Completelink Limited

Prestwood Coach House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This comprehensive inspection visit took place on the 17 April 2018 and was unannounced

Prestwood Coach House is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Prestwood Coach House is registered to accommodate 40 people in one building. Some of the people living in the home are living with dementia. At the time of our inspection 26 people were using the service. Prestwood Coach House accommodates people in one building and support is provided on two floors. There is a communal lounge and dining area, a conservatory and a garden area that people can access.

There is a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

When we completed our previous inspection on 21 November 2017 we found risks were not always reviewed or managed in a safe way. There was not always enough staff available for people and they had to wait for support. Staff understood when people were at risk of harm and how to report this; however when safeguarding incidents had occurred we could not see how lessons had been learnt. Infection control procedures were in pace however they were not always followed. It was also unclear when people lacked capacity to make decisions for themselves and when needed decisions had not always been made in people's best interest. People were unlawfully being restricted and this had not been considered. Referrals to partner agencies were not always made in a timely manner. Concerns were raised around the training and induction of agency staff. People did not always receive care in their preferred way. Care plans were not always reviewed to reflect people's needs and when people had cultural needs these had not always been fully considered. People were not always sure how to make a complaint. Staff did not feel listened to and when needed that action was taken. People and relatives did not always know who the registered manager was. Quality checks did not always drive improvement within the service.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions safe, effective, responsive and well led to at least good. We did not receive the action plan from the provider in the time frames we set. We again requested the action plan from the provider and this was sent to us.

At this inspection we found risks to people were not managed in a safe way. We saw that people were not transferred in a safe way and care plans and risks assessments were not always reflective of people's current needs. When care plans were in place people were not always supported in line with these. When people were identified as at risk of harm staff did not always have the necessary information to offer the correct support. As all safeguarding's had not been considered or reported appropriately we could not be assured

people were protected from potential abuse.

Correct procedures were not always followed to ensure people had taken their medicines, meaning people were placed at increased risk of receiving the wrong medicines. We could not be assured there were enough staff available for people as they had to wait for support. Infection control procedures were in place however these were not followed to reduce the risk of cross infection.

Staff received training however we could not be assured people's competency was assessed as they did not always demonstrate an understanding in key areas such as MCA. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service did not support this practice. Where we had raised previous concerns about people not been referred to health professional we saw these had been made. However people were using equipment they had not been assessed for and guidance had not been sought from relevant professionals in this area.

People were not always supported in a kind and caring way and staff were sometimes rushed when delivering support. People's choices and dignity were not always considered. When people were living with dementia or had communication needs the provider had not considered how to fully support these people. People and relatives thought improvements could be made to the food and drink within the home.

People did not always receive individualised care in their preferred way. Concerns had been raised about the equipment within the home. People did not always know how to complain and when people had complained these had not been responded to in line with the provider's procedures. People and relatives were not happy with how concerns were actioned and responded to within the home. People and relatives did not also feel they were involved with planning and reviewing of their care.

Concerns with the management of the home were raised and people, relatives and staff did not feel supported or listened to. The provider had not taken the necessary action to comply with the regulations. The audits that were completed were not effective in identifying concerns or used to drive improvements within the home. People's suggestions were not always acted on or used to make changes. People's information was not stored in a confidential way and the provider did not always notify us of significant events that occurred within the home.

The provider ensured staffs suitability to work within the home and people were happy with the care staff that supported them. People were able to make choices about how to spend their day and encouraged to maintain relationships that were important to them. People were provided with the opportunity to participate in activities they enjoyed. The provider was displaying their rating in line with our requirements.

Staff had protective equipment including gloves available when needed. Staff understood whistleblowing procedures. When people had as required medicines there were protocols in place for when medicines could be administered. People had the opportunity to attend health appointments when needed. Information relating to current legislation was available for staff to consider.

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

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

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

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

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.
People were not always transferred in a safe way. Risk assessments were not always in place, followed or reviewed to reflect people's needs. People continued to wait for support and they were not always protected from the risks associated with medicines. Infection control procedures were in place but not always followed. We could not be assured safeguarding concerns were reported appropriately. Staff used protective equipment. The provider ensured staffs suitability to work within the home.

Is the service effective?

Requires Improvement

The service was not always effective.
Capacity assessments were not always in place and there was no evidence decisions were made in people's best interest. We could not be sure the training staff received enabled them to support people as needed. We received mixed views about the food people received within the home. People were not always referred to health professionals when needed. People had the opportunity to attend health appointments when needed. Information relating to current legislation was available for staff to consider.

Is the service caring?

Requires Improvement

The service was not always caring.
People were not always treated in a kind caring and dignified way. People's individual choices were not always respected. People were happy with the care staff that supported them. People were offered verbal choices as to how to spend their day. And they were encouraged to maintain relationships that were important to them.

Is the service responsive?

Inadequate

The service was not responsive.
People's care was always not assessed to ensure it was safe and relevant to their needs. We could not be assured the equipment people were using was safe and appropriate to their needs. People did not receive care in their preferred way or that was individualised. People's communication needs had not been

fully considered. People and relatives did not feel involved with planning their care. People's cultural needs were considered and people had the opportunity to participate in activities they enjoyed.

Is the service well-led?

Inadequate

The service was not well led.
The providers remains in breach of regulations and have not made the necessary improvements needed to comply. There are concerns with the management of the home and the lack of leadership. The provider had not notified us about all significant events within the home. Audits were not driving improvements. Staff did not always feel supported or listened to. The provider was displaying their rating in line with our requirements. Staff knew about the process for whistleblowing.

Prestwood Coach House

Detailed findings

Background to this inspection

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

This inspection visit took place on the 17 April 2018 and was unannounced. The inspection visit was carried out by two inspectors 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.

This inspection was informed by notifications we received from the service and information from members of the public, which included whistle blowing that we received after our last inspection. They pointed out some concerns about the care people received within the home .Concerns were also raised about the staffing levels within the home and the environment. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used all of this information to formulate our inspection plan.

At the inspection we gave the home manager and providers the opportunity to send us anything relevant following our inspection for us to consider. After the inspection we received a lasting power of attorney for one person, we reviewed this as part of our inspection.

We spent time observing care and support in the communal area. We observed how staff interacted with people who used the service. We spoke with eight people who used the service and three relatives. We also spoke with four members of care staff, the home manager and the registered manager who is also the nominated individual. We did this to gain people's views about the care and to check that standards of care were being met. The providers attended the meeting at the end of our inspection where we offered high level feedback.

We looked at the care records for ten people. We checked that the care they received matched the information in their records. We also looked at records relating to the management of the service, including

quality checks.

Inadequate

Is the service safe?

Our findings

At our last inspection we found risks to people were not always managed in a safe way and risk assessments were not always reviewed to reflect people's needs. We found infection control procedures that were in place were not always followed. There were not enough staff available and people did not always receive the support they needed. These were breaches of Regulation 12 and 18 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014. We could also not be assured when safeguarding incidents had occurred these had been fully considered and the provider did not always have systems in place so that improvements could be made and lessons learnt. At this inspection we found the provider had not made the necessary improvements and we found further areas of concern.

We saw that one person was transferred between their wheelchair and arm chair. Two staff did this by standing either side of the person and lifting them under their arms. Later we observed two different staff using the same manoeuvre for a different person. This practice is unsafe and does not meet the guidance from the health and safety executive for moving and handling in care homes. We looked at records. For one of these people there were two different recordings in relation to mobility. One stated, 'I am able to mobilise independently' and the other stated, 'It is necessary for me to have two staff present'. We spoke with staff about this. One member of staff said, "No we don't lift the person. They should be using the standing aid if they are unsteady." There was no documentation of this equipment in the person's records and we did not see this used for this person during our inspection. The home manager was unable to confirm to us how this person should be transferred safely. The care plan had been reviewed in March 2018 and had not been updated to reflect this person's current needs. For the second person we found the same concerns, information recorded in the person's care plan did not reflect what we observed during our inspection. This meant these people were not transferred in a safe way and staff did not have the information available to ensure these people were not placed at risk.

We could not always be sure risk assessments and care plans were followed to ensure people were safe. For one person we saw documented in a eating and drinking care plan. 'Unable to feed myself and need assistance to eat and drink.' It was also documented that this person needed 'a specialist diet as they couldn't chew.' During our inspection for both breakfast and lunch we saw this person ate independently. During breakfast we also observed that no staff were present in the communal areas whilst they were eating. This meant this person was placed at an increased risk as they did not receive the support as recorded in their care plan. We looked at records for another person. It was assessed that they were at high risk of developing pressure damage. There was no guidance in place for staff to follow as to how to reduce the risks for this person. We spoke with a member of staff who said, "I am not sure they are at risk anymore." This meant when people were identified at risk staff did not always have the necessary information to offer the correct support.

On arrival at our inspection we saw that one person had their tablets on a table next to them in the communal area. There were other people in the communal area some who were mobile and the nurse was not present. After approximately 20 minutes the person administered these tablets independently which was not witnessed by the nurse. Furthermore throughout the morning of our inspection we saw that two

other people had their medicines in their bedroom for them to administer independently. We checked records for these three people and there were no documentation or risk assessments in place in relation to this. Two of the three people confirmed to us that their medicines were left with them each day and the nurse did not observe these being taking. One of the people said, "No they don't come back and check if I have had them." Another person told us, "They always bring me my medication and just leave it with me." This meant we could not be assured that correct procedures for administering medicines were followed and people were placed at increased risk of receiving the wrong medicines.

At our last inspection there were procedures in place to manage infection control within the home. However, we could not be assured these were always effectively implemented as we observed two people were transferred using the same sling. People using the same sling increases the risk of cross infection. At this inspection we observed the same concerns. We saw that three people were transferred in communal areas using the same sling; furthermore some of these people were transferred to receive personal care in the bathroom. We spoke with staff who told us, "There are still not enough slings for everyone. There are only two for the standing hoist, one medium and one large". Another staff member said, "Not everyone has their own sling so they have to share. There are two or three people who have individual slings." A relative also raised concerns they told us, "I have concerns about infection control. They use the same sling for everyone which cannot be right."

In the action plan the provider sent us following our last inspection they told us, 'The provider is satisfied that there are sufficient slings in the home to meet individual client's needs safely and no further purchases are required at this time.' This meant the provider had not considered our information and had not taken the necessary action to reduce the risk of cross infection within the home. We were told and we saw during our inspection that when people had a percutaneous endoscopic gastrostomy (PEG) in place infection control procedures were not followed in line with NICE guidance. A PEG refers to a flexible feeding tube which is placed through the abdominal wall and into the stomach. We saw and the home manager confirmed that syringes people used were stored on tea towels in their bedrooms. This demonstrated infection control procedures were not always followed.

We could not be assured that equipment within the home was clean, suitable for the purpose or properly maintained. People and relatives raised concerns about equipment within the home. One person said, "The bath chair is sometimes a problem, they get you up on it and then it gets stuck, so you are up there with no clothes on until they can get it working again. I think this is bad for the staff and it often hurts them trying to sort it out." Another person told us, "If I press my buzzer I have to wait to go to the toilet. This is not because there are not enough staff but because the only working hoist is already in use. I have had to wait over an hour on occasions by which time it is too late. It's unpleasant and degrading but not fair to blame the staff". We saw in people's risk assessments that daily checks should be completed on equipment such as the hoist. We reviewed this and saw this was not being completed. The equipment had been externally tested and after our inspection the provider sent us further evidence to confirm this. Relatives also raised concerns, one relative said, "Most of the equipment is old and dated. The chair in that bathroom is very rusty". We observed this was correct. Another relative told us, "The chairs are in bad condition, they are stained, smell and are damaged in places but they are still using them." We saw people's comfortable chairs we ripped, many had tears or holes in them and they were unclean.

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

Although we observed that since our last inspection more staff were available for people. People still had to wait for support at mealtimes. At lunchtime we observed that people were seated waiting for lunch for 15

minutes before it was served. Once lunch began to be served 25 minutes later seven people were still waiting for staff to become available to support them with their meals. This was as people could either not mobilise independently to collect their meals or they needed one to one support from staff to eat. We saw that during mealtimes one staff member went on their break, meaning the number of staff available to offer support to people reduced. We spoke with staff about this. One staff member said, "Yes it's a change the registered manager made since the last inspection, the times of breaks have changed. Having it at this time has impacted on the lunch experience for people." This was information that the provider had put into their action plan. We also saw that the home manager who told us they were not included in the staffing numbers on the day of our inspection was supporting people during lunchtime.

People raised concerns about staffing levels within the home. One person said, "The staff numbers did go up and we had a 'floater' who was able to come around and spend a bit more time with us, just sorting out the little things the others don't have time to do and having a chat. They tell me this has changed again now and we are back to the basics again." Another person told us, "I do have a buzzer and they usually come quite quickly if I press it, but there are still some days when they are short staffed that I have to wait a while." Since our last inspection five fewer people were living at Prestwood Coach House. One staff member said, "We increased the numbers of staff after the last inspection but as the numbers have reduced again. so have the staff. It's based on occupancy and not people's needs." They went on to say, "We can't get everything in its rushed we would like time to spend with people and do things properly." Another staff member told us, "Sometimes we feel like we are racing around." The home manager confirmed to us that numbers of staff had reduced and that staffing levels within the home were based on the occupancy and not the individual needs people had. This meant we could not be sure there were always enough staff to offer support to people.

This is a continued breach of Regulation 18 (1) of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

Procedures were in place to ensure any concerns about people's safety were reported appropriately to the local authority. However we could not be assured these procedures were followed and all concerns were reported as safeguarding incidents when needed. For example, we saw an alleged incident of theft that occurred within the home had been documented. Although this had been recorded and some internal investigation had taken place this incident had not been resolved and had not been reported to safeguarding for consideration. This meant people were not always protected from potential abuse. We also saw that when medicine errors had occurred within the home these had not been considered as potential safeguarding concerns. The home manager confirmed to us these incidents had not been reported. This meant we could not be sure all incidents had been considered as potential safeguarding concerns or reported appropriately.

This is a breach of Regulation 13 (1) of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

When incidents occurred or things went wrong within the home there were no current systems in place to demonstrate improvements could be made and lessons learnt. We spoke with the home manager and asked them to provide any evidence of this to us; we did not receive this during or after our inspection.

When people had medicines that were on an 'as required' basis we saw there was guidance known as PRN protocols available for staff to ensure people had these medicines when needed. There were effective systems in place to store medicines to ensure people were safe from the risks associated to them.

At our last inspection we raised concerns with cross infection in relation to the use of commodes. We saw and staff confirmed this had been resolved. Another staff member said, "People who need one have them in their rooms now so we just use those for that person." Another person staff member told us, "I'm not sure we had anymore, we just thought it would be better like that, it's not nice sharing equipment like that." We saw that domestic staff were available during our inspection and were cleaning various areas within the home. Staff confirmed that there were protective equipment such as gloves and aprons available for them when needed. This demonstrated that protective equipment was used in the home in line with infection control procedures. We also saw displayed in the entrance that the home had been rated as five stars by the food standards agency .The food standards agency is responsible for protecting public health in relation to food.

A member of staff who had recently started working at the home confirmed to us they completed all the relevant checks before they were able to commence in their role. This meant the provider had checked staff's suitability to work in the home. As we had checked staff recruitment as part of our last inspection and found no concerns we did not revisit this as part of this inspection.

Requires Improvement

Is the service effective?

Our findings

At our last inspection it was unclear when people lacked capacity to make decisions for themselves, and when needed, decisions had not always been made in people's best interest. People were unlawfully being restricted and this had not been considered. This was a breach of Regulation 11 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014. We also found referrals to partner agencies were not always made in a timely manner and concerns were raised around the training and induction of agency staff. At this inspection we found some improvements had been made however further improvements were needed.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so or themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked to see if the principles of MCA were followed. When people lacked capacity to make decisions for themselves capacity assessments were not always in place. At our last inspection it was unclear how decisions regarding people's capacity had been made and all the assessments we looked at were generic. Capacity assessments we looked at did not always have a date and there was no outcome to the decision if the person lacked capacity or not. At this inspection we found the same concerns. We looked at a capacity assessment for one person who we had looked at during our last inspection. No changes had been made since our last inspection despite us raising concerns. We had found at our last inspection consent forms continued to be been signed by relatives on behalf of people even when people had the capacity to do this themselves. We were told by the home manager that relatives had the legal power to do this however when we reviewed the relevant documentation this was not always correct. This meant the principles of MCA were not followed.

At our last inspection we found when people were being potentially restricted this had not been considered. The registered manager told us that applications to the local authority had not been made. At this inspection we found a person we had raised concerns about had been referred to the local authority and a DoLS approval was now in place. However, there were no capacity assessments in place for the restrictions that were placed upon this person, meaning the correct procedures and the principles of MCA had not been followed. For other people we looked at, some people had capacity assessments in place in relation to 'making decisions that affect their life and well-being or 'unable to make decisions that affect their life.' However when restrictions had been placed upon these people such as use of bed rails or sensors these areas had not been considered or assessed. When people lacked capacity we did not see how decisions had been made in people's best interests. We discussed this with the registered manager who told us, "I have assessed people". However they were unable to provide us with this information.

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

Staff received an induction and training to help them offer support to people. Although staff told us the training they received helped them support people, we could not be assured how effective the training was. For example, staff told us they had received MCA and DoLS training however some staff did not demonstrate to us an understanding in this area. One staff member said, "I am unsure on this". Another staff member asked if it was the same as safeguarding. The registered manager also did not demonstrate an understanding to us. Staff also told us they had received safeguarding training and were able to demonstrate an understanding of this. However as safeguarding's had not always been reported in line with procedures we could not be assured staff understood their role and responsibilities in this area. Staff also told us they had received moving and handling training however we observed unsafe practices during our inspection. This meant we could not be sure the training staff received enabled them to support people as needed, and that the provider was checking the competencies of staff after they had receive training.

We received mixed views about the food people received within the home. One person said, "The food is okay but the meat is not always very good quality." Another person said, "We have a choice, the food on a whole is nice." We saw that at meal time people were offered a verbal choice of meals. Throughout the day people had hot and cold drinks next to them on tables. We saw that one person had a hot drink next to them on a table for several hours before they started to drink it. We spoke with the person about this. They said, "Its stone cold, I could do with a fresh one." They then looked around for staff and shrugged their shoulders when one was not available. This meant we could not be sure people were always happy with the food and drink they received. After the inspection the provider completed a mealtime satisfaction survey and sent this to us. This confirmed that people had mixed views on their mealtime experience. When people received soft diets we saw this was provided for them however relatives raised concerns about the choices people were offered. One relative said, "They have to have a soft diet so whenever I come they tend to just have potatoes and gravy." Another relative commented, "They have to use thickener in my relations drinks but they are usually so thick it will not come out of the cup." After the inspection the provider sent to us menus that were available for people to choose from, we saw there was a choice offered each day for all foods including soft diets.

At the last inspection we saw the home was not designed to support people living with dementia, we did not see any signage or adaptations that would offer appropriate support for people. For example, all bedroom doors were the same; there were no pictures or personal objects in communal areas that may help people identify rooms as being theirs. At this inspection we found the same concerns.

At our last inspection we found referrals to health professionals were not always made in a timely manner. At this inspection we saw the people we had raised concerns about had been referred to the relevant professional for advice. We saw recommendations for these people were now in place. During our inspection these people were supported in line with these requirements. For other people we reviewed we saw that they had not always been referred to the relevant professionals for assessments with equipment. For example when people were using equipment to access the bath or shower. This meant people were not always referred to health professionals when needed.

People had the opportunity to attend health appointments when needed. One person said, "If I am unwell I can ask to see a doctor". A relative told us, "The team leaders are very responsive to my relations needs. If they are concerned as they are a bit under the weather they will report to the nurse straight away." Records confirmed people saw the doctor and chiropodist when needed.

At this inspection we found when agency staff were working within the home an induction of the building had been completed with them.

We saw when needed some information was available in care files relating to current legislation. For example; one person had been seen by a specialist nurse. There was printed guidance alongside the persons care plan with information in relation to their specific conditions. This meant staff had this information available to consider when offering support to people.

Requires Improvement

Is the service caring?

Our findings

People were not always supported in a dignified way. We saw when people were hoisted staff were not always mindful of people's dignity. On one occasions we saw a person's clothing was not adjusted so their dignity could be maintain. Staff were not always patient when supporting people. At lunchtime we saw one person was offered one to one support by a staff member. The staff member tried giving the person more before they had finished each mouthful. At one point the staff was holding the persons hands down on their lap to prevent them from pushing the spoon away. This demonstrated care sometimes appeared rushed and people were not always supported in a kind and caring way.

People's choices were not always respected. One person told us they were unable to use a professional of their choice, this person was able to make decisions for themselves. The person told us, "I want to use this independent person to visit here who I would pay privately; This was refused by the providers as they did not have the relevant checks." The person was very angry and upset by this and felt they were being restricted from making a personal choice. They said, "It is my Human Right to have whoever I wish offer me support, I do not see what grounds they [the providers] have to dictate this to me and prevent me from looking after my own health and wellbeing." We spoke with the home manager who confirmed this was the case. They told us it was the decision of the providers. The person added, "I think the provider should come and explain the reasons for refusing to let me have my own hairdresser. It's not right to refuse me, it should be the least they can do."

Most people were happy with the care staff who supported them. One person said, "They are a good bunch of girls and I get on with them very well." Another person told us, "The staff are very caring and they work very hard." The atmosphere in the home was friendly and relaxed and we saw staff laughing and joking with people throughout our inspection. People were supported to maintain contact with their friends and family. People told us their relatives and friends could visit whenever they wanted and were welcomed and acknowledged by the staff who were familiar with them. One relative told us, "The care staff are friendly and welcoming. They always say hello and if I asked them anything they try and get the answer for me."

People were offered verbal choices on how to spend their day. We saw some people choose to spend time in their rooms. One person told us, "I chose to remain in my bedroom. I have all that I need in here. I have lots of visitors and do not need the company of the other people that live here." Staff told us they offered people verbal choices about what clothes they would like to wear, what activities they would like to participate in and what they would like to eat. We saw during our inspection people were offered these verbal choices.

Inadequate

Is the service responsive?

Our findings

At our last inspection we found people did not always receive individualised care in their preferred way. Care plans were not always reviewed to reflect people's needs and when people had cultural needs these had not always been fully considered. This was a breach of Regulation 9 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014. We also found people did not always know how to complain and the home had not fully considered how to support people living with dementia. At this inspection the provider had not made the necessary improvements.

People's care was not assessed to ensure it was safe and relevant to their needs. We saw documented in people's care files that some people could not access the bath or use some of the equipment within the home. For example, in one person's care file it stated, 'Person is included in the weekly bath list, due to poor posture the person is unable to use the bath chair.' There was no other information recorded as to how they were supported. We spoke with staff about this. A staff member explained to us why the bath chair was unsuitable. They told us this person used a different piece of equipment that was purchased for another person. We asked to see to the assessment from the health professional who had deemed this equipment as suitable. The staff member said, "They have not been assessed, the staff made the decisions. We were told to try them in it and it seemed okay so that's what we used." This meant people were not appropriately assessed to use equipment.

A relative also raised concerns in relation to a pre admission assessment that had been completed by the registered manager. They told us they were informed that the relevant equipment which was needed would be in place for the person when they moved into the home. When the person came into the home they felt the correct equipment was not provided for them. They told us they had requested this equipment from the home and as it had not been provided they had purchased the equipment themselves. The relative said, "We asked repeatedly for these but they were not forthcoming, which is disappointing as it's a nursing home." The provider had identified in their 'equipment required for admission assessment' what equipment was needed. The provider had not referred this person to the relevant professional before they were admitted to the home or since they had been there so their needs could be appropriately assessed. This meant we could not be assured the equipment this person was using was safe and appropriate to their needs.

People did not receive care in their preferred way. A person told us, "Everything is done in a very regimented way, we are not treated as individuals and our needs are not addressed properly." Another person said, "I don't really have a say when I get up or go to bed the staff just tell me when it is time." At the last inspection people raised concerns that they could only receive a shower once a week. At this inspection no improvements had been made. One person told us, "I have a shower once a week, I have requested to have one daily or at least twice a week would be better. I have been told they could not do this for me as everyone will want it and they don't have the staff." All the residents we spoke with and documentation confirmed that people only had a shower or bath once a week. A staff member said, "It is awful we are the ones that have to tell the people no, we would love to be able to do it but we just don't have the time. People can't have the care they want, it's embarrassing." We spoke with the home manager and registered

manager who did not understand the importance of providing care that was personalised to people's individual needs and preferences. The home manager said, "It's a care home people have to accept that what happened at home won't happen here." They continued, "We can't honestly offer someone a bath everyday due to time. If we had infinite staff numbers then I guess we would."

The care plans we looked at did not always reflect people's individual needs. For example since our last inspection a choking risk assessment had been introduced for people who were at risk. The information in each of these risk assessments were the same and photocopied for each person and did not details the relevant individual risks people may have. There was a section on the risk assessment where the person's name and diet could be written. We discussed this with the registered manager who did not see this was not individualised. Furthermore other care plans continued to be written clinically and sentences or paragraphs that did not apply to people continued to be crossed out. When people needed individual care plans for specify areas of care these were not always in place. For example one person had a PEG in place there was no care plan or risk assessment in place for staff to follow to ensure they were supported in the correct way.

This is a continued breach of Regulation 9 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

At our last inspection we found people did not always know how to complain. At this inspection we found further concerns. The home manager told us since the last inspection no complaints had been received. However people and relatives told us concerning information. A person told us about a complaint they had recently made about some equipment. They told us this had not been resolved and they had not been updated. We could not see this complaint had been recorded. We spoke with the home manager who confirmed no action had been taken. This meant the provider had not responded to complaints in line with their procedures. People and relatives told us they did not know who to complain to and were not happy with the actions that were taken. One person said, "I have written complaints in the past but no-one ever looks at them or come back to discuss them so why bother." A relative said, "There is a huge blame culture between the Home Manager and Registered Manager. One blames the other but it just seems to get just get batted back between them and the problem does not get resolved." Another relative told us, "I am not sure now who to complain to because the registered manager and the home manager just pass it back to each other."

This is a breach of Regulation 16 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

At our last inspection the home was supporting people who were living with dementia; but they had not fully considered any dementia support. For example, at mealtimes people were asked the day before what they would like to eat at mealtimes. There were no pictures or prompts used to support people to make their choices and there was no reminder of what they had ordered when the meal arrived. Therefore we could not be sure people understood the choices they had made. At this inspection no improvements or changes had been made. Staff were not aware of accessible information standards (AIS) and we could not see how this was used within the home. AIS were introduced by the government in 2016, it is a legal requirement for all providers of NHS and publically funded care provision to make sure that people with a disability of sensory loss are given information in a way they can understand. Communication care plans were in place for some people. When people had sensory loss such as visual impairment there was no specific guidance or resources available within the home for these people to effectively communicate. The communication plans we looked at detailed information such as, 'encourage two way communication' and 'speak slowly', meaning people's communication needs had not been fully considered or assessed.

People and relatives did not feel involved with planning their care. None of the people we spoke with felt they had any involvement or understanding about their care plans. One person said, "I am not involved at all, if I was my choices and preferences would be taken into account and considered. I try to be involved as I keep telling them what I want, but does that happen, no." Some of the relatives we spoke with were not aware of a care plan and were unsure if an up to date assessment of their relations needs had been made. One relative said, "I feel communication around this is lacking." Another relative told us, "My relation has a specialist need but we are not really sure what the care is of this no-one has discussed it."

At our last inspection people's cultural needs were not fully considered. We saw for the person we raised concerns about at our last inspection a care plan had been put into place to offer support to the person with this. This meant the provider was considering people's cultural needs.

People had the opportunity to participate in activities they enjoyed. One person said, "There are things going on that I can get involved in if I wish to." We saw displayed around the home up and coming events. This included external entertainers. We saw that daily newspapers were available for people to read within the home. There were activities coordinators in post and we saw they supported people to participate in activities. During the morning of our inspection people had the opportunity to be involved with a baking session.

There was currently no one receiving end of life care as we had receive this at our last recent inspection we did not review this information again.

Inadequate

Is the service well-led?

Our findings

At our previous two inspections we found there was a lack of confidence that concerns raised would be dealt with and people did not always know who the registered manager was. Quality checks were in place but did not always bring about changes. This was a breach of Regulation 17 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014. We also found that we were not always notified of significant events within the home. At this inspection we found the provider had not made the necessary improvements and we found further areas of concern.

We have inspected this service twice within a five month period. After our last inspection we requested an action plan from the provider on how they were going to make improvements and comply with the regulations. We did not receive this action plan within the times scales we set. We followed this up with the provider and the action plan was sent to us 12 days after it was due. Since our last inspection we have also received whistle blowing information on the service which raised concerns to us.

In the action plan we received on 17 January 2018, the providers gave us assurances they understood and could meet the legal requirements under regulations 9, 11, 12, 17 and 18. The action plan included action such as, 'Departmental Managers will be more involved in formal and regular Quality Checks to drive improvement throughout the home.' As at this inspection we could not see this was being completed we could not be assured the providers understood the requirements of the regulations to ensure they were compliant. Furthermore the provider is still in breach of regulation 9,11,12,17 and 18 as well as new breaches. Therefore the provider has not taken the necessary action to ensure improvements have been made within the home.

There was a registered manager in post. People, relatives and staff continued to raise concerns about their availability within the home and the support they provided. One person said, "I don't see the registered manager and I am not sure they visit very often. I understand from the staff they are not very supportive." Another person told us, "I don't think the home is well led." Staff and the home manager confirmed to us since our last inspection the registered manager had not been involved with the running of the home. One member of staff said, "Nothing at all has changed. I have read the report as I saw it on line but the registered manager has not shared it with us or discussed it with us. They just do not care." Another staff member said, "I think [Registered manager] may have been in here once since you last came." We reviewed the action the provider and registered manager had sent to us since our last inspection stating how they would comply with the regulation. We could not be assured the registered manager understood their responsibility around registration with us as they told us, 'A photograph has been displayed in the foyer of the home which also identifies [registered managers name] as the Registered Care Manager for clarity in future."

Staff continued to feel that they were not listened to by the registered manager and the providers. One staff member said, "We raise our concerns, for example about the profiling beds but nothing changes. We have been raising this for years." The home manager told us they shared this with the providers at their health and safety meeting. We saw documented that 18 beds were required. Two people had these in place and they had purchased their own. The risk assessment stated the home manager had been raising their

concerns with the providers for 12 months. After the inspection the provider sent us information confirming five beds had been purchased. This meant that 13 beds were now required. The provider also confirmed to us that investment will continue and will include the purchase of additional profiling beds and other equipment. They also told us they has made significant financial investment in the home over the last few months to provide excellent catering facilities, wet rooms, addressable fire alarm system and automatic lighting which enhances the environment and new suspended ceilings in all communal areas.

People, relatives, staff and the home manager continued to raise concerns about the management of the home. A person told us, "The owners do not have enough involvement and the staff are not supervised or supported, I think they only care about the money. If they cared about the residents or staff they would support them better." A relative said, 'I know they find it uncomfortable when we are here because we challenge them." Another relative told us that providers were, "Very negative and defensive." At the last inspection the registered manager who is also the nominated individual told us the home manager was responsible for the day to day running of the home. However this staff member worked as a nurse and did not always have the time needed. Since our last inspection the home manager had been given protected time for three days a week. Staff and the home manager confirmed they had received no additional support from the registered manager since our last inspection. On the day of inspection the home manager was additional to the numbers but as there was only one nurse on duty we saw they were supporting people with clinical needs and due to people having to wait at mealtimes they also supported people. This meant the home manager did not have the time or support to manage the home.

We saw that some audits were completed by the provider however they were not always effective in identifying areas for improvement, as they were not always completed in a timely manner For example, we saw that a medicines audit had been completed. However this had not identified a medicines error we had identified during our inspection. This meant we could not sure the audits in place were effective in identifying concerns. The home manager told us they had identified this error however as it was an agency staff member no further action had been taken. Furthermore one of the actions from the medicines action plan that had an immediate start date was not always being completed. No one had identified this and action had not been taken to rectify it.

We also saw when incidents occurred within the home the provider was completing a tally of this information. For example when and where the incident occurred. We were told and we saw this information was then shared at the health and safety meeting for discussion. When we reviewed this we found the information was not always accurate. For example, the amount of incidents that we saw in the accident and incident records did not match what was shared at the meeting. When trends were present, for example incidents had occurred during the night this had not been identified or shared. This meant action was not always taken to drive improvements within the home.

People and relatives told us their opinions were not sought or considered. One person said, "I have never had a general questionnaire to complete about my satisfaction of the home." Another person told us, "I have never been invited to a residents meeting, I don't think they have them." The home manager confirmed these were not taking place. Another person said, "We don't have any questionnaires to complete or any residents meetings." We saw that there was a suggestion box in the entrance to the hall. Relatives told us they had put comments in there. We spoke with the home manager who told us, "I don't have a key the provider has that. Nothing has been shared with me so I am unaware."

Records were not stored securely. People's care files were stored in an unlocked cabinet in an unlocked room; we were freely able to access these through the inspection. We also saw confidential information about people's dietary requirements were displayed on the hatch to the kitchen, when this was opened it

was visible to people and relatives who were in the communal area. This meant people's rights to confidentiality were not always maintained.

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

The provider had not notified us of all significant events that occurred within the home, in line with their legal requirements. For example, we had not been notified about the alleged abuse incident in relation to theft within the home.

This is a breach of Regulation 18 (2) of the Care Quality Commission (Registration) Regulations 2019.

Staff knew about the whistle blowing process. Whistle blowing is the process for raising concerns about poor practices. One member of staff said, "It's about reporting any concerns about poor care people are receiving". Another staff member said, "I would report to the CQC anonymously if I was really worried". We saw there was a whistle blowing procedure in place. This showed us that staffs were happy to raise concerns if needed.

The provider was displaying their rating in the home and on their website in line with our requirements.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not notified us about all significant events within the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care was not assessed to ensure it was safe and relevant to their needs. We could not be assured the equipment people were using was safe and appropriate to their needs. People did not receive care in their preferred way or that was individualised.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Capacity assessments were not always in place and there was no evidence decisions were made in people's best interest.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always transferred in a safe way. Risk assessments were not always in place, followed or reviewed to reflect people's needs. People were not always protected from the risks associated with medicines. Infection control procedures were in place but not

always followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment We could not be assured safeguarding concerns were reported appropriately.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints had not been responded to in line with the providers procedures.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The providers remains in breach of regulations and have not made the necessary improvements needed to comply. There are concerns with the management of the home and the lack of leadership. Audits were not driving improvements. Staff did not always feel supported or listened to.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing People continued to wait for support.