staff who were had not had training to meet the needs of people

with mental health issues. Staff competencies were not always assessed as they did not have appropriate supervision or appraisals.

People were not always provided choices that met their reasonable preferences and people did not always like the quality of the meals. However, people at risk of dehydration or malnutrition did have systems in place to support them. People had access to health care professionals to support them with their health needs.

Staff at the service did not always treat people with dignity and respect. There were times where people were ignored for periods of time throughout the day. There was evidence of lack of choices for people at the service around how their care was to be delivered.

People were not always consulted about the care they wanted. The routines of the home were imposed for staff convenience rather than to meet the personal choices of people. We did see times when staff were caring and considerate to people.

People's preferences were not consistently being sought by staff. The provider was not always responsive to people's needs. There was no detailed information in people's care plans around the support they needed. There was a lack of guidance around care for people with a mental health diagnosis.

There were not enough activities on offer specific to the needs of people. There were long periods of time where people had no meaningful engagement with staff. People that wanted to go out did not always have the opportunity.

There were not effective systems in place to assess and monitor the quality of the service. Although some audits had been undertaken these had not been used to improve the quality of care for people.

There was a complaints procedure in place however people were not encouraged or supported to voice their concerns.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The provider had informed the CQC of significant events.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The overall rating for this service is 'Inadequate' and the service therefore remains 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 time frame. 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.

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

inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were not enough staff deployed at the service to meet people's needs.

People were not always safe because risks of harm had not always been managed. People were not always protected from environmental risks.

Staff were aware of their roles and responsibilities in how to protect people however people told us that they did not always feel safe.

Safe recruitment practice was not being followed.

Medicines were administered, stored and disposed of safely.

Is the service effective?

Inadequate

The service was not effective.

People were not always supported by staff that had the necessary skills and knowledge to meet their assessed need.

Staff did not understand how to apply legislation that supported people to consent to treatment. Where restrictions were in place this was not always in line with appropriate guidelines.

Although people had sufficient amounts to eat and drink people were not satisfied with the quality of the food.

People were not always offered choices around meals and drinks.

People were supported to have access to healthcare services and healthcare professionals were involved in the regular monitoring of people's health.

Is the service caring?

Inadequate

The service was not caring.

Staff did not always treat people with dignity and respect and there were practices by staff that did not promote choices for people. However we did see occasions where staff were kind and attentive.

People's preferences, likes and dislikes had been not always been taken into consideration and support was not always provided in accordance with people's wishes.

Is the service responsive?

Inadequate

The service was not responsive.

People's needs were not always assessed on a continuous basis and the care plans were not updated to reflect changes.

There was not always detailed information regarding people's care, treatment, and support.

People did not have access to activities that were important and relevant to them.

People were not encouraged to voice their concerns or complaints about the service.

Is the service well-led?

Inadequate

The service was not well- led.

The provider did not have systems in place to regularly assess and monitor the quality of the service the service provided.

The provider had not met breaches in regulation from the previous inspection.

The provider failed to seek, encourage and support people's involvement in the improvement of the home to improve the quality of care.

Appropriate notifications were sent to the CQC.

Haven House Residential Care Home

Detailed findings

Background to this inspection

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

This was an unannounced inspection which took place on the 06 February 2017. The inspection team consisted of three inspectors.

Before the inspection we reviewed the information we had about the service. This included information sent to us by the provider, about the staff and the people who used the service. We also reviewed information from the Local Authority Quality Assurance team. Due to concerns raised to us about the staffing levels at the service we inspected sooner than we had planned to. On that basis we did not have a Provider Information Return (PIR) to review before the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed notifications sent to us about significant events at the service. A notification is information about important events which the provider is required to tell us about by law.

As part of the inspection we spoke with 11 people and four members of staff. We looked at a sample of four care records of people who used the service, medicine administration records and supervision and recruitment records for staff. We looked at records that related to the management of the service. This included minutes of staff meetings and audits of the service.

The last inspection was on the 15 July 2016 where breaches were identified in the lack of appropriate mental capacity assessments, the lack of staff at the service and the lack of person centred care plans. We also made recommendations around mitigating risks to people.

Inadequate

Is the service safe?

Our findings

On the previous inspections in April 2016 and July 2016 we had identified a breach in staffing. There had been some improvements to the staffing levels in July 2016; however, we found on this inspection that levels of staff on duty had been reduced. There was insufficient care staff on duty and there were not enough staff available for activities and housekeeping.

We asked people if there were enough staff at the service. Comments included, "There isn't enough staff here, I notice it more during the day", "It depends (they said sometimes there was and sometimes there was not)", "There is plenty of staff."

We found that people's needs were not always met because there were not always enough staff employed and deployed to meet people's needs in a safe way. One person had returned from hospital and their mobility needs had increased. The person required two care staff to move them at all times. Staff levels had not increased to account for this. During the day there were two care staff to support 15 people living at the service. This meant that whilst this person was being supported by the two staff there were 14 people left unsupported. We could see from staff rotas that additional carers had been planned for this person's return from hospital. However, this had been reduced to two carers with no explanation as to why. One member of staff told us that two care staff during the day was not enough, "It's really challenging (with the person here). You have to visit them in their room every 15 minutes." We saw that the person was constantly moving in their chair whilst we were there which put them at risk. One member of staff said that the person was constantly sliding off their bed or out of their chair. On the morning of the inspection the person had to be hoisted from the floor as they had attempted to get up without support. Another member of staff said, "I think we should have more staff, the work is so stressful and it's challenging. Having another carer would help." We raised our concerns with the Local Authority about the staffing levels for the person that had returned from hospital.

At night there was only one member of staff awake and one member of staff asleep to be woken only in an emergency. One member of staff told us, "One awake staff at night is not enough." They told us that they had to provide personal care regularly to three people during the night and that one member of staff was not sufficient. They said, "I don't believe people are bathed or showered enough (as there were not enough staff during the day)."

On the day of the inspection there were limited activities available for people due to the lack of staff available. Other than a board game being played in the morning by three people no other activities were on offer. An additional carer had been deployed to undertake cleaning duties at the service, however, during the inspection this member of staff was asked to take two people to an appointment and to undertake other tasks. This left the member of staff with little time to attend to their cleaning duties. One member of staff said, "We are expected to deep clean every room each week but there is not enough time to do this." The cooking was undertaken by one of the carers on duty whilst the second carer was constantly checking on the person that was being cared for in their room. This left little time for staff to interact with people in any meaningful way.

There were not always enough staff employed and deployed to ensure that people were kept safe and to participate in activities this was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always protected from being cared for by unsuitable staff because robust recruitment was not in place. In one member of staff's file there was no evidence of a criminal records check. There was one reference for one member of staff (the requirement for the service was two references) and this reference had not been obtained from the care establishment that the member of staff said they had worked at. The reference had been obtained from a non-care setting. The previous managers had also identified gaps in the recruitment files. This included gaps in staff's previous employment and missing evidence relating to the member of staffs address. We asked the provider to send us evidence that the criminal records had taken place after this inspection and this has now been provided.

There were not robust recruitment procedures in place this is a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they did not always feel safe from the risk of abuse or improper treatment. There were people at the service who told us that they were concerned about how particular staff would treat them. Staff were able to tell us the types of abuse that may occur including verbal and physical. There was a service safeguarding policy that detailed what staff needed to do to protect people, however, people did not always feel protected.

Accidents and incidents were not always recorded or followed up with action taken. Over a period of four months there had been 15 unwitnessed falls to seven people at the service. These had been recorded but there was not sufficient evidence of what action was taken to reduce the risk of these happening again. One person had been referred to the local hospital to review their mobility; however, there was no evidence to support how the other six people had been supported to reduce the risk of falls. Another incident stated that one person had been given the wrong medicine. There was no evidence to show what action had been taken, whether the person had any adverse reaction to this or what steps had been taken to reduce the risk of this. The member of staff told us that they had not had additional training in medicines. They told us that they felt that they should have been given this.

People were not always protected from the risks of unsafe care. The care plans did not contain detailed information about actions required in order to provide safe care. One person had returned from hospital where their mobility had significantly reduced. The care plan identified that the person was unable to move in bed independently and that they required two to four hourly 'turns' in bed. There was no record of repositioning charts in daily notes, and with only one member of staff awake at night the turning of the person could not have been undertaken. The care plan stated that they had increased susceptibility to pressure sores, which had not been risk assessed. There had been a note left from the previous manager to state that a MUST (Malnutrition Universal Screening Tool to assess people's risk of malnutrition) should be completed for people. This had not been undertaken. There were also no Waterlow Scores (a tool to establish a person's skin integrity) recorded in people's files. The manager had asked these to be completed before the inspection however this had not been done. This meant that staff had not assessed people's risk of malnutrition and pressure sores.

People would not always be safe in the event of an emergency because appropriate plans were not in place. In the event of an emergency, such as the building being flooded or a fire, there was no service contingency plan to detail what staff needed to do to protect people and make them safe. Personal evacuation plans were not in place for every person at the service. Not all staff had been fire safety trained. One member of

staff that had received this training was not aware of how to safely evacuate people from the service in the event of an emergency. We have asked the provider to deal with this urgently; however, to date this they have not confirmed that this has been done.

As care and treatment was not always being provided in a safe way this is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were other aspects to the service that did not promote safe care. The environment was not always clean or well maintained. Staff told us that there was no place to store people's soiled pads during the night. Staff were storing clinical waste in bags in the bathrooms that were easily accessible to other people at the service. In the minutes of a staff meeting held on the 7 December 2016, staff were told not to use the resident's bathroom to wash their hands. That meant that after tending to personal care the staff were required to use the sink at the back of the kitchen downstairs. This posed a risk of cross infection. When we arrived at the service the downstairs toilet needed cleaning. This had not been dealt with by the end of the inspection. The toilet light pull was stained and dirty and there was built up grime and rust around the frame of the toilet which made it difficult to clean. One member of staff told us that there was not enough time to clean the service in the way that they wanted to. The Local Authority fed back to us that the day after the inspection people's rooms were unclean.

As the premises and equipment was not maintained to a safe standard this is a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were aspects that people's medicines were being managed in a safe way. Where there had been gaps in the MAR charts staff had filled them to state why there were was a gap, for example, when people were away visiting their families. We noted MAR charts contained relevant information about the administration of certain medicines. In addition, each person taking 'as needed' medicines, such as pain killers, had an individual protocol held with their MAR chart. This described the reason for the medicines use, the maximum dose, minimum time between doses and possible side effects.

Inadequate

Is the service effective?

Our findings

On our inspection in April and July 2016 we found that staff did not always follow the principles of the Mental Capacity Act (MCA) and Deprivation of Liberty (DoLS). The requirements were still not always being followed.

People's rights were not always protected because the staff did not always act in accordance with the MCA. MCA is a legal framework about how decisions should be taken where people may lack capacity to do so for themselves. It applies to decisions such as medical treatment as well as day to day matters. Mental capacity assessments were not undertaken correctly to ensure people's rights were protected. An MCA regarding 'custody of Xs cigarettes' found that the person lacked capacity. It stated the person could not weigh up information to reach a decision themself because, 'X does not agree with it however it was in Xs best interests – Xs health and wellbeing.' This demonstrated a lack of understanding of MCA. The evidence listed did not justify a lack of capacity decision and it did not take into account the principal that people can make unwise decisions should they wish to. In another file the person the MCA stated that the person lacked capacity to consent to medicine with no rationale behind this. Two other people were required to ask for cigarettes as it was deemed to be 'in their best interest,' however, we were told by staff that both people had full capacity to make the decision by themselves. Not all staff had been provided with training in MCA. The staff we spoke to on the day were unable to tell us what MCA was or the principles behind it.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. We noted that DoLS applications had not been completed in line with current legislation to the local authority for people living at the service. We noted from records that one person wanted to leave the service and Police had brought the person back. There had been no consideration over their capacity or any DoLs application considered in relation to this.

As care and treatment was not always provided with the appropriate consent this is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff were not suitably qualified, skilled and experienced to meet people's needs. There were people at the service that had a mental health diagnosis. Two members of staff told us they were not equipped to deal with some of the people that lived there and had not had training around mental health. We reviewed the training records and found that out of nine staff four had not completed MCA and moving and handling, health and safety and infection control training. There were six staff that had not completed first aid training and two staff had not completed fire safety training. Only two staff had completed training around mental health needs. We asked staff whether they understood mental health diagnosis and they said that they did not. One told us, "We need more training. It would help us understand more the kind of people we are dealing with." Staff told us that they did not feel their induction was sufficient. One member of staff told us that they shadowed a night shift for one and a half shifts and from that point on was working four nights a week on their own. They said, "When I first started my training was rubbish. We did some online training but

this was not enough."

We asked about how staff were formally supervised and appraised by the provider. Staff told us they had not had a formal supervision since they started at the service. Neither had they met with their manager to discuss their performance and whether they required additional training. Both staff felt that this should have taken place. There was a list of supervisions that should have been taking place the week of the inspection, however, the manager taking these supervisions had left the service.

As staff were not always receiving the appropriate training and supervision to undertake their role this is a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people about the food offered at the service and we also observed care in communal areas at lunchtime. There were no chefs working at the service as they had recently left. One person said, "When the chef does it (the cooking) it's nice, when they (staff) do it it's disgusting. They give you a choice of two things and if you don't like either you're stuck." Another person said, "I'm a vegetarian and the two chefs would cook me vegetarian dishes." They were not aware that the chefs had left the service. On the day of the inspection the person was offered a ready-made vegetarian meal. Another person said, "I had noticed a change for the better (in the meals) but it will revert back to the old meals now. The food was dire."

The local authority had visited the service the previous week of the inspection and stated that people were being served tinned Chilli Con Carnie and tinned curry. The menu listed on the board on the day of the inspection stated that the meal for the day was Lasagne (with a Vegetarian option); however people were served Chilli Con Carnie. One person was heard commenting, "It doesn't taste like chilli, it tastes like mince. There is no chilli in this." There were other people commenting that they enjoyed the meal and extra was given to those that wanted it. Everyone had access to a drink at all times, although not necessarily their choice of drink. When people asked for a drink, they were given one but they were never asked what drink they wanted.

We recommend that people are provided with choices of fresh food and drink specific to people's individual needs.

Nutritional assessments were carried out as part of the initial assessments when people moved into the home. These showed if people had specialist dietary needs. People's weights were recorded and where needed advice was sought from the relevant health care professional. Where people needed to have their food and fluid recorded this was not always completed accurately. For example in one person's notes it stated that the meals had been given but no record of the amounts.

We looked at care plans in order to ascertain whether people's health care needs were being met. We noted the provider involved a wide range of external health and social care professionals in the care of people. These included GPs and community nurses.

Inadequate

Is the service caring?

Our findings

On our inspection in April 2016 we found that care was not designed with the input of people who used the service. There had been some improvements in this on the July 2016 inspection, however, on this inspection there remained institutionalised practice from staff in the service.

People on the whole were accepting of the way they lived their lives at Haven House. However, we found that people's individual wishes and needs were not considered by the Provider. Instead what we found was that people's wishes and wants were secondary to how the service was run. For example, staff were asked to wake people early (from 5am) to ensure that they were ready for breakfast at 7am. One person told us, "I am told to come down for 6.30am but I don't get up until 9.30am and I miss breakfast. I will have a couple of biscuits instead." In the evening staff were asked to ensure that the television in the lounge was turned off at 10pm regardless of who was watching it. One member of staff said, "We were told by other staff that if people ask for a biscuit (whilst on night duty) say no to them as if one asks they will all ask." They told us that they did not agree with this. We were told by staff and people that three people were woken three times a night to ask to go to the toilet to prevent them from 'wetting the bed'. One member of staff said, "I don't know why because I have never known them to wet themselves."

There were examples of where the wishes and needs of people were secondary to how the service was run. People were told when they were allowed their last cigarette in the evening and others were restricted to how many cigarettes they could have in one day. One person told us, "X does love having a cigarette. She is told when she can have them. I bought some for her and her face lit up." We checked the person's care plan and there was nothing to suggest that the person should not have had cigarettes when they wanted. One member of staff said, "I have been told to give two people their last cigarette at 9pm when they have their medicines and bed time." They said they did not understand why they could not stay up later or have cigarettes when they wanted. All of the people told us that they could make themselves a drink but were never encouraged to do so. We did not see staff encourage people to make themselves a drink.

There was no evidence in people's care plans that people and relatives (where appropriate) were involved in the planning of their care. None of the care plans contained information around how people communicated, their spiritual needs, their likes and dislikes and whether they had a preference to a male of female carer.

People's rooms were not personalised and lacked the homely feel. People told us that they were not involved in how their rooms were decorated and did not have an opportunity to choose their curtains or furniture. One member of staff told us that the rooms were bland in colour and the furniture was old. We found this to be the case. People did have their own personal belongings in their room.

The provider had not ensured that care and treatment was provided that met people's individual and most current needs. This is a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people whether staff were caring towards them. One person said, "They are caring, they certainly work long hours" whilst another said, "They're friendly and we chat about life." However, other comments from people included, "It could be worse" and, "You are stuck here aren't you." Another person said that they felt they had not received the emotional support they needed from staff but that some staff were caring.

People were not always treated with respect and dignity or encouraged to make decisions for themselves. The food that was purchased for people was all 'basic' from the supermarket. The breakfast on offer each day was either 'basic' cornflakes or porridge. One member of staff said, "We are told to make the porridge with water instead of milk to save on the milk." One person told us, "They buy the cheapest cornflakes. I don't like the milk, it comes in a packet. Now the chef has gone we will go back to basic food again. I buy my own cereal now and staff let me know when it is running out." For those people not wanting to have cornflakes or porridge they were required to buy their own cereal. We saw these stored in the cupboard. Fresh milk was not provided to people instead they were given 'long life' milk which was bought in bulk. We saw from records that approximately £2.00 per day each person was spent on the food budget for 16 people at the service. People were not offered a cooked breakfast. One member of staff said, "At the moment we are not having a cooked breakfast as there are not enough staff." There was no evidence that people had ever been offered a cooked breakfast. One person told us that they were never offered a cook breakfast and assumed this was not an option. Another member of staff said that that cooked breakfast was never an option.

There were times where staff did not treat people in a caring way. During the morning people sat in their chairs in the lounge with little interaction from staff (as they were busy) apart from to offer them a drink. One member of staff told us that a person became unwell during the night and wanted reassurance from them (which they gave). The member of staff said that the next day when they handed over the information they were informed by another member of staff "Not to talk to people in the night."

We found that it was cold at the service on the day of the inspection. Staff told us that the heater was on a timer and that it had turned off. We asked if the heating could be turned on again as we could see that people were cold. One member of staff told us, "The heating is not on at night and people are cold." They told us that the heating was turned off at night and came back on in the morning. They said that people would often complain to the member of staff that it was cold at night.

As people were not always treated with dignity and respect this is a breach of |Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did times where staff treated people in a kind and dignified way. One member of staff always knocked on people's doors before they entered their room. We saw pleasant interactions with staff and people but due to how busy staff were this did not happen often.

Inadequate

Is the service responsive?

Our findings

At the previous inspections in April and July 2016 care plans were not detailed and people did not always have access to activities. At this inspection we found some improvements in the care plans, however, there was still a lack of guidance for staff. People still did not have access to sufficient meaningful activities.

We asked people whether there was enough to do at the service. Comments included, "There are nil activities. Most people just sit around watching telly all day long", "We play games like snakes and ladders and scrabble and I can go to the Vines (day centre) on a Tuesday and Thursday", "We are not doing a lot today. I occasionally get bored. Sometimes there isn't a lot to do" "I only watch telly but there are things going on", "If I desperately wanted to go out I would hire a car", "I don't go out anywhere. I would like to go to the record shop."

On the day of the inspection there was no evidence of meaningful activities on offer specific to the needs of people. There were long periods of time where people had no meaningful engagement with staff. Those that were able could go out when they wanted. However, those that were dependent upon staff support to go out did not get as much opportunity. One member of staff told us, "People haven't got enough to do. I think we should be allowed an allowance to plan for activities." They told us that when they did take two people out to the shops they were told to have them back for lunch as they were not allowed to stay out for lunch. Another member of staff said, "People can get bored here. We need someone to do activities." On the board inside the entrance hall it stated that today's activity taking place would be 'Craft Activity,' however this did not take place. It stated that other 'Ongoing activities' were nail polishing, going for a walk, trips to the village, life skills, peeling vegetables and washing and drying up. Other than one person cleaning the tables after lunch and another person sweeping the floor none of these activities took place. People were sat around for most of the day either watching television or asleep in the chair. Two people did go out independently on an activity they had arranged themselves and on other days people that were able visited their family or went shopping.

There was a risk staff may not have the most up to date and appropriate information available to them for people. One care plan identified risks around delusions that the person suffered as a result of their mental health condition. This stated staff should 'encourage X to verbalise their thoughts and feelings' and to 'encourage X in differentiating between their own thoughts and reality.' This was then contradicted in May 2016 which stated 'staff should not challenge Xs delusions.' In daily notes, staff documented that they had been challenging Xs 'delusion' that X could walk. A 'resident's daily report chart' document dated February 2017 said 'Still having delusional thoughts that X could walk, but staff explained that X could hardly stand but X gets upset. There was no clarity about how the person's mental health needs would be met. Another person's care plan stated X 'actively hallucinates' with no detail around how this presented itself. The care also stated that they had other mental health needs. The only support detailed for staff was, 'support me to enable me to manage my hallucinations and delusions in a positive way' with no guidance around how this should be done. Staff told us on the day of the inspection that they did not understand the mental health conditions that people had and would not know how best to support people.

Care and treatment was not always provided that met people's individual and most current needs. This is a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some of the care plans recorded outcomes and goals for people. For example, one care plan contained information on how staff should support with catheter care and how the person liked to lie in bed to avoid acid reflux. Some aspects were geared towards the person's mental health, for example, under personal care it stated, 'staff to observe me for any deterioration in my mental state which could lead to self-neglect.' Daily notes showed staff were recording the person's mental state and recording if they had concerns about the person's mental wellbeing.

We asked people if they would know how to make a complaint. One person said, "I'm too scared to make a complaint (the person told us that they felt too intimidated by some staff to make a complaint) "I've not had to complain but I'd say something." There was no mention in the residents meeting minutes of how people should complain if they were unhappy about something. There was a complaints folder in place however there had been no recorded complaints since the last inspection.

Inadequate

Is the service well-led?

Our findings

There is a history of non-compliance with the regulations and we do not have confidence that the provider is able to sustain and embed the improvements the previous managers started to make. In September 2015 the service was rated inadequate and breaches were identified in a number of areas. As a result warning notices were issued. When we re-inspected in April 2016 improvements had not been made and further breaches had been identified. Therefore instead of improving the service and care people received the provider had allowed the service to deteriorate and had failed to take action in a timely way. During the July 2016 we found that there had been improvements but there were still actions that they needed to take. Since the last inspection the provider had recruited a management company to oversee these improvements. However, at this inspection they had given notice to leave the service.

There is a history of non-compliance and lack of action by the provider to improve the care. On the inspections in April and July 2016 we identified breaches in regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. The provider did not have effective systems in place to monitor the quality of care or drive improvement. The provider had not taken responsibility to ensure that the appropriate work was being carried out.

Since the last inspection the management of the service had deteriorated. There had been three managers at the service since July 2016 that had all left. People at the service could not tell us who the manager was now and were disappointed at the managers leaving as all of them had a positive impact on them. One told us, "The (previous manager) was very good to me." Another person said, "The managers keep coming and going." There was no manager in charge on the day of the inspection and this left a senior carer in charge of the service.

Although there were some systems to assess the quality of the service provided in the home we found these were not always effective. These systems had not ensured people were protected against some key risks described in this report about inappropriate or unsafe care and support. We found problems in relation to lack of activities, staffing levels, staff training, care plans and the cleanliness of the environment and the food.

There were aspects to the quality assurance that were not used to drive improvement. There was no system in place to identify and mitigate risks or to analyse accidents to learn from them. Accidents such as falls or incidents (such as missed medicines) were recorded by staff but they had not investigated the possible causes. We saw that relatives and residents meetings had taken place and although improvements to the service had been discussed these had not been followed through. For example, in a relatives meeting in October 2016 there was discussions around people being involved more in the community, undertaking more activities and alternative food and stock providers. This had not taken place. In a residents meeting in November 2016 increased activities were discussed and whilst these had increased for a short time they had declined again.

Staff attended meetings; however, these were not used as an opportunity to improve the quality of the

service provided by them. In the last meeting in December 2016 staff raised concerns about the quality of the cleaning products that had been used. Staff told us on the day of the inspection that this still had not changed. The shortage of night staff was also discussed but to date this has remained the same. There was no management oversight of how jobs were distributed with staff. One member of staff told us that they were expected to provide all of the personal care to people at the service whilst the other member of staff did paperwork and cooking. They told us, "It's really challenging. Some colleagues work as a team but others leave you to do all of the work." Another member of staff said, "We never know what work we are supposed to be doing."

As systems and processes were not established and operated effectively this is a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The manager had informed the CQC of significant events in a timely way.