Care UK Community Partnerships Ltd

Whitebourne

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 24 April and 2 May 2017. Both visits were unannounced.

Whitebourne is a care home providing residential care for up to 66 people, some of whom are living with dementia. At the time of our inspection there were 63 people living at the service.

There was a registered manager in post. 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. Since the inspection management arrangements at the home have changed. At the last inspection in 2015 we did not identify any breaches of the regulations. Since then the service quality had deteriorated and the provider failed to have effective oversight in order to identify what was going wrong and to make improvements. Since this inspection the provider has increased their quality assurance checks and has implemented a new action plan to make the improvements needed. The local authority and the CCG have informed us that some improvements have been made and others are still in progress.

Some people were not being protected against potential risks because risk assessments and guidelines for staff were not in place for people who have behaviour that challenges the service. Mobility care plans lacked the detail required for people to be adequately supported and to enable staff to attempt to prevent falls. Some staff did not have a good understanding of what might constitute abuse. Where potential abuse had occurred due to the behaviour of a small number of people this had not been identified or reported appropriately.

There were not sufficient staff to meet people's needs. People and staff members confirmed this. Staff did not have enough time to spend with people and staff told us they did not have time to update care plans so these were out of date. Due to a lack of staff people's needs were not always being met and there was a high incidence of unwitnessed falls. We spoke to the provider about this. They accepted they did not have sufficient staff to meet people's needs and agreed to increase the staffing, and to not accept any more referrals at this time.

Staff did not always work in accordance with the Mental Capacity Act 2005 (MCA). Staff were unable to describe the principles of the MCA and some people did not have their capacity assessed to consent to their care or other important decisions.

Staff had not always received the induction training needed to meet people's needs. Staff had received on-going training.

People were not supported by staff who had regular supervisions (one to one meetings) with their line

manager. The provider had a supervision and appraisal policy, which set out how many one-to-one meetings staff should have each year and included staff at all levels. This was not being followed. Since the inspection this has improved and staff are being supervised.

Staff were not always caring or treating people with dignity and respect. Although other individual staff did show compassion and care. People were not being assisted with personal care regularly.

People's care was not always planned and plans lacked the detail required for staff to know what care to provide to people. Staff told us the care plans were out of date.

Care that was provided was not always person centred. People were unable to choose when they received care. Staff did not always know people very well.

People did not have a sufficient range of activities to stimulate and interest them especially for those who remained in their rooms and there was little if any activity at weekends.

The provider had systems in place to monitor the quality of the service and make improvements. However, these were not always effective. They did not identify that some people's care was not planned, that care plans lacked detail or that care plans were out of date. The incident analysis had not been completed since December 2016. This meant that the registered manager was unable to learn from what was taking place and did not put prevention plans in place. People's feedback was not acted upon.

The registered manager had not notified CQC of some significant events

Medicines were administered safely. Medicines were stored securely and in an appropriate environment. Staff authorised to administer medicines had completed training in the safe management of medicines.

The provider followed safe recruitment practices.

The risk of fire had been assessed and plans were in place to minimise these risks.

The staff met people's dietary needs and preferences. Staff offered people help with eating and drinking and provided support where people wanted it. We saw some individual examples of staff being caring towards people.

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals.

People were encouraged to be independent and people and relatives knew how to complain.

The registered manager and senior staff were not always supportive to care staff.

Staff were involved in the running of the home. Regular meetings took place and staff were able to contribute to the agenda.

During the inspection we found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. We also made four recommendations to the registered provider. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service has therefore been placed in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent
enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe

Some people were not being protected against risks because risk assessments and guidelines for staff were not in place. Staff were not clear about how to recognise or report potentially abusive situations.

There were not sufficient staff to meet people's needs.

Medicines were administered safely.

The provider followed safe recruitment practices.

The risk of fire had been assessed and plans were in place to minimise these risks.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always work in accordance with the Mental Capacity Act 2005 (MCA).

Staff had not always received the induction training they needed to meet people's needs.

People were not supported by staff who had regular supervisions (one to one meetings) with their line manager.

The staff met people's dietary needs and preferences.

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals.

Is the service caring?

Requires Improvement

The service was not always caring.

While some individual staff were very compassionate and caring others showed a lack of care.

Staff did not always treat people with dignity and respect

People were encouraged to be independent.

Is the service responsive?

Requires Improvement

The service was not always responsive

Peoples care was not always planned and plans lacked the detail required for staff to know what care to provide to people

Care that was provided was not always person centred.

People did not have a sufficient range of activities they could be involved in.

Is the service well-led?

Inadequate

The service was not well led

The registered manager and senior staff were not always supportive.

The systems in place to monitor the quality of the service and make improvements were not effective.

People's feedback was not always responded to.

The manager had not notified CQC of some significant events.

Staff were involved in the running of the home.

Whitebourne

Detailed findings

Background to this inspection

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

This inspection took place on 24 April and 2 May 2017. Both visits were unannounced. The inspection team consisted of five inspectors. There were three inspectors on each visit.

Prior to this inspection we reviewed all the information we held about the service, including information provided by the local authority, and data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law.

Before the inspection, we did not ask the provider to complete a Provider Information Return (PIR). This was because we inspected the service sooner than we had planned to because of concerns about the safety of people receiving care. The PIR 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 took this into account when we inspected the service and made the judgements in this report.

As part of our inspection we spoke with 17 people, one relative, one friend, 16 staff, a visiting health care professional and the registered manager. We also reviewed a variety of documents which included the care plans for 25 people, four staff files, training records, medicines records, quality assurance monitoring records and various other documentation relevant to the management of the home.

We last inspected the service on 9 September 2015. At that inspection we found no breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service safe?

Our findings

People told us they felt safe and their relatives told us that they felt their family member was safe. One person said, "I have a key to my room and I lock it." A second person said, "Yes I feel safe." A relative said, Yes they are safe."

Despite these comments however, we found some people were not being protected against potential risks because risk assessments and guidelines for staff were not in place. One person who had been sexually inappropriate with a number of people over a number of months had no risk assessment in place, care plan or guidelines in place for staff to follow to protect others or this person from harm. We spoke to the provider about this who immediately implemented behavioural care plans. A referral was completed to the local authority safeguarding team and a protection plan put in place. Since the inspection this person has left the home.

In the first three months of this year people had fallen 52 times. Forty one of these falls were un-witnessed. Falls risk assessments had been completed and mobility care plans were in place. However the care plans lacked detail to enable people to be adequately supported. We spoke to the provider about this and in response they agreed that improvement was required. They told us falls diaries and falls location charts would be introduced for each person, and staff would be alerted at handovers about people who were at a high risk of falls. They also told us that they planned to monitor falls more closely and that a new falls prevention policy and analysis would be implemented. Subsequently the provider told us that they had provided falls training to senior staff which covered the impact of falls, risk assessment, care planning, post fall record keeping, and trends analysis. We will check this at our next inspection.

One person who had a skin tear did not have a risk assessment or care plan in place for their skin integrity. However staff were providing appropriate care because they knew the person rather than because their care had been planned to safely meet this need.

People not being protected from the risk of harm was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff understanding of what abuse was varied. One staff member said, "If someone's not looked after, not given enough to eat, financial, physical, mental. I'd report it to the manager and if I had to the police or CQC." Others including the registered manager and senior staff members did not recognise that a person sexually harassing female persons was abuse, and did not see that there were any risks. The registered manager said, "We have not had any complaints from family members about him." They had not correctly reported all of the instances or taken other actions to protect the person or others. Since the inspection the provider has provided safeguarding training and workshops for staff. A further workshop is planned with the local authority.

Failing to recognise, respond and report abuse or allegations of abuse is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not sufficient staff to meet people's needs. We asked people and staff about staffing levels. One person said, "They are short staffed. We don't get that much help." A second person said, "Staff come quickly when I press the buzzer. There is absolutely enough staff," and a third person said, "I choose to sit in the dining room. I don't see many staff." One staff member said, "There's lots of agency and staff have left. We try to make it so people don't notice and so it doesn't affect them but they can see. They say they can see we're short staffed and running around. We say we're not and try and reassure them. We try to give the best care we can and have someone in the dining room or lounge. When there is only one staff on the unit and someone's incontinent you can't cover the lounge as well. There's one carer today on each unit. There's three people who need two staff. At weekends I have to do people's breakfast and medicines at the same time." A second staff member said, "I've always loved my job but I'm leaving at the end of the month. There are so many staffing problems here. Because of vacancies we've been running with nine staff. We don't have enough time to spend with people. They get bored and depressed. They (people) are not getting their needs met and it's heart breaking." A third staff member said, "There were so many staff off sick and I can see why. It's because you're trying to do so much and it's been an impossible task at times. You just want to do your best. It got to the stage where you just didn't know who you had [staff] each morning; you just dreaded coming in in the morning. Staffing levels did go down. It was a choice between spending time with the residents and getting the paperwork done. It just hit rock bottom." A fourth staff member said, "We are only allowed nine staff now because of the agency expense. We don't have enough time to sit with people and the care plans are out of date."
On a number of occasions we observed people being left on their own in lounges for long periods of time. Staffing rotas showed us that in the first two weeks of April there were either eight, nine or 10 care staff on duty during the day and five at night. The provider's dependency tool calculated that there should be 12 staff members on duty during the day and six at night. We have been informed by the local authority that when they visited they saw people in lounges without staff present and that there was little interaction between staff and people.

We discussed our concerns about staffing levels with the registered manager who did not agree they were of concern, but did say recruitment was difficult because of new care homes opening in the local area. We then spoke to the provider. They told us there should be 12 care staff on duty during the day. They accepted they did not have sufficient staff to meet people's needs and agreed to increase the staffing, and to not accept any more referrals until staffing levels could support peoples care.

The lack of a sufficient number of suitably deployed staff was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were administered safely. Medicines were stored securely and in an appropriate environment. Staff authorised to administer medicines had completed training in the safe management of medicines. There were appropriate arrangements for the ordering and disposal of medicines from the pharmacist. Staff carried out medicines audits to ensure that people were receiving their medicines correctly. The supplying pharmacy had also recently completed an audit and there was only one action, which was to update the homely remedy list. A homely remedy is a medicine that is available over the counter in community pharmacies.

The provider followed safe recruitment practices. Staff files included application forms, records of interviews and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (DBS). DBS checks identify if prospective staff have a criminal record or are barred from working with people who use care and support services. Records seen confirmed that staff members were entitled to work in the UK.

The risk of fire had been assessed and plans were in place to minimise these risks. The fire detection system was tested regularly. Fire drills were being completed and all staff had received fire training. Personal Emergency Evacuation Plans (PEEPs) were in place for every person. These gave staff the knowledge they need to safely support each person in the event of a fire and how they should be helped to evacuate the home. There was also an emergency evacuation box in place

Requires Improvement

Is the service effective?

Our findings

Staff did not always work in accordance with the Mental Capacity Act 2005 (MCA). The 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.

Staff were unable to describe the principles of the MCA and some people did not have their capacity assessed to consent to their care or other important decisions. During the inspection we heard a person who had just moved in being told they could not keep their cigarettes, and that they would have to hand them in to the office. The staff member had no idea at that point if the person had capacity as no assessment had taken place, or if having their cigarettes was a risk. We were told this was the house rules.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Applications had been made to the local authority but staff did not recognise that people's liberty was being restricted when they couldn't leave the home.

We spoke to the provider about staff's lack of understanding of the MCA. They told us that 83 per cent of staff had received training. They planned to provide additional training in partnership with the local authority. We will check this when we carry out our next inspection.

We recommend that the provider reviews their MCA training so that staff are able to work in accordance with the MCA to protect people's rights.

We asked people and relatives if they thought staff had the training to meet people's needs. There were mixed views from people and relatives about this. One person said, "I think they know what they are up to." A second person said, "They know what they are doing," and a third said, "Haphazard – some good, others slapdash." One relative said, "I don't think staff are trained to talk to people."

Staff had not always received the induction training needed to meet people's needs. One staff member said, "I was just chucked on the floor, in at the deep end." Another staff member said, "I wasn't really shown what to do properly. I wasn't made to feel welcome." A third staff member said, "Staff just showed me round." We did observe one new staff member on their first day supporting someone to eat without having received any training. Records showed that 12 staff had started work in 2016. None of these staff had completed their induction. We spoke to the provider about this who confirmed that new staff should be shadowing, that they had received induction packs and had been allocated a buddy. They planned to arrange support meetings for new staff.

We recommend that the provider reviews their induction process so that it supports new staff effectively.

Staff had received on-going training. One staff member said, "I have in house training and e-learning on the computer. I have just been put on a NVQ course." A second staff member said, "I have just completed an end of life care course. It was really good." A third staff member said, "I am doing an NVQ Level 3 and have passed my medication training," and a further staff member said, "I am confident I have received all training needed including COSHH (Control of Substances Hazardous to Health) , infection control, moving and handling and safeguarding." The training records showed that staff received regular training in dementia awareness, fire awareness, food safety, health and safety, infection prevention and control, the Mental Capacity Act (2005), moving and handling and safeguarding.

People were not supported by staff who had regular supervisions (one to one meetings) with their line manager. One staff member said, "I have never had a supervision." Records showed that 19 staff had not received supervision in the last three months. The provider had a policy of supervision and appraisal, which set out how many one-to-one meetings staff had each year and included staff at all levels. This was not being followed.

We recommended that the registered manager ensures all staff receive supervision on a regular basis.

The staff met people's dietary needs and preferences. The chef said, "I have a list and a board with people's pictures on. It tells me what people's likes and dislikes are and whether anyone is on a special diet. For instance there is one person who has a gluten free diet. I speak to people to see if they like the food." People told us they enjoyed their meals and that the food at the home was good. One person said, "I think they feed us very well." A second person said, "The food is very good and quite well cooked," and a third person said, "Sometimes it's quite good. They make a point of presenting a choice." We saw staff offered people a visual choice of both items on the menu to help them make a choice. When people received their meals, staff asked whether they were happy with their choice. One person said they did not like either of the main course options and staff offered them a range of alternatives, which they were happy with. People were offered second helpings and staff encouraged people to drink with their meals. Staff offered people help with eating and drinking and provided support where people wanted it.

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals. One person said, "My GP has looked at my legs and given me some pain relief." A second person said, "Staff will get the doctor if I need it, and they will come and sit with me while the doctor is here," and a third person said, "They make a good job of keeping people pretty healthy here." Two staff members told us they accompanied people to hospital appointments. We saw that staff had made a referral to the community psychiatric nurse for another person. We observed staff calling the GP for someone who was reporting pain.

Requires Improvement

Is the service caring?

Our findings

People told us that staff were caring. One person said, "I am 100% well looked after. I couldn't fault the staff." A second person said, "I am not neglected, staff are very good," and a third person said, "They're (the staff) very good and kind to me." Another person described staff as motherly towards them. A visiting health care professional said, "Staff are great, it's a lovely place. Staff know people well. I have seen nothing of concerns or worries."

As well as peoples positive views we also saw some caring and compassionate interactions between staff and people. However e also saw some examples which showed not all staff were demonstrating the same level of compassion. During the inspection a person arrived for respite care. Staff could not find the pre-admission assessment for this person and left them alone while they went to find it. An hour and 20 minutes later the person asked an inspector for help because they said they didn't know anyone, they didn't know what to do and were desperate for a drink. We also observed a staff member come onto duty, not acknowledge any people living in the home and go and sit with a relative for 15 minutes to discuss their (the staff members) family members health problems.

People were not always treated with dignity and respect. During the inspection one person whose preference was to get up early was left in bed until 12.30pm in urine soaked bed clothes and duvet. The team leader had requested three times that the care staff member support the person but this was not done. The team leader did discuss this with the registered manager. The response was to provide extra training for the carer. We spoke to the provider about this and were told it was the person's choice and that the staff member needed training to help them deal with such situations. A person told us, "Baths are like gold. I used to have one (at home) every day (meaning they don't now get them so often)." A relative told us, "Yesterday staff didn't clean his teeth," and another told us that their relative's personal hygiene was often missed. Staff meeting notes in March identified that one person was not being assisted regularly and was being left incontinent, another person was not being shaved daily, some people were not being assisted to clean their teeth and used incontinence pads were being left in people's rooms. We observed people sitting in the lounge with little interaction from staff apart from to offer them a cup of tea. We also observed that a large percentage of women were not wearing bras. We did talk to the registered manager about this and were told it was either through choice because people found them restricting, or because relatives had not supplied them. We then spoke to the provider who told us they would review this and include people's preferences in their personal hygiene care plans. Subsequently the provider has told us they have supervised staff and emphasised the caring aspects of their roles as well as identified a dignity champion in the team.

People not being treated with dignity and respect was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did see some caring interactions between staff and people. One person who wanted to go home and became upset was approached by a staff member to check they were OK. The staff member listened and

offered to take the person to the garden after lunch. The person then said, "She's a good girl, she is so kind." We heard a staff member chatting to one person in their room about the pictures on their wall – some new ones had been added. They were taking time to listen to the person and asked questions. We also saw one staff member knelt down besides people to gently rouse them from sleep to offer them a drink.

Staff told us they respected people. One staff member said, "I make sure they have enough towels and the door is locked when they are having a bath. I ask them first before I do things and give them choices." Another staff member said, "It's the way you speak to people. You have to respect their opinions and how they feel about things."

People were encouraged to be independent. People told us they were independent and could choose what to do. One staff member said, "I encourage them (the people) to walk themselves if they can. I put a fork in their hand and encourage them (the people) to eat."

People were encouraged to be involved in the running of their home. Monthly residents meetings facilitated by activities staff were being held. Topics of discussion included the food and activities. Regular residents and relatives meetings were also being held. One was held in March 2017. Fifteen people and 13 relatives had attended. The topics discussed were the replacement of bedroom furniture and fittings, the dining experience, the use of agency staff, and activities.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive the care they needed. One relative said, "Staff could be more persuasive, they walk in and ask them if they want a bath they say no and they don't offer again. Their personal hygiene often gets missed."

Peoples care was not always planned and plans lacked the detail required for staff to know what care to provide to people. Staff told us the care plans were out of date and that the reason for this was lack of staff. One staff member said, "The residents have to come first, not the paper-work." Another staff member said, "A lot of care plans need updating, but residents come first." However we found and staff told us that they were not always able to provide responsive care due to lack of staff. Some people who had broken skin or were assessed as being at high risk of getting pressure sores did not have care plans for this. One person who had a skin tear didn't have a care plan for this. Some people with behaviour that challenged the service did not have their care planned.

Care that was provided was not always person centred. People were unable to choose when they received care. One staff member said, "We try to prioritise in the mornings so we see the ones who are incontinent first and the more independent ones later. We know we shouldn't but it's the only way we can do it to fit everything in." Another staff member said, "Night staff should get three people up on each unit. Usually the harder ones, sometimes the doubles. It depends on the night staff themselves."

Staff did not always know people very well. One staff member told us they get to know people by "talking to them and asking them questions. I listen to them and read the care plans for any changes. The care plans are good." However, they were unable to tell us the reasons why a particular person was living in the home (i.e. they came from home due to self-neglect) or how often they should be or were checked. Another staff member said, "I used to do the tea rounds a lot and it's a good way to get to know people's likes and dislikes as you chat with them." However, they could not tell us why another person had moved into the home. An agency staff member who had worked in the home for five weeks told us they had not had a chance to read people's care plans because they were always busy.

People not receiving person-centred care was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people and relatives did say staff were responsive. One person said, "If I want anything, I only have to ask." One relative said, "I did ask for (person's name) to see the hair dresser, they offered and the carers washed their hair. It was a nice response." Another relative said, "He had a fall in the dining room, they called the paramedics and me straight away."

Some people did have their care planned and we did observe that some care provided was responsive. One person who had behaviour that challenged had a care plan in place for their behaviour and staff demonstrated an understanding of their behaviour and the guidance in place to support them to relieve

their anxiety. Another person who was losing weight and was having difficulty eating was referred to the Speech and Language Therapy (SALT) team for an assessment.

People did not have a sufficient range of activities they could be involved in. One person said, "I don't like singing, why should I." A staff member said, "People could do with more activities and especially those living on the first floor more opportunities to go into the garden." We observed very little activity taking place during our inspection. On the first day there was a seated exercise in the upstairs lounge. It was well attended and people were engaged. No other activities were observed that day. On the second day we didn't see any activities taking place in the morning. We asked a staff member about this and were told that a reminiscence session had taken place in the larger lounge area. However, we found it was music only playing and no discussion. Eight people were in this lounge singing along to the old songs, and at times there were no staff members in the lounge. Staff did organise activities to take place Monday to Friday which included ball games, movies, puzzles, sing along, arts and crafts, pet therapy, carpet bowls, bingo and quizzes. Nothing though was available at weekends and there was very little for people who were unable to leave their rooms.

We recommended that the provider review the activities available to people and provide activities that meet people's preferences and interests and reduce social isolation.

People and relatives knew how to complain. There were three complaints recorded in the last year. These included a relative complaining that her father was being overlooked when food and drinks were being handed out, one person who complained that they felt left out because they were served last, and another relative about their mother being in a bed soaked in urine. All were responded to with people happy with the outcome.

Inadequate

Is the service well-led?

Our findings

People and relatives told us they did not know who the registered manager was. One person said, "I don't think I have met the manager." A second person said, "Who is the manager? I couldn't tell you." And a third person said, "We don't see or hear from them." A relative told us, "The manager has never come to see me. I know her face."

The registered manager and senior staff were not always supportive to care staff. Staff had mixed views on whether they were supported. One staff member said "I don't see the manager a lot, because I'm working upstairs. She's (the manager) always been kind towards me and encourages me to speak to her if I need to." Another staff member said, "I have good support from the team leaders, especially (name of person). I'll go to her for anything, they are really good," but then went on to say "Staff are leaving. There's no support from management at all." A third staff member said, "Sometimes the manager's supportive, her door's always open and we can go and chat but I think it gets her down as well; all the staff leaving. She does try. If we speak to her about it she says what do you want me to do?" A fourth staff member said, "Staff are off with stress and depression. When you raise it, nothing materialises," and another staff member said, "Some (staff) have left and others are leaving at the end of the month. They're going places where it's not as stressful and they get a thank-you from the manager." Records show that staff were not receiving regular supervision were they would have had the opportunity to say how they were feeling.

Not providing appropriate support to staff was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We did see the registered manager go and help staff when people were upset about something. The manager said, "I go and help if someone is not behaving. They (the staff) ring me." However it should be noted that the use of the phrase 'when people are not behaving' is demeaning towards people.

The provider had systems in place to monitor the quality of the service and make improvements. These included medicines, documentation, infection control and health and safety. However, these were not always effective. They did not identify that some people's risk assessments were not completed, care was not planned or that care plans were out of date. They had not identified that staff were not always providing compassionate care or that staff numbers were well below the required level to provide the quality of care the provider states in their statement of purpose. A documentation audit carried out in early March 2017 did however identify that people's care plans were not identifying how to minimise the risk of falls but nothing was done to rectify this.

The registered manager reported accidents and incidents to the provider. The accident analysis was completed every month. In the last 11 months the registered manager had identified people had over 150 falls (most un-witnessed) but saw no pattern or reason for these. The incident analysis had not been completed since December 2016. This meant that the provider and registered manager were unable to learn from what was taking place and had not put prevention plans in place.

People and those important to them had opportunities to feedback their views about the home and quality of the service they received. People had completed a survey in March 2017. Forty five people had responded. People were asked about whether the home was a safe place to live, whether they received the care they needed, taking part in activities, being treated with dignity and respect, the food and being able to have a say. The area identified for action was people being able to have a say as 24% people did not feel they had a say. Thirteen relatives had recently completed a telephone survey in February 2017. This included questions on staff responsiveness, cleanliness, how relatives were treated, availability of staff, ease of access to the home manager and food. The majority of responses were positive. It did identify areas for improvement. These included access to baths and showers and clothing getting mixed up. However, no actions were identified from these surveys. Subsequently the provider sent us a copy of the May survey. This was mostly positive and identified three areas for improvement, two of which were the same as the previous survey. The provider told us, "What we would expect is that the Home Manager take note of the three areas and ensures via his/her own monitoring that progress is made to improve, laundry experience/practice, mealtime experience and delivery of personal care."

Staff had identified in team meetings that people were not receiving the personal care they needed. This was not acted upon.

Not having effective systems to monitor quality in place, not having measures in place to reduce risks, and not responding to feedback were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The manager had not notified CQC of some significant events. Significant events should be reported so we can monitor the service and to ensure they responded appropriately to keep people safe. These included incidents of sexual abuse.

Not notifying significant events to CQC was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Staff were involved in the running of the home. Regular meetings took place and staff were able to contribute to the agenda. One staff member said, "We have team meetings. We can put things on a list if we want to talk about them." The registered manager also held meetings with team leaders. Discussion items included the dining room experience, person centred care, and health and safety. However staff did not feel able to share concerns with the management or the provider and they told us when they had tried the response was unsupportive and nothing had changed.

Following the inspection a new manager has been appointed to the home. The provider has a service improvement plan in place which the manager and provider representatives have implemented.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had not ensured all significant events were reported to the Care Quality Commission

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured people were receiving person-centred care

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had not ensured people were being treated with dignity and respect

The enforcement action we took:

Served warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that people were protected from the risk of harm.

The enforcement action we took:

Served warning notice

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 ensured that people were protected from abuse

The enforcement action we took:

Served warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to monitor the quality of the service and make improvements.

The enforcement action we took:

Served warning notice

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 suitable staff were deployed. The provider had not ensured staff were sufficiently supported.

The enforcement action we took:

Served warning notice