Harbour Healthcare Ltd

Elburton Heights

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

About the service: Elburton Heights is a care home that can accommodate up to 85 people that require nursing or residential care. At the time of the inspection 61 people were living at the home. The service is split into four units that offer either nursing services or residential care. Two units look after people living with dementia; one is a nursing unit and one is a residential unit. There is a further nursing unit and another residential unit.

Rating at last inspection: The rating at the last inspection was Requires improvement overall. The report was published on the 24 September 2018. This service had been rated repeat Requires improvement at the previous two inspections and we had met with the provider to discuss our findings and their subsequent actions.

Why we inspected: We inspected because we received concerns about people's care from a variety of sources. CQC have been liaising closely with the local safeguarding adults team. The areas of concern were used to inform our planning for this inspection.

Enforcement: Following our last inspection we found four breaches of regulations. There was a lack of appropriate records, which placed people at risk of receiving inappropriate care. Not all staff were receiving appropriate training, supervision and appraisal, necessary to carry out their
duties. The provider has failed to ensure people received safe care and treatment and risks to people's health and safety had not been fully assessed and measures to reduce risks were not fully effective. The provider had failed to have effective governance systems and quality assurance processes to assess, monitor and drive improvement. At our last inspection we told the provider to provide us with an action plan about how they would ensure compliance with the regulations and by when.
This was a repeated 'Requires Improvement' rating so we met with the provider in December 2018 for reassurance that there would be improvements. We placed two conditions on the location registration that:
1.□The Registered Provider will complete monthly audits of staff training and supervision, service users' records relating to their current care and risks, medicine management, audits relating to the environment: and write a report on what you have found, with the actions you intend to take as a result of these audits.
2.□The registered provider will send the commission a monthly report on the 1st working day of each calendar month the findings and actions of the points above.

Despite this, at this inspection this rating had deteriorated to 'Inadequate'.

At this inspection we found action had not been taken to address all the concerns and breaches of regulations found at the previous inspection and we found these areas had deteriorated and were inadequate as well as finding further concerns.

People's experience of using this service

•□The quality of people's care raised serious concerns, mainly related to the nursing units known as Willow and Maple where 39 people were living.

•□People that were dependent on staff to pre-empt and meet their needs were being failed by the service.

•□People were not receiving care that was fully safe, effective, caring, responsive to their needs and well-led.

•□The service is now judged to be inadequate in keeping people safe, providing effective care, as well as a lack of caring and responsive support, and leadership.

•□Most people living on the nursing units, Willow and Maple, were living with dementia or conditions affecting their communication and/or understanding. Therefore, they were unable to comment on their direct experience of living at Elburton Heights. Relatives and staff all told us how they had concerns and had brought them to the manager and staff on the nursing units but had not seen an improvement.

•□There was a severe lack of staffing numbers to enable people's needs to be met on Willow and Maple which resulted in poor care and people's basic needs not being met.

•□Risks in relation to people's care and lifestyle were not known fully by staff, assessed, understood and managed in a way that kept them safe. For example, in particular to ensure adequate nutrition and hydration, safe management of falls, effective skin pressure area care, safe manual handling and caring, and safe management of people's behaviour which could be challenging for staff. Monitoring records were poor with many gaps which meant we could not be sure people were safe or having their needs met consistently.

•□People did not live in an environment that was dementia friendly, homely or promoted their dignity and independence.

•□There was poor infection control management particularly in relation to the maintenance and cleanliness of equipment.

•□The culture of the service did not always respect and promote people's rights, dignity and independence. There was a lack of understanding about people's needs due to a lack of training and competency checks, poor communication between management, nurses and care workers and care plan information was not used to help facilitate person centred care.

•□There was a lack of care, engagement and stimulation on the nursing units to ensure people lived a good quality life. Activities offered did not take into account individual interests and preferences or consider individual's abilities with the focus being on the activity itself.

•□The leadership and auditing of the service had not been robust and had failed to identify and act quickly on the concerns we found in relation to practice, the environment and culture of the service. The nursing units lacked leadership because nurses and care staff did not have time, and often nurses were from agencies and lacked knowledge of people's needs. This meant that people had continued to receive a service that was not fully safe, effective, caring or responsive to their needs.

•□The provider had failed to act in a timely way on areas of concerns found at the last inspection or within their own audits.

•□The service is now judged to be inadequate in keeping people safe, providing effective care, as well as there being a lack of caring and responsive support, and being inadequately led.

•□We did see some positive interactions during the inspection, with staff being kind, friendly and patient when completing tasks, especially on the residential units.

•□People seemed to enjoy the food they were offered.

We note that the majority of this report reflects on serious failings found on the nursing units Willow and Maple. We also inspected the residential units and found there to be overall good care although there were also issues with the use of the dependency tool and a lack of 'as required' medicines information for staff to follow. In contrast to the predominant examples in the report people and relatives said on the residential units that they were happy with their care. The environment was homely and comfortable, staff were visible and there were regular activities.

Follow up:
We were so concerned during the first day of our inspection that we spoke to Plymouth City Council about our initial findings and practices we had concerns about. We asked the manager to immediately source additional staff for the nursing units and ensure that staff had the information they needed to support people and ensure they were safe. Following the feedback from our fourth day of inspection we sent an initial summary of our findings which had raised serious concerns about people's safety on the nursing units. We asked the provider to send us a detailed action plan by 25 March 2019 to assure us that the issues were being addressed as a matter of urgency, which we received. This provider action addressed our initial findings and gave some reassurance that these issues would be addressed as priority. The local authority, safeguarding team and quality assurance and improvement team (QAIT) are all involved in monitoring the progress, reviewing, and assessing the people most at risk.

The overall rating for this registered service is 'Inadequate'. This means that it has been placed into 'Special Measures' by CQC. The purpose of special measures is to:
• Ensure that providers found to be providing inadequate care significantly improve.
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

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.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded. We will have contact with the provider and registered manager following this report being published to discuss how they will make changes to ensure the service improves their rating to at least Good.

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.

Details are in our Safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our Effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our Caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our Responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our Well-Led findings below.

Elburton Heights

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. This was a responsive comprehensive inspection in response to various concerns received. Concerns included; poor staffing levels, falls management and lack of stimulation and engagement/activities.

Inspection team:
The inspection was completed by three inspectors from the adult social care inspection team, a pharmacist and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service: in this case in relation to dementia.

Service and service type:
Elburton Heights is a 'care home' providing residential and nursing care. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Elburton Heights is a large, spacious purpose built home with four units; two for nursing care (Maple and Willow) and two for people receiving residential care (Sycamore and Elburton). Two units care for people living with dementia (Willow and Sycamore). Our concerns mainly relate to the units known as Maple and Willow.

The service did not have a registered manager. The previous registered manager had left the service and cancelled their registration with us. At this inspection a manager was in post having been employed since December 2018. However, they had not yet registered, although they had started the application process. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The manager was present throughout the inspection as was the regional manager.

Notice of inspection:
The inspection was unannounced on the first day.

What we did:

During the inspection, we observed care for all the people on the nursing units, Maple and Willow and spent more time with eight individuals. We spoke with 25 people overall who used the service and 10 relatives who were visiting. Most of the people on Willow and Maple were living with dementia or mental health issues and therefore had limited communication to tell us about their direct experiences.

We spoke with the manager, regional manager, administrator, HR manager, two activity co-ordinators, a domestic, maintenance man, cook and kitchen assistant. We spoke with four registered nurses and 17 care workers and two visiting health professionals.

We reviewed a range of records. This included nine people's care records such as support plans, ten medicines records and seven related medicine care plans, care folders in people's rooms, food and fluid charts and accident and incident reports. We observed medicines administration for seven people and spoke to four members of staff about medicines. We looked at four staff files, which included recruitment records, supervision notes and training certificates. A range of records were also reviewed relating to the running of the service including, policies and procedures, audits and training plans. We also looked around the premises.

Following the inspection, we spoke to the local authority quality monitoring team and the safeguarding team who ensured there was a protection plan in place over the weekend of 16 March 2019 and local authority reviews were planned to keep people safe. We also gave initial feedback about our concerns on the first day of the inspection and asked that staffing levels be increased immediately on the nursing units. On 22 March we sent the provider our initial findings relating to our concerns and asked for an action plan by Monday 25 March 2019 which we received.

Inadequate

Is the service safe?

Our findings

At the last inspection guidelines were not always in place to support staff to manage risk safely. At this inspection we found risks in relation to people's care and lifestyle were still not understood and managed safely on the nursing units.

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

Some people and relatives said they felt safe in the service, however this was on the residential units and despite this feedback we found significant concerns about the people's safety on the nursing units.

Assessing risk, safety monitoring and management. Learning lessons when things go wrong

- People's records in care folders did not always reflect their current risks such as falls, epilepsy, weight loss or risk of skin pressure damage. Care plans had risk assessments but staff admitted care plans were not read or used as working tools. Therefore they would not know how to minimise risk. For example, staff should maintain a high level of hygiene and daily showers for one person due to an ongoing intimate health issue. This person smelt of urine and was very sleepy in bed, their record in their room said 'wet pad' on most checks. The health issue continued to be an issue with a recent hospital admission. Their personal care record had gaps and there was no evidence of them having regular showers.
- People's pressure area care was not well managed and people remained in the same position for long periods despite being at risk. One person was lying on the same side for at least four hours on the first and second day of our inspection. Another person with thin skin required a pillow between their feet, they had no pillow and their feet were right up to the end of the bed. They were also not moved on 15 March for five hours and they smelt of urine. Their personal care records were incomplete.
- Where people were at risk of weight loss or poor nutrition or required additional fluids to minimise the risk of infection, these issues were not adequately managed. For example, staff did not ensure those affected were offered snacks, a high calorie diet, re-offered meals when people had declined at the time of offering. This put them at risk of infection and malnutrition. Despite monthly audits by management, food and fluid charts were very poor with lots of gaps, and entries only made at set meal times. One person had lost 10kg in one month and their relative was very worried about their welfare.
- People at high risk of falls did not have this well managed to keep them safe despite care plans identifying risks and stating measures staff should take such as 'they required supervision when up and about'. People were moving around the home unsupervised, one person was observed in bare feet on two days of our inspection. One person with a known 'extreme high risk of falls', with five falls in 24 hours in September 2018, had a recent black eye and had had eight falls since 13 February 2019 and five falls in January 2019. Overall on Willow there had been 21 incidents in January 2019 and 20 in February 2019 up to the 13 February. Actions taken were not minimising risk. For example, a pressure mat in one person's room was not helpful to minimise their repeated falls in the corridor. One person had fallen when having personal care and sustained a graze. Staff said this was because they had to hold onto the sink in the shower room. The

incident record had no date, or follow up recorded which had been noted in the February monthly audit. We asked for a grab rail to be fitted in the shower room.

• Eight people on Willow were at risk of falls. They were all seen to be left alone for long periods during the day. One person was moving around using their feet in a wheelchair without supervision. Staff said the person liked to do this but they were at risk of falls. On the third day they were in an armchair but were left for two hours unsupervised in the lounge, repeatedly trying to get up, until we asked staff to assist. We saw four people were left unattended to other than for coffee time at 11.00 for the whole morning. The manager said there was a check sheet. This entailed staff just signing that they had visually seen people, not whether they were safe and had everything they needed. Monitoring records were incomplete, some with no records of checks between 8am and 7pm. Only one staff member had had training in falls management. This put people at risk of falling unsupervised despite risks being identified in their care plans.

• One staff member wrote to us anonymously to say, "One person has had so many unwitnessed falls because staff don't want to fill the paper work out out, if they are on the floor staff leave them. I'm looking for another job it's so bad."

• People with known risks associated with their mental health and behaviours, did not have their needs identified, assessed and acted on to keep them safe. For example, staff on Willow did not know anything about what one person's 'mental health issues' meant. They knew some people living with dementia displayed behaviour which could be challenging and aggressive, which we saw, but no action was taken. This put people at risk of negative interactions which were recorded. These risks although detailed as part of a risk assessment or plan of care for the people concerned were not managed or implemented. This meant that staff were not supporting people's mental health needs consistently to maintain their wellbeing. Most people's care file records in their rooms on Willow did not mention that some people were living with dementia and how that affected them.

• People who had known risks associated with particular health conditions did not always have their needs identified, assessed and acted on to keep them safe. For example, one person was diabetic but staff were not able to tell us how they managed this such as foot care or what their range of normal blood sugars should be. Staff did not know what their plan said. This meant people may not be receiving the care they needed.

• The provider had systems in place to record incidents and accidents. However, we saw no evidence of a system to effectively analyse this information or to recognise and respond to patterns and triggers. The monthly falls audit was completed but no effective actions had been taken to minimise falls in the future and people continued to fall. There was no record of how staff could minimise falls, for example in the records which staff accessed in peoples' room folders.

• Some people had bruises that staff did not know how they had occurred. One relative said their loved one had had bruised shins due to the poor manual handling. We saw another person being pulled backwards in their wheelchair by an agency worker with their feet dragging on the floor. Another person had a very large bruise on their hand on the first day of our inspection, which day staff said could have happened when the person was hoisted during the night. There was no investigation, although an incident form had been part completed but there was no action other than a body map showing the bruise. The managers' monthly audit sent to head office in February 2019 stated about one person with no feeling in their legs, 'whilst giving personal care noticed a lot of bruising on legs. [Person's name] says it is from carers putting her in the hoist and it has been happening for a long time. They are hoisted Monday, Wednesday and Friday'. No action had been taken other than to complete a body map and inform the nurse. We saw another bruise on a person's left upper arm which was not recorded anywhere. Body maps were not signed off when an issue had resolved.

• We saw the training matrix showed only 11 of the staff overall had completed practical moving and handling training and these were all dated 2016/17. One staff member said none of the agency staff had practical manual handling training either, we did not have details of their training. People on the nursing

units had high needs, 18 people on Maple required hoisting and nine on Willow. A visiting health professional said hoisting for people for continence support did not seem to be a usual task. An agency care worker said very often staff moved people requiring a hoist on their own as there were not enough staff and they only did 'pad changes' rather than assisting people to use the toilet. Another agency care worker said they did not know whose sling was whose and they did not know how to work the hoist. We saw little use of the hoist throughout the inspection. This puts people at high risk of harm.

• Staff recording of people's daily care was not robust enough to ensure changes in people's care, mood, and that risks were passed on, reviewed or monitored. For example, the nurses and care workers did not communicate, and wrote in separate folders that each did not look at. On the third day the agency nurse, who did not know people, had to be asked by us to check how a person was as they were not feeling well. On that day the care plans had been locked in a cupboard and care workers could not access them. On the first day of the inspection we asked the manager to devise a handover summary sheet for staff and the agency nurse had to refer to this to find out people's names or ask a relative. This puts people at risk of unsafe, inconsistent care.

Using medicines safely

The administration and recording of medicines on Willow and Maple units was not always safe or effective and therefore the service could not demonstrate that people had received their medicines as prescribed.

• Staff were trained and assessed as competent to administer medicines. However, we saw that they did not always keep people safe because of poor systems to order, administer and monitor medicines. Not all nurses working in the service were trained to use all aspects of the electronic medicines system. This meant when the system had not been updated when medicines were received, the staff could not accurately record medicines administration.

• Some medicines were prescribed to be given at specific times. However, records showed that staff gave these medicines at the usual medicines round time, rather than the specific time indicated. This meant people may not have received the full benefit from their prescribed medicines.

• The records for the administration of external preparations were not completed in a consistent manner. One safeguarding alert about medicines made prior to our inspection included that a person's prescribed topical medicine had not been followed up or obtained from the pharmacy, so was not being used as prescribed.

• Medicines were kept secure. However, the temperature of the medicine's refrigerators and medicine room temperatures were not always recorded. When recorded they were within the accepted range.

• When medicines were prescribed for use "when required" there was not always sufficient information for staff to use these medicines effectively, including sedative medicines used for people displaying agitation or mental health issues. There was no evidence that staff used other techniques to comfort people other than referring to their GP for medication.

The provider has failed to ensure people received safe care and treatment and risks to people's health and safety had not been fully assessed and measures to reduce risks were not fully effective. This is a repeated breach of Regulation 12(1)(2) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe Care and Treatment.

Staffing and recruitment

At the last inspection in July 2018 people, relatives and staff did not all agree there were sufficient staff. Staff then commented about the high use of agency staff though the agency staff were experienced and used

regularly at the service. At this inspection we found there to be a serious lack of staff to meet people's needs and keep them safe on Willow and Maple. This was also stated by all staff and relatives we spoke to and indicated by the staffing rotas. We therefore immediately asked the manager to source additional staff going forward and especially over the weekend. There was ongoing recruitment but a high level of agency staff were still used, including the registered nurses in charge on Willow. There was no agency induction or competency check to ensure they knew what to do and what was expected of them.

•There were not enough qualified, skilled and experienced staff on duty on the nursing units to meet people's basic needs. Although the provider and managers used a dependency tool this did not reflect the actual needs of people living on the units, including the residential units. It did not include staff time needed for managing behaviours which could be challenging or provision of engagement and stimulation. The managers said staff and relatives had raised this concern previously and this had been shared with the provider, however no actions had been taken. A review on the national care home website had also raised this issue with no response. All staff shared their concerns about low staffing levels and said they had raised this many times. It was not clear why concerns about staffing levels had not been addressed sooner following the last inspection in July 2018 other than through ongoing recruitment. Staffing levels were not included in the February 2019 audit.
•One staff member said, "They never have staff who know the residents as they treat their staff awfully. They leave all of the nursing floor residents in bed all day even if they are able to sit out. They leave residents in the same chair for at least 12 hours." We saw elements of this happening throughout our inspection.
•Staffing rotas on Maple and Willow showed shift levels in the day was one registered nurse, which was often agency, and four care workers. Staff and rotas showed there were sometimes three care workers at the weekend. On 14 March 2019 there was only one staff member on Elburton and the same on the 15 March 2019 which the manager was trying to cover.
•Care delivery was task focussed with people being assisted to get up when staff were free. Breakfasts only started at 9am and went on until 11.40 for some people. Lunch was then at around 12.30. The registered nurse was busy doing the medicine round until 10.45 and 12.05 on one day and did not get involved with assisting care staff. At 12.05 on the first day of our inspection there were still five people in bed with their curtains closed waiting for assistance to get up and wash. There was an unclean odour in their rooms.
•There was little evidence of people being assisted to go to the toilet and we did not see the hoist in use very much despite many people requiring a hoist to mobilise. Most people wore continence aids and records showed mostly 'pad changes' which repeatedly recorded 'wet pad' meaning people were often in wet pads. This was the case for all the people remaining in bed after 12 noon on the first day. Staff all said people were mostly wet when they got to them. One relative was moving their loved one to another home as they had found them standing and urinating with no assistance in their room and wet on more than one occasion.
•One staff member wrote to us to say, "I know on Willow there are a couple of people staff put to bed at 6pm-8pm and leave them in a wet bed until the following morning. Staff don't change people until the morning so they are all left wet through the night."
•Care files in people's rooms did not show that people were being assisted to wash every day despite some people having specific instructions in their care plan for daily showers. There were lots of blank records and the shower chair was dirty and the bath dusty. One relative said staff had not been able to say when their loved one had had a shower. Staff said they did not have time. There was no detail about how people liked to be supported with personal care.
•People on the nursing units had an overall high level of need. For example, on Willow nine people required regular assistance for continence management and mobilising from two care workers. Nine people required assistance with eating and drinking. On Willow, there was a registered nurse and four care workers at the time of the inspection. On Maple, there were 18 people requiring assistance regularly from two care

workers and 14 people needed help with eating and drinking. We did not see any staff with people unless they were carrying out a task. This increased to six care workers on a shift on the nursing units during the day after we raised our concerns. We asked the provider to evaluate night staffing levels as soon as possible.

•□People were only offered meals at the set mealtimes despite some people refusing them, sometimes all day. There were no records of people being offered food or snacks in between these times. There were long gaps in people receiving fluids and we did not see people with fluids or being assisted other than at tea rounds if people were ready to have a drink then. Staff told us that on Maple sometimes the coffee morning and afternoon tea round were completely missed due to lack of staff.

•□People's rooms and communal areas on the nursing units were messy and not made to look homely or tidy.

•□Most people stayed in their rooms all day or sat in the corridor outside the nurses' office. The manager said people liked to sit there but this was the only comfortable, communal place to sit. Staff did not have time to encourage people to do anything else and there was not a comfortable or stimulating environment when people did get up. Staff did not use the lounge other than for certain people, mainly those in wheelchairs as staff said they were easy to move. There were only six chairs placed randomly in the lounge on Willow and the table was used for staff record keeping. Only two people used the dining room for breakfast using specialist wheelchairs, there were no dining chairs. Only one person in a wheelchair used the lounge on Maple and then was left alone all morning in the middle of the room. Staff did not engage anyone with any activities going on in other units and said they often did not have time to take people.

There were not sufficient numbers of suitably qualified, competent, skilled and experienced staff to ensure people's basic needs were met and they were kept safe. Not all staff were receiving appropriate training, supervision and appraisal necessary to carry out their duties. This is a repeated breach of Regulation 18 1, 2 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing

•□There was a good recruitment process was followed to help ensure staff employed were suitable to work in the service. Records confirmed a range of checks including references, disclosure and barring checks (DBS) had been requested and obtained prior to new staff commencing work in the home. Staff recruitment was ongoing.

Systems and processes to safeguard people from the risk of abuse

•□People on the nursing units were not kept safe from avoidable harm or abuse although staff undertook training in safeguarding vulnerable people. People living with dementia when sat outside the nurses' office on Willow, were displaying behaviours such as shouting, swearing at each other, pushing their zimmer frame at people as they passed, and this was then ignored by staff throughout our inspection. Relatives who visited regularly said this happened all the time, which made their loved ones anxious. One person had funded one to one care due to their anxiety and their relative's needs not being met. They said people had nothing to do, staff did not have time to stop, or did not support people to sit in areas that were safe or promoted a calm environment. Records showed examples of incidents that were recorded but no actions were taken to minimise them except for repeatedly moving people at that time.

•□There were no care records read by staff on the nursing units relating to how staff were to minimise any negative behaviours to keep people and staff safe. For example, there was no care plan about how to minimise a person's anxiety. Records, particularly during the night included, "walking up and about trying doors, grabbing staff and other residents and invading their space", "bit staff's arm" and "walking into other resident's rooms". Another person's records did not include how to manage aggressive behaviour, "Trying to change dressing, refused and was kicking" and "Dressing changed shouting and kicking" and "Became upset during care intervention, shouted at staff and pushed over bucket of water".

•□Actions were either nil or to ask the GP for medication for 'challenging behaviour' rather than look at ways to meet people's needs holistically. For example, a care plan from some years ago in their file, said they liked a strict routine and to know what was happening- 'important that care staff are consistent' and they responded better to staff they were familiar with to reduce anxiety, especially male staff. The person's incident report said they did not want their face washed and had pushed the water over. Refusals of care were frequently noted but no actions taken to see why or if related to staff or timings. The manager did not know about any of these incidents and they were only being recorded in daily records which were not audited.
•□Staff told us they did not feel comfortable raising concerns with management as nothing would be done and they did not have time. Supervision records showed staff had raised issues for many months as there were not enough staff to supervise people safely. Disciplinary action was carried out for not being able to complete tasks despite staff raising concerns.
•□We could not be sure all safeguarding incidents had been notified to the local authority and us. We saw in daily records one person had pinched another person in the corridor with no further actions noted.
•□Bruises were noted on some body maps or injuries noted in daily records such as, bruised eye, red arm, red elbow, back graze. There was no follow up recorded to ensure these issues were addressed or pain control adequate. Body maps did not record when issues had been resolved.
•□One person was placed in a 'sensory area' when they became distressed and vocal. Staff pulled the curtains but did not stay with them. There was no care plan about how the sensory area should be used or for how long. Staff said when people had gone to any activities on the residential unit they were often brought back if they made a noise.
•□The provider and managers were working with the local authority team during the current whole service safeguarding investigations.

The provider has failed to ensure people were protected from abuse and improper treatment. This is a breach of Regulation 13 1, 2 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safeguarding

Preventing and controlling infection

•□Although, policies, procedures and training were in place in relation to infection control, parts of the environment were not clean and hygienic.
•□There was no checklist in place which included checks of the equipment such as wheelchairs, shower chairs and mattresses. A domestic said they did not know who was responsible for the cleaning of equipment. A shower chair on Willow was filthy and brown and we asked for it to be disposed of. A mattress in one person's room that a person had slept on the night before was lifted up and was wet with urine which had made the wooden slats mouldy over time. We asked for this to be replaced. The only assisted bath on Willow had not been used for some time and there was a layer of dust evident inside. There was a broken sofa on Sycamore which we asked the manager to replace.
•□The corridor carpet on Maple was stained. The domestics said they had asked and asked for it to be replaced as they could not clean it, and it was noted in the maintenance audit in January 2019. They said because staff were rushing they left rooms in a mess often. We saw overflowing bins and dirty gloves left on the side in people's rooms before the domestics were able to get to clean rooms. Three people on Maple ate at a dirty, unwiped table.

The quality assurance systems in place to monitor the quality of the service had failed to identify and address these poor standards of hygiene and infection control. This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Premises and equipment.

• Fire checks and training were carried out. Information was available in people's files about what would happen in the event of a fire. There were personalised evacuation plans in place to inform staff and emergency services about the needs of each individual if they needed to be evacuated from the building.

Inadequate

Is the service effective?

Our findings

At the last inspection in July 2018 this key question was rated as 'Requires Improvement'. At this inspection the rating had deteriorated to 'Inadequate'.

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

Inadequate: There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

Supporting people to live healthier lives, access healthcare services and support

- Staff were not always identifying when people were ill and in need of further assessment or following up health issues.
- On the third day of the inspection, we identified a person who was not feeling well. The agency nurse did not know them and we had to ask them to attend to them. Their relative said they had a history of recurrent chest infections but this was not on the handover sheet or in their care file in their room.
- An agency care worker told us they had asked for a urine sample for one person four days ago but did not know if it had been taken. The person's daily records did not say, the issue had not been highlighted or followed up. Nurses and care workers wrote in separate records, without reading each other's and the agency nurses said they used the diary. However, any tasks relating to health were not ticked off or signed to say completed so this was unclear.
- There was poor monitoring of preventing people from choking despite people having been identified in the care plans as at risk. One person had clear instructions for staff from the speech and language team (SALT) about having drink thickener. Their relative said sometimes they have it, sometimes not. There was no list of what constituted a soft diet and the person sometimes had biscuits. Their relative brought in food as they were concerned about them not receiving adequate diet of what they liked. A care plan review in January 2019 said the person was continuing to lose weight and indicated care was being followed. We asked staff to put a copy of the SALT advice in people's care files in their rooms so staff would know what to do. The advice said to sit upright, observe and re-refer if difficulties. Offer single sips and observe swallow'. There were no records showing their swallowing was monitored and their relatives were concerned.
- Another person had a dietary notification form saying they should be having yoghurt twice a day, custard and a supplementary drink once or twice a day to promote adequate intake. This was not happening despite being seen by the dietician for weight loss in October 2018.
- One person on Maple had drinks within their reach despite being at risk of choking. Their dietary notification form said to review this monthly in October 2018 but there were no reviews recorded.
- A safeguarding alert made just prior to the inspection by a visiting health professional had found a person unresponsive at the table, a poor skin colour with their head dropped and extended backwards. The care worker was continuing to feed them their lunch and said, "They often do this" and did not appear to understand the risk of choking.
- One relative had been concerned their loved one was frail. This person was left unattended most of the

inspection, they were walking unattended in the corridor in their nightie on the afternoon of our second day and we had to ask staff to assist. They had deteriorated by our third day being left unattended in bed. A diary entry on 15 March stated the GP was to visit to review poor diet and medication and possible end of life. However, we saw staff only with them briefly for tasks and when we offered them a drink they were able to drink holding the cup and appeared thirsty. Staff said they had deteriorated but did not attend to them.

•Records of people's needs and ensuring they were up to date and current was not always evident. There was poor diabetic care. Two people on Willow were diabetic and required regular foot care. We found two records of visits from the podiatrist in their care plans, one unnamed and on a piece of scrap paper. Staff did not know about the advice for the person, 'monitor any knocks to feet and to call if deterioration' and another visit 'prop person back in bed as feet are pressed against bed frame and could lead to complications'. This had not been done. They had a history of skin ulcers. The other podiatry record said 'please monitor feet daily and ensure feet elevated'. Their feet were not elevated throughout our inspection. There were no records showing any monitoring of their feet and staff said they were not following any advice. One relative was moving their loved one to another service and was very tearful as they said staff were always giving them sugar and they were diabetic. The nurse on the first day of our inspection could tell us the range their blood sugar had been but not what it should be and there was no record of what their blood sugar should be. Only 26% of staff had received training in diabetic care.

•One person with a complex intimate health condition had a care plan stating, "Lie on side, give reassurance, sit at an angle on propad cushion, drink plenty and have fruit and vegetables as well as daily shower". We did not see evidence this advice was followed. We found them sat straight on their cushion, no daily showers and minimal fluid and nutrition were recorded. They had recently been to hospital due to this condition. Daily records did not show how this was monitored and staff said they just told the nurse if the condition was not good and required treatment which was often.

•One person had had an occupational therapist assessment on Maple. The health professional had had to ask for the person's nails to be cut as they could damage their skin and their feet were at high risk of pressure skin damage from a foot condition. The health professional had advised staff in January 2019 but found their feet still touching and skin deteriorating. They raised a safeguarding alert with the local authority on the first day of our inspection. Advice was again not communicated effectively.

•Records of people's health detailed when some professionals had visited or been contacted, but could be on separate sheets of paper in different files meaning people's needs could be missed and staff admitted they did not know the advice when we asked them,

•Health professional recommendations had not been implemented into people's plan of care, recommendations had not been followed and incidents had continued to occur.

•Health professionals such as the tissue viability specialist and occupational therapist said they had been concerned about continuous staff and management's failure to understand and follow advice. They did not think the manager had been pro-active since being in post as issues continued to occur.

•One person was classed as 'residential' on the nursing unit. There was no daily records for the 14 March 2019 day or night. They appeared unwell and 'chesty'. The GP had prescribed antibiotics to start should they become unwell. We asked the nurse to check the person's temperature, pulse and blood pressure. The observation form was blank since their admission for respite care four days before. Antibiotics had not been ordered just in case. The clinical lead nurse said, "They are residential, the district nurses should be caring for him". We advised, that they had a duty of care. and ensured they were cared for.

•Staff did not read the care plans. However, if they had, people's care records were disorganised and did not provide easily accessible and clear detail to staff and others about their past and current health needs. Information about people's health was found to be randomly filed amongst other records or scattered around the offices and staff room, especially on Maple. Activity records for one person contained entries all about another person. We took an hour to read one complete care plan file to enable us to let staff know what the person's needs were. A visiting health professional on the third day was reviewing a person and

said it was very difficult to make sense of the file. An occupational therapist had asked staff how to record their visit on 15 March 2019. The staff on duty were agency and did not know and took a long time to find a template for them to write on.
•□People did not have Hospital Passports. Hospital Passports include information about people's needs and how they choose to be supported. This information helps ensure people receive consistent care in the way they need and prefer if they are admitted to hospital or other healthcare facility. This is especially important if people are also living with dementia and staff, especially agency staff, not knowing people's current and correct needs.

The above concerns demonstrated a failure to ensure care and treatment was provided in a safe way for people. This is a repeated breach of Regulation 12 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Adapting service, design, decoration to meet people's needs

•□At the last inspection we found people were not always empowered to be independent by the design, adaptation and decoration of the service. At this inspection we found the environment on the nursing units did not promote independence or provide a pleasant place to be. This did not promote and respect people's individual and diverse needs.
•□The environment was tired, and did not provide people with a homely environment they could be proud of. Communal areas were sparse with little available for people to occupy their time. Some people spent long periods of time in their wheelchairs with only the television for visual stimulation and activity or where they could not see a TV.
•□The adaptation of the environment did not sufficiently meet people's needs or promote their independence. For example, some rooms were untidy and cluttered despite people being at high risk of falls.
•□The environment was not 'dementia friendly'. People were not aided to find their own rooms, some with only room numbers on the doors, despite records showing people going into other's rooms. There were no visual clues to aid people locate a toilet seat, bathroom or any coloured crockery or visual communication aids to promote independence for people living with dementia. Some calendars and clocks in people's rooms were incorrect.

The environment failed to promote people's independence and the design and decoration did not meet people's needs especially in relation to living with dementia. This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance

•□We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA), whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
The Mental Capacity Act provides a legal framework for making 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes and hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

•□People had not always been consulted about their care or asked for consent before care was delivered. For example, a lack of involvement with one person had not recognised their need for a regular routine or preference for regular or male staff. Staff records showed staff went to deliver personal care or change dressings without asking if the person was happy with this at that time. Records showed various examples of refusals of personal care' and aggressive behaviour which had not been connected to what the person wanted. Records showed people being 'taken' to the bathroom for personal care resulting in an aggressive outburst and personal care being completed despite the person clearly not being happy. In the lounge people were put in their chairs without making sure the person was happy, often chairs placed in the middle of a room or at random angles. Relatives said they had not been consulted about care needs. One relative's loved one had a mattress on the floor and a pressure mat which is a restriction in their movements but this had not been discussed with them.
•□We were told people had capacity or lacked capacity. However, records did not demonstrate how this had been assessed or how staff recognised that capacity fluctuated and changed dependent on the activity or changes in situation. We saw staff doing tasks to people such as assisting them with eating and drinking without enabling them to do this with support themselves. Staff also listened to people living with dementia who said 'no' once such as not wanting to get up or wash but did not encourage or try and sit with the person to reduce anxieties. People living with dementia can tune into their feelings and because there was no comfortable space to sit during the day or any engagement or activity, there may be no reason to get up.
•□Some people had records showing expressions of wanting to go home or go outside. This had not been listened to and people had not been reassured or a plan devised to help them go outside or have a change of scenery.
•□There was evidence that people had had appropriate DoLs applications, however some of these had expired.

The provider had not ensured that care and treatment had been provided with the consent of the relevant people. This is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law.

•□Some people had lived at the service for some years. There were no admission records for one person or a care plan detailing their very complex mental health needs and history. We found an old care plan from when the care home was called Springfields which had some information. Other than that staff only knew there were mental health needs and had no care plan to support person centred care delivery. The February 2019 audit showed that 18 people had been identified as not having pre-assessment documentation in their files. This meant the care plans may not reflect people's needs prior to moving into the service.
•□We found risks associated with people's care that demonstrated the service was not always ensuring people's needs and choices were met (Examples are detailed throughout the report)
•□We found concerns throughout the inspection that reflected care was not always being given in line with standards, guidance and regulations (Examples are detailed throughout the report).

There was a lack of assessments and consistent timely health care. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet.

•□People were not always supported to eat and drink enough to maintain a balanced diet on the nursing units. During this inspection we were concerned that people were not receiving enough to eat and drink. On

Willow there were 11 people who required staff assistance to eat and drink and 14 people on Maple. Staff all said this was very difficult as there were not enough staff and they did what they could. For example, four care workers on each unit and at times only three. During the first day of our inspection people were still having breakfast at 11 - 11.20am on Maple and Willow. Night staff did not provide any breakfasts, which started at 9am. There was no provision for people to access snacks or drinks themselves.

•□People living with dementia or with other health needs were at risk of not having enough food if they disengaged with their meal because staff were not identifying when this was happening and were not encouraging and supporting them to enjoy their meal.

•□Food and fluid charts showed many gaps with some people not receiving any food or drink at all some days or just a few spoons of porridge. Those records showed people had refused meals but there was no evidence of staff re-offering food or seeing if people would eat or drink an alternative. Fluid charts were not totalled to show what people had drunk in a 24 hour period and there was often no record of their optimum total required. Some people had only had between 100 - 500mls some days. There were no fluid and food records at all for people at risk on Willow on the first day of our inspection at 12 noon so we asked staff to start them.

•□People who required high calories for weight loss had been prescribed supplementary drinks. We saw little evidence of these being given during the inspection or within food and fluid charts.

•□We were told people could make choices about what they had to eat. However, information about meal choices was not provided to people in a way they could understand on the nursing units. People were not shown plates of food so they could choose and the kitchen had no details of what people's preferences, likes and dislikes were. Staff agreed that not everyone would be able to see and understand a notice on the wall.

•□However, most staff had received training in hydration and nutrition.

The above concerns demonstrated a failure to prevent harm or risk of harm which was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff support: induction, training, skills and experience

•□Staff said they did not feel well supported with training. Some staff had completed dementia care training. One care worker said they had completed virtual dementia care training which they said had been interesting. However, we saw no follow up or competency checks to ensure staff were putting their learning into practice on the nursing units, with Willow being a specialist nursing dementia care unit.

•□Despite the service specialising in dementia care only three staff had received training in recent years in dementia care. This was evident in the way people were cared for in a non person centred way. Staff had not read care plans and did not know how people's individual dementias affected people. For example the care staff said, "Well they always do that", about the people that shouted or cried.

•□The training matrix sent to us with the February 2019 Key Performance Indicator audit showed there were many gaps in staff training. 15% of staff had received moving and handling practical training; 59% had completed first aid and resuscitation, and training relating to choking incidents, 26% in diabetes and epilepsy. We found failings in moving and handling and knowledge about choking, which put people at risk. However, most staff had received training in health and safety, infection control, safeguarding, medication and fire safety.

•□The service action plan sent to us stated there were named staff 'champions' for health and wellbeing, continence, tissue viability and moving and handling but we did not see any evidence of how this was implemented or affecting care delivery.

The above concerns demonstrated a failure to ensure there are sufficient numbers of suitably qualified,

competent, skilled and experienced staff to ensure people's needs are met safely. This is a repeated breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Inadequate

Is the service caring?

Our findings

At the last inspection in July 2018 this key question was rated as 'Requires Improvement'. At this inspection this rating had deteriorated to 'Inadequate'.

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

Inadequate: People were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls and some regulations were not met.

Respecting and promoting people's privacy, dignity and independence

•□People were not respected and supported by compassionate staff on the nursing units due to lack of staff, staff knowledge of people's needs and poor leadership. Practices did not always promote independence, and people's individual needs were not understood and promoted. Relative comments included, "I worry about them all", "People just shout and swear outside the office" and "People are shouting outside [person's room] all the time, it doesn't help his anxiety".
•□People were disrespectfully referred to by staff as room numbers, needing to be "fed", "done" and "toileted" in respect of their care needs.
•□Staff were not caring when using a tick list to check people were safe and well. The form was initialled by staff to say they had walked around the unit, signing that they had visually seen people but did not check they were safe, did not interact with people, check they had everything they needed or were comfortable. Despite these visual checks one person living with dementia was curled up on the armchair (of which they had fallen out of before), with bare feet, in their nightie still with a paper bib on, covered in a dressing gown with porridge on, in the afternoon. We showed staff but they did not do anything. This was also seen by the provider. Earlier the person had been able to identify their family photos and cried. Staff said, yes she cries a lot but there was no actions to comfort or manage the person's anxiety despite having a history of a close bereavement.
•□If people living with dementia were asked a question and said no, staff did not spend time to encourage or support people to get up or get out of bed so some people stayed in their rooms all day or in bed with no interaction. There were no activities or engagement on the nursing units other than for tasks. Most people could not use a call bell and relied on regular staff checks.
•□There was a 'This is Me' document placed in room care records after the first day of the inspection. This was not person centred and was a tick list of their task needs or a comment, for example that they liked lemonade only.
•□People did not enjoy a pleasant social experience at meal times, some people ate where they were sitting on their laps or they were fed cold food and drink in a rushed manner. There were no records of what people liked to eat and their preferences other than some hot drink instructions. We saw one care worker assisting one person to eat by standing over their bed with the person half lying down feeding them with a spoon. This person would have been able to hold their spoon and support themselves with prompts.
•□People in general looked unkempt, nails dirty or long (a visiting occupational therapist had to ask staff to

cut one person's nails to avoid skin damage), had bare feet or with dirty clothes. One relative said their loved one was often wearing the same clothes for some time. On the first day especially some people had an odour about them. One relative said, "I asked when my mum had last had a shower and they couldn't find out."

•□Staff did not ensure that people's dignity was maintained. We had to ring the call bell for one person who spent an hour lying on their side with their head by the mattress, covered in porridge. They did not have a call bell lead so we had to arrange for one to be fitted. Their undergarments and continence aids were showing, with an open door. Staff said the person was always making themselves uncovered but did not go and assist until we asked. We later saw them in the same position with the door still open.

•□Staff used the large lounge as a thoroughfare to the unit. Staff were constantly walking through this area totally ignoring people sitting there. One person was reaching out to staff each time but was ignored. Another person was shouting, 'I want to die' which was clearly upsetting relatives. By the third day of our inspection, the provider had blocked off this entrance.

•□People's rooms were kept clean but were not made homely. They were either cluttered like a storeroom or bare and had not been made to be comfortable places for people, despite risk assessments stating staff should ensure rooms were not cluttered for people at risk of falls. A domestic said, "Staff are in such a rush to support people they are not cleaned properly and they then leave rooms in a mess. We left spare bin liners but staff don't use them."

•□Relatives said their loved one's belongings were not cared for. People's rooms were untidy with clothes not always folded or items put away. One relative said, "I've had to put a note to staff saying I will wash mum's fluffy socks or they are ruined or lost. You speak to individual staff but no-one remembers."

•□At this inspection we found little action had been taken to address concerns raised by the previous inspection report in July 2018 despite a new manager starting employment in December 2018. No staff had read the report and they were not aware of these concerns.

•□We did observe some lovely, kind and positive interactions between people and staff when they spent time together completing tasks. However, mostly people were left alone if they were quiet.

•□Parts of the home especially outside the nurses office and the 'sensory area' on Willow were not comfortable and calm places for people to sit. The 'sensory area' was messy and full of mismatching furniture that was tired with a stained carpet. The area outside the nurses office was very noisy and in a corridor. As staff walked through, this aggravated some people living with dementia. Throughout the inspection the people living with dementia sitting here swore and argued with each other in a negative environment. One person, living in a room by this area, had one to one care during the day but staff said they regularly threw items and were agitated during the night but their night care had not been reviewed. This did not promote a pleasant quality of life.

•□There was also signage directed to staff displayed or areas where staff wrote their records. This did not promote a clear message to people that it was their home and not just the workplace of the staff who provided support.

•□The bathrooms, especially on Willow, were stark and not inviting. We asked staff on the first day of our inspection to remove a tub of communal toiletries in the shower room and ensure people used their own.

•□Despite people mostly living with dementia, rooms were not easily signposted to enable people to find their rooms independently. Records showed examples of people going into each others rooms, especially at night. Some rooms had a name door sign, others just a room number but nothing to make them stand out for people living with dementia who were mobile.

•□Support plans were only task focussed concentrating on people's personal care needs rather than on the whole person, their lifestyle and progress. For example, a tick box to indicate- skin care, bed bath, shower or bath. Hair care, condition of skin and oral hygiene. These were often blank with the odd day having a tick or comment such as 'personal care and pad change'. There was no evidence of staff asking again, if people refused when asked first, or details of how people liked to be supported with personal care. One relative

said, "They never moisturise her face or clean her eye which has a blocked tear duct so I do it when I can." Their records just said 'personal care given'. The person was living with dementia and required full support. Another relative had had to put a note on a board in their room saying the person was blind in their left eye as they had to constantly tell staff. During our inspection we still saw staff trying to talk to the person living with dementia on their blind side.

•□Staff told us how two people especially had deteriorated with their dementia. However, support plans did not describe the support needed by people to maintain their personal space or any plans in place to help them to develop and progress their independent living skills.

•□The mealtime environment did not facilitate a pleasant meal time on the nursing units. Two people ate in the small dining room in their wheelchairs on Willow but there were no other chairs in there. Three people ate in the communal area on Maple. Only some people were offered to move to a dining area, most people ate where they were sitting or in bed. Staff said they did not have time and generally moved people who were already in a wheelchair.

•□Two people were eating on their lap or from a low coffee table, spilling food. There were no dining tables at all in the main communal area. Nowhere was easy to identify for people as a dining area. There were no tablecloths or tableware. No menus or pictures of meals for people to see and no condiments or seconds were offered.

Ensuring people are well treated and supported; respecting equality and diversity

•□79% of staff had received equality and diversity training.

•□However, staff did not access the information about people so that their differences and diverse needs would be understood, respected and welcomed.

•□People's spiritual and cultural needs were not documented or known by staff to enable them to be known and therefore met. Staff did not have the time on the nursing units to meet these needs. For example, one person had been noted as possible end of life care in the diary on Willow. This person was in bed and left alone all day on our third day of the inspection, other than for tasks. They were clearly anxious when we met them and wouldn't let go of our hand. On the second day they were walking around the corridor in their nightie and bare feet until we asked a care worker to be with them. The care file in their room just gave brief details 'personal care by one carer'.

•□One person was left alone for all three days of our inspection other than for tasks, they sat with nothing to do in the same chair away from others. On the second day they were ripping paper towels left on the table. Two relatives said, "The staff don't come near because [person's name] can be rude (they were living with dementia) and they don't like her. We see it." We did not see any staff talk with this person even when leaving them a drink on the table.

•□Some people were able to go to join the coffee morning on the other unit on a Tuesday. Records showed these were the same people or those who were up and dressed or had a relative with them. Therefore, not all people had a chance to join in activities or discuss what they would like to do. People were not asked or encouraged to do anything and there were no items for people to look at or occupy themselves with. The television stayed on the same channel with no discussion with anyone, for example. Staff knew little about people and any knowledge was not translated into care delivery.

Supporting people to express their views and be involved in making decisions about their care

•□People and their relatives did not feel involved in their care on the nursing units. None of the relatives we spoke to had seen a care plan.

•□People's support plans did not evidence how people were involved in matters concerning the home and their care. Nursing staff had signed to say support plans had been reviewed but it was not evident if and how

people had been involved in this process. Care workers said they had never seen the care plans or been asked about people's care. Support plans were not available in a format people could access and understand.
•□Relatives on the nursing units said they did not feel welcome and had not seen the manager or had not found them helpful. They all said the manager was not on the units at all. One elderly relative of someone with very complex needs said they had been told, "If they didn't like the care given why didn't they leave." We saw brief acknowledgement of relatives by staff but no meaningful interactions with relatives on the nursing units. Relatives said staff did not have time. One relative said they used to have meetings in the small lounge but now it was cluttered and like a staff room so only staff used it now.

The care and treatment of people was not appropriate, did not meet their needs or reflect their preferences. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Not treating people with dignity and respect is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Dignity and respect.

•□We note that the majority of this report reflects on serious failings found on the nursing units Willow and Maple. We also inspected the residential units and found there to be overall good care although there were also issues with the use of the dependency tool and lack of 'as required' medicines information for staff to follow. In contrast to the predominant examples in the report people and relatives said on the residential units that they were happy with their care. The environment was homely and comfortable, staff were visible and there were regular activities.
•□People on Elburton and Sycamore received care from regular staff employed by the home who knew people well.
•□Some staff showed good empathy and kindness and expressed their concerns, for example, that they couldn't spend more time with people because of the staffing levels.
•□Positive comments from people and relatives included, "It's pretty good. [Person's name] has settled and the staff are friendly and helpful which I find reassuring", "The care staff are very friendly", "I come every day and I'm made to feel welcome by most of the staff" and another relative said, "I'm kept up to date on [person's name's] care".

Inadequate

Is the service responsive?

Our findings

At the last inspection in July 2018 this key question was rated as 'Requires Improvement'. At this inspection this rating had deteriorated to 'Inadequate'.

Responsive – this means we looked for evidence that the service met people's needs

Inadequate: Services were not planned or delivered in ways that met people's needs. Some regulations were not met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control. End of life care

- People were not receiving personalised care and support on the nursing units. This was related to a lack of staffing levels and communication of people's needs. Staff did not know people's needs or how to meet them because they did not have adequate communication or use the care plans. Staff did not know how people liked to be supported with washing and dressing other than 'requires one staff for personal care' or 'requires full assistance with toileting needs, doubly incontinent' in brief summaries of task needs in care folders in people's rooms. Sometimes continence checks were not done for seven hours and then stated 'wet pad'. All five people in bed on the first day of our inspection had full continence aids and smelt of urine. We had to ask the manager to urgently develop handover summaries for each person on the nursing units which they started after the first day of our inspection. Even then staff did not know what one person's mental health needs were, what a particular syndrome was or how people's dementia affected them and how to minimise incidents due to behaviours which could be challenging or falls.
- Staff all told us they had nothing to do with activities or engagement and we only saw very brief interactions with people during tasks and no activities on Maple or Willow throughout the inspection. People, including those who could not use a call bell, were sat for long periods alone; especially 9-12pm and 2-4pm on the nursing units.
- Maple had one person in a wheelchair sat in front of the television placed in the middle of the room on their own. They could not ring a bell and staff did not regularly check if they needed anything other than for tasks. Willow lounge was very big with windows down one side. There were only six armchairs at random angles around the edge and a maximum of five people used the room during our inspection. Staff were not present and people were left alone for long periods, other than the tea rounds. Two relatives that visited regularly said this was always the case and most people were usually in bed. Staff were present around 1pm when they sat at a table at the back to do records but did not talk to people.
- On the first day of our inspection, the people in the stark lounge on Willow sat with a whole day of BBC News on the television about recent mass shootings until we asked staff to change the channel. They then did not ask people if or what they would like to watch. On the third day the television stayed on one channel all day. No-one appeared to be able to see or watch it.
- Because staff did not read the care plans they could not tell us people's backgrounds or what they liked to do. We looked at activity records. There were two activity co-ordinators who did not go onto the nursing units. Relatives said they had never seen them there and staff said they did not do one to one time with

people. Records showed little input, one person went to the weekly coffee morning and the hairdresser but there was nothing in between. Another person attended any activities on the other unit but only because they had a daily visitor, and in between there was no input. The agency staff employed for one to one also only sat with them and did not attempt to stimulate the person. One person had nothing recorded since 2 February 2019. There were no activity records between 2 and 22 February. Another entry said "distressed" with no further entry until a "chat" five days later and a haircut five days after that. Daily care records did not have any records of engagement activities or stimulation other than relatives visiting. One relative said, "I've never seen anyone sat with them and I visit every day." Their care file in their room did not mention their anxiety or bereavement or health needs requiring support. It was noted they were often agitated, anxious and displaying aggressive and distressing behaviours. One record said "Unsettled but happier when offered a hairdresser visit", "seemed to enjoy book" and "In a good mood since shower" but also "agitated for four hours" and many other such comments with no actions recorded. Their care plan which staff did not read identified the person's anxiety and said they liked company and to be with staff when they were anxious.

•□There were lots of items in the activity room which staff could have used to engage people but the focus of activity provision was on Elburton and Sycamore, the residential units, where people had less complex needs and more communication. Relatives said they had tried bringing in items such as jewellery and perfumes to try and stimulate people but staff had not been involved and were not pro-active in facilitating engagement because they were too busy. Staff told us, "100% we need more staff, of course we can't be with people. It's obvious" and "We can't be with people, there's no time". They said if someone made a noise on the other units having been taken for an activity there they were brought back to Willow.

•□Two care plans had no details of what people liked to do. The 'Get to know me' form was blank despite the person having complex mental health needs and requiring particular support for their wellbeing.

•□People were not able to do what they wanted to do. An agency care worker at 9am said a person would like to get up as they didn't like breakfast in bed. At 10am they were still in bed without breakfast. One relative had left a scrapbook of family photos but said staff had never used it and it was lost five months ago. They said, "A cup of tea works miracles when [person's name] is anxious. I've told them many times but they haven't got time. I've been here all week and staff think it's funny [person's name] is asleep all the time. I'm worried so I'm moving them out." An agency worker said, "I've only seen [person's name] asleep in their chair. No, I've never seen any stimulation." They told us how one person would love some grapes and wanted to go to the shop. This had never happened although a shop was across the road.

•□People did not receive individual personalised care. Staff did not encourage people to make choices as much as they could. Some people living with dementia may benefit from being shown visual choice, for example pictures. People who required assistance with their communication needs did not have these individually assessed or communicated so staff could meet them using suitable communication systems. The Accessible Information Standard is a framework put in place making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. This was not happening for people.

•□One person was recorded as wanting to go to bed every day. Staff did not encourage them or find out what they wanted to do so the person just went to bed all day. When their relative visited, the person then went to the dining room in a wheelchair and was more engaged. They used to enjoy smoking a pipe but staff said they had not had time so this now did not happen. On the first day the activity co-ordinator came to see if anyone wanted to go to a music session but no-one was ready to go in the morning. A care worker said, "I don't think people are the focus here" and another, "People need stimulation, we don't have time to encourage people to get up because there's nothing to get up for." Most people were in their rooms sleeping all day or doing nothing on the nursing units.

•□As found at the last inspection in July 2018, people's end of life wishes were documented on a TEP (Treatment Escalation Plan) to inform staff if people wanted to be resuscitated or if they wanted medical intervention at the end of their life. Some people's care plan held information on their actual wishes for their

final days. However, we found not all records had been completed and staff did not read them. This information would help ensure people wishes were respected.

The above concerns are a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person centred care.

Improving care quality in response to complaints or concerns

• Although there was a complaints file for written complaints, and there were four between May and October 2018, each relative concerned told us they had spoken to either staff or the manager but nothing had happened. One relative said they had been spoken to rudely by the manager because they complained often. Their relative was left alone for most of the time during our three days of inspection, unable to call for assistance, and records showed they were eating very little with meals, and snacks were not re-offered or preferences discussed. They also had a syndrome which no staff knew what it was, or how it affected the person.
• Another relative said they had complained about the unkempt condition of their loved one, odour, and missing items from their room, but nothing had been done. They had had to put a note in the room that they would do the clothes washing, for example because items were either lost or ruined.
• One relative had chosen to move their loved one because their concerns had not been listened to and so they had raised a safeguarding concern with the local authority. They said, "Care staff at Elburton Heights have been giving [person's name] sugar although they are diabetic and insulin dependent, this has happened on numerous occasions. When I raised my concerns to the staff and it was dismissed." They had also found their loved one unkempt one afternoon with food all down their front from lunchtime, soiled and urinating on the floor, and therefore felt moving her was in her best interest. They expressed they were not the only one who "has cried to the manager about the type of care provided." This person we saw left unattended and dirty in their bed exposed and uncomfortable each time we saw them. An agency care worker did not know what their mental health needs were. We found lack of staff communication of people's needs and the same issues during our inspection for other people.
• Another relative had also raised a safeguarding alert. They told us they had said to the staff that their loved one was losing weight as staff were rushed but staff had said they were eating well. They said they struggled to be provided with information from staff, including medical recommendations which staff had been informed of. They felt so many agency staff might be a contributing factor to what they felt was poor care.
• Relatives with loved ones on Willow and Maple did not feel listened to or confident that talking to staff on the nursing units would ensure action. They did not find the manager approachable or knowledgeable about people.

There is a failure to listen to people and take appropriate actions in relation to complaints. This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At the last inspection in July 2018 this key question was rated as 'Requires Improvement'. This was a repeated 'Requires Improvement' rating so we met with the provider In December 2018 for reassurance that there would be improvements. We placed two conditions on the location registration that:
1.The Registered Provider will complete monthly audits of staff training and supervision, service users' records relating to their current care and risks, medicine management, audits relating to the environment: and write a report on what you have found, with the actions you intend to take as a result of these audits.
2.The registered provider will send the commission a monthly report on the 1st working day of each calendar month the findings and actions of the points above.

Despite this, at this inspection this rating had deteriorated to 'Inadequate'.

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Inadequate:There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

•At the last inspection we found the service was not being effectively assessed and monitored by the provider to ensure its on-going safety and quality. The provider had failed to recognise that people lived in an environment which did not always have a positive and inclusive culture. The providers ethos of promoting people's independence was not embedded into staff practice, and people were not being supported to be empowered and motivated to live fulfilled lives. At the time of the last inspection the service did not have a registered manager in post and the service was being overseen by an acting manager.
•At this inspection there had been a new manager in post since December 2018. They said they were aware of the previous report and were working towards addressing those issues found. However, we found none of the issues had been addressed on the nursing units. Relatives and staff, including agency staff, on the nursing units said they had never seen the manager on the units and did not feel listened to. The management team did not seem to understand people and staff experience day to day on these units. A nurse had told a visiting health professional on 12 March 2019 that there were poor management decisions such as taking food and fluid charts away for some people. The nurse said they had risked getting into trouble and replaced these.
• One nurse had been disciplined for not completing tasks despite raising concerns repeatedly within supervision sessions. During the third day of our inspection the clinical nurse was taking a large folder of monthly audits to the nurse to complete during their shift. They would have known that due to our findings on the first day that there was a lack of staff and high workload, and therefore this was inappropriate and unsupportive. Staff called the clinical nurse the 'computer nurse' and felt there was a blame culture rather than a supportive environment.

•There was no leadership on the nursing units. Nursing staff were very busy. On Willow the morning medication round finished at 12.05pm, on the third day of our inspection. Nurses were often agency, there was no agency induction file or process. Agency staff relied on verbal handovers. One agency nurse had only worked two shifts before and said the handover was mainly, 'slept well'. Care staff worked in isolation, organising their own breaks (despite five people being still in bed on the first day) and there was no-one to oversee their work or competency or offer role model support. The care staff barely spoke to the nurses and on the third day of our inspection did not even know their names.

•There was very poor communication in general on the nursing units. Handovers were verbal and relied on the quality of the night staff, also often agency staff. On the first day of our inspection care staff did not take notes. They did not use care plans at all and relied on brief instructions within people's care folders in their rooms such as 'requires assistance of one care staff' and 'needs reminding to use her walking aid'. There was no mention of how their dementia affected them, their anxiety and subsequent behaviours which could be challenging with medication given, complex health needs requiring daily showers, and continuing extreme high risk of falls. By the end of the first day we had to ask the manager to devise a summary of people's needs to ensure staff had something to work with. Even then on the third day of our inspection we could not be sure staff knew people's full needs to keep them safe. For example, recurrent chest infections, what a particular syndrome was, people's appointments, and what 'mental health issues' meant for one person.

•Staff, relatives and other agencies said they felt the culture and atmosphere of the home did not show person centred care and knowledge of people's individual needs. Visiting professionals said they had repeatedly communicated advice about people's health but this was not followed. We found some information in professional documents within care files but these were not known by staff. A health professional told us, "We had previously spoken to nursing staff about it and advice from the tissue viability team which we passed onto staff but this had not been adhered to."

•Because the nurses were generally agency staff who did not know people and had also not read the care plans there was no leadership. Relatives and staff said the manager was never on the nursing units so there was no-one to challenge staff about their competency, knowledge or practices.

•Staff, including regular agency staff all said they received no thanks or support for their work. Comments included, "You never see the manager, no-one listens", "We have no leader, we just do our own thing. I've never seen a care plan and I don't know what the nurses do." They did not feel supported or listened to at all and some felt bullied when tasks had not been completed. Supervisions were minimal although the manager had started completing some. Out of 87 staff only 11 had received recent supervision.

•Supervision notes repeatedly showed records of staff raising concerns. Comments included, "Workload- finds it difficult to cope which triggers stressful situations", "Impossible to complete paperwork on a daily basis, system needs to improve" and "Poor skill mix. Need more staff so quality of care can improve". The action stated "on going recruitment and train staff" and did not address staffing levels. Other staff had said in supervision, "Difficulties- staff turnover and levels. Willow needs more staff which management should do" and "Staff not pulling their weight and sickness. Lack of strong team". There was no action plan or response.

•There was very low staff morale on the nursing units. Staff told us the good nurses had left, some after many years and others were considering leaving. They said they didn't feel appreciated, "Every time we are short staffed and we all suffer." Permanent staff comments included, "The manager and clinical lead never speak to us or say good morning." The two visiting health professionals did not know who the manager was. Positive comments were only from agency staff who were employed to support people on a one to one basis.

•The management team had failed to address concerns in a timely manner and many aspects of the service, highlighted as requiring improvement at the last inspection in July 2018, had not been dealt with. For example, safe medicines management, risk management (falls, pressure care, accidents and incidents, nutrition and hydration, staff training, supervision and appraisal and record keeping). We also found the

service required improvement in caring. However, some of the information about people's needs lacked detail and was not in all cases accurate. This could mean care was not always provided consistently, particularly when staff were new or did not work regularly in the home. This potential for inconsistent care had not been picked up and addressed by the provider's oversight and auditing processes." We recommended at that time that the provider reviewed the current staff practices in respecting the dignity and care of people. We found in March 2019 these failings, despite being known, remained the case.

•In relation to medicines on the nursing units, the service was auditing the medicine administration records on a weekly and monthly basis to ensure that medicines were given as prescribed. There was no information recorded which could demonstrate that issues that arose were being dealt with in a timely manner and that learning took place. There had not been a review of the recording of the application of external preparations or the information to ensure that medicines being used "when required" were used to the best effect.

•The regional manager had been supporting the new manager, however they said they were not surprised about our findings and had already decided in December 2018 to not admit anyone to the nursing units. However, we could not see evidence of any urgency to address any issues they or head office were aware of. The regional provider representative had completed a monthly compliance visit on 14 and 15 February 2019. Various issues had been identified such as lack of notifying safeguarding of pressure sores, and three care plans, and body maps relating to pressure care 'completely out of date'. An issue with weight loss was noted in records but no evidence of checking their weight loss plan was being followed. Meal time dining experience audits were only done on Elburton residential unit, where we found no issues. Activities stated- 'there is a full monthly programme of activities and 121 time with residents' which was not correct at all. Falls- 'There is good recording of falls but limited information about what we are doing about it'. Care plan audits state that a lot of work needs to be completed to raise care plans to an acceptable standard. This was not acknowledged, that care staff and nurses were not reading the care plans as working documents. No infection control audits since October 2018. Only 40% of training had been completed overall. The home manager was to schedule a night visit. We had also suggested this as we had concerns about staffing levels at night. This had not happened. It was noted that there was a considerable amount of work to do to be compliant. There was no mention of staffing levels.

•The regional manager told us the auditing process included, sharing the audit with the provider and discussing the findings at monthly provider team meetings, and a weekly governance call to discuss concerns. The provider had sent an action plan following the last inspection, however auditing processes did not evidence that checks were made to ensure meaningful action had been taken to address concerns and meet the regulations.

Continuous learning and improving care

•The provider and management team had failed to respond in a timely way to concerns and breaches of regulations found at the last inspection.

•The provider and management team did not have sufficient oversight of the service to ensure concerns were addressed and improvements made.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics Working in partnership with others

•We did not see the manager or management team on the units especially nursing. Staff and relatives all said they rarely saw the management team on the nursing units. This did not enable them to ensure robust leadership, role model, and challenge staff practice and the environment they were working in, or to see that people's needs were not being met.

•□Despite a relatives' meeting in December 2018, relatives with loved ones on the nursing units did not feel supported or listened to by the manager.
•□Although there had been a recent quality assurance survey with 19 responses, mostly positive, this did not reflect our findings on the nursing units.
•□There was little evidence that people were supported to play a full and active part in their local community

The lack of good governance is a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.