Barchester Healthcare Homes Limited

Sutton Grange

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 9, 23, 27 February and 9 March 2018. All four days were unannounced which meant the service did not know we were going. We undertook this urgent comprehensive inspection as a result of concerning information we received from the local authority in relation to the care people who used the service received. Following the first day of our inspection we met with senior members of the management team on behalf of the provider, which included the nominated individual to discuss our concerns. The service was last inspected on 23 and 24 May 2016 and was rated as good overall. Effective was rated as requires improvement and a recommendation was made in relation to the meal time experience for people who used the service.

During this inspection we identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to; safeguarding people from abuse and improper treatment, staffing, risks, the environment, infection control, deprivation of liberty safeguarding, records and good governance. We will report on our actions for these when this is complete.

We also identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to, consent, staff training, nutrition and hydration, person centred care, dignity and respect, equality and diversity and activities. You can see what action we have taken at the bottom of the full version of this report. We made the following recommendations in relation to induction training for new staff, the timely involvement of professionals and receiving and acting on complaints. We also identified a breach of Regulation 18 of the Care Quality Commission (Registrations) Regulation 2009 (Part 4). Notification of other incidents.

Sutton Grange is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Sutton Grange is registered to provide accommodation for persons who require nursing or personal care and treatment of disease, disorder or injury for people living with a dementia, older people and people with a physical disability. The service can accommodate up to 70 people in four separate units; Banks view, Silver birch, Blossom walk and Red house gardens. Banks View specialised in the nursing care of people living with a dementia, Silver birch specialised in general nursing care, Blossom walk specialised in the care of people living with a dementia and Red house gardens specialised in personal care needs.

On the first day of our inspection 57 people were receiving care at the service. On the subsequent days of our inspection 51 were receiving care at the service. A registered manager is required as part of the services registration requirements. At the time of the first day of our inspection there was a registered manager in post. On day two, three and four of the inspection a new home manager had taken over the day to day responsibility for the home. 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.

Systems to ensure people who used the service were protected from abuse were inadequate. We observed a number of incidents where people were exposed to the risk of harm. Whilst some people told us they felt safe in the home others told us they did not.

Risk assessments failed to include detailed and relevant information to support and protect people from any identified risks. We saw a number of identified risks in the home that had not been acted upon appropriately, such as choking for people who used the service. We identified a number of infection risks in the home, including dirty gloves left in public areas, a dirty soiled bed pan and a lack of liquid soap and paper towels for people to use.

We identified a number of concerns in relation to the safe handling of medicines. Staff were seen to be disrupted during the administration of medicines. Gaps in medication records were seen, which meant people did not receive their medicines as prescribed. Records to administer medicines covertly were brief and lacked detail about how to administer these safely. We were made aware of an incident that had occurred relating to administration of medicines covertly.

We identified a number of concerns in relation to the dining experience for some people living in the home. Records we looked at had not been completed in full and where specialist guidance had been provided we saw this had not been followed.

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.
Relevant assessments and applications to the assessing authority in relation to Deprivation of Liberty Safeguarding (DoLS) had not been completed appropriately. There was no safe system in place to monitor how many people had applications in relation to DoLS. None of the records we looked at had evidence of formal written consent to support the delivery of care to people.

There was insufficient, suitably qualified and knowledgeable staff to ensure people received safe care. Recruitment procedures were in place; however we saw induction training was inconsistent and not all staff had completed relevant inductions. Whilst some staff had received relevant and up to date training and competency checks not all staff had completed training to support the delivery of care to people.

We saw some evidence that people who used the service received good care. However, this was not consistently provided across the service. We saw one person being spoken to in an inappropriate manner and another person was dressed inappropriately.

There was limited evidence that people had been actively involved in the development of their care files in relation to their choices and needs. Some people were treated with dignity and respect; however not all people had a positive experience. We saw staff failed to respond appropriately when one person needed support with their personal care.

Whilst there was some evidence of care planning that supported the delivery of care for people. A number of records we looked at identified significant shortfalls in their content and how they supported the delivery of care to people. Where people required end of life care their care plans had not been developed to reflect their individual needs.

There was insufficient activities on offer to people who used the service. The feedback about the activities on offer to people was mixed.

We saw a system in place for dealing with complaints; however not all complaints had been acted upon appropriately. We saw some positive feedback in questionnaires from people and relatives. System's and processes to assess the quality of service provided was inadequate and therefore failed to ensure Sutton Grange was safe for people to live in. There was a lack of oversight from the management in the home. It was clear a number of shortfalls in the operation of the home had impacted on the safety and delivery of care to people.

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.

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

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

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

You can see what action we told the provider to take at the back of the full version of the report. 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.

We identified a number of concerns relating to how the service kept people safe. We saw a number of incidents that placed people at risk of harm.

We identified serious concerns relating to the staffing levels, knowledge and the deployment of staff in the home. Whilst recruitment procedures were seen to be satisfactory, induction training was inconsistent and not all the records we looked at confirmed staff had completed inductions on commencement to their role.

Risk assessments failed to include detailed and relevant information to support and protect people from any identified risks. We saw a number of identified risks, such as choking risks that had not been dealt with appropriately. We identified a number of infection control risks, which placed people at risk of infection.

We identified a number of concerns in relation to the safe handling of medicines; gaps in medication records were seen. Systems to ensure people received covert medicine as prescribed in line with guidance were inadequate.

Is the service effective?

Inadequate

The service was not effective.

Not all of the people who lived at the home were seen to have a positive dining experience. We saw a number of gaps in food and fluid records for people. Where specialist guidance had been provided we saw these had not been followed.

Relevant assessments and applications to the assessing authority in relation to Deprivation of Liberty Safeguarding (DoLS) had not been completed appropriately. There was no evidence of formal consent recorded in the care files we looked at.

Training records we looked at identified a number of staff had

not completed relevant and up to date training to support the delivery of care to people.

Is the service caring?

Requires Improvement

The service was not consistently caring.

We saw some concerns relating to the care people received. We received some positive feedback from both people who used the service and relatives. However we heard one person being spoken to in an inappropriate manner.

There was limited evidence that people had been actively involved in the development of their care files in relation to their choices.

People's equality, diversity and human rights was not always respected.

Is the service responsive?

Inadequate

The service was not responsive.

Some care plans we looked at had information in them about how to support people's needs. However, a number of records we looked at identified significant shortfalls in their content. This would prevent accurate and safe care being delivered.

There was insufficient activities on offer to people who used the service. The feedback about activities was mixed.

We saw a system in place for dealing with complaints; however not all complaints had been acted upon appropriately. We saw the service had received some positive feedback in thank you cards.

Is the service well-led?

Inadequate

The service was not well led.

System's and processes to assess the quality of service provided was inadequate and failed to ensure the home was safe for people to live in.

There was a lack of oversight from the management in the home. It was clear a number of shortfalls in the operation of the home had impacted on the safety and delivery of care to people.

There was evidence of positive feedback in questionnaires

received from people who used the service and relatives.

Sutton Grange

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part by notification of an incident relating to one person who had lived at the home. At the time of the inspection the incident was subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk of pressure ulcers, care planning, risk assessments, staffing, nutritional support and leadership and management of the service. This inspection examined those risks.

We were also made aware from the local authority safeguarding team of other concerns in relation to the safe care and treatment for a number other people who used the service. These included the delivery of care, staffing, altercations between people who used the service, incidents and accidents and the leadership and management of the home. As part of this inspection we checked whether the service was meeting the needs of people and what actions the provider took to ensure people were safe. During this inspection we identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safeguarding people from abuse and improper treatment, staffing, risks, the environment, infection control, deprivation of liberty, consent, staff training, nutrition and hydration, person centred care, dignity and respect, equality and diversity, records, activities and good governance. We also identified a breach of Regulation 18 of the Care Quality Commission (Registrations) Regulation 2009 (Part 4), Notification of other incidents.

We also made recommendations in relation to induction training for newly recruited staff to the home, the timely involvement of professionals, receiving and acting on complaints.

The inspection took place on 9, 23, 27 February and 9 March 2018. All four days were unannounced which meant the service did not know we were going. Day one of the inspection was undertaken by two adult social care inspectors. Day two of our inspection was undertaken by five adult social care inspectors, one

adult social care assistant inspector and a nurse specialist. The team was also supported by two experts by experience. Both had experience of people living with a dementia and older people. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Day three of the inspection was undertaken by a pharmacist inspector. Day four of the inspection was undertaken by two adult social care inspectors.

Prior to our inspection we looked at all of the information we held about the service. This included any feedback, compliments, safeguarding investigations and any statutory notifications the provider is required to send to us by law about any incidents in the home. We also looked at the Provider Information Return (PIR). 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 took this into account when we inspected the service and made the judgements in this report. Due to technical problems, the provider was not able to complete a Provider Information Return (PIR). As part of our planning we spoke with a number of professionals about the home and the experiences of people living there. We used a planning tool to collate all this evidence and information prior to visiting the home.

To understand the experiences of people who lived at Sutton Grange we undertook observations in all four units within the home. This included the lounge and hallways, as well as observing the dining experiences in all units. We also undertook a tour of the home. This included all communal areas, the kitchen, laundry and a sample of people's bedrooms. We spoke with 16 people who were in receipt of care at the time of our inspection, thirty family members and obtained feedback from one visiting professional.

We spoke with a number of staff working in the home at the time of our inspection, which included three nurses, fourteen care staff, one activities co-ordinator, the clinical lead, one member of ancillary staff and the chef. We also spoke with the new home manager and the new deputy manager, as well as the regional director of the service. We also had a meeting with senior members of the management team. This included the senior regional director, the director of regulation, the chief operating officer and the general counsel and director who was also the nominated individual.

We also checked a number of records relating to the management of the home. These included; care files for 16 people who used the service, eight staff files, the training matrix, duty rotas and dependency tools, audits, surveys and team meetings.

Inadequate

Is the service safe?

Our findings

We received mixed feedback about whether people who used the service felt safe in the home. People or their relatives we spoke with told us, "They are always here when you want them and they work very hard", "I've no reason to be frightened." However, others told us, "No, because of the different men, you have to be careful" and "Not at the moment, a service user [people who used the service] urinates in [name's] waste paper basket. I've asked them [the staff] to keep the door closed. I've asked them to move [my relative] to [another unit]."

We asked staff about the procedures for acting on any allegations of abuse. Staff told us they would report any concerns affecting the safety of people who used the service. They told us, "I would report any concerns to the manager." However, during our inspection we identified a number of risks relating to how the service kept people safe. Examples of these included a high number of incidents and accidents where records confirmed no analysis of patterns or trends had been completed. We saw one person had an unwittnessed fall. Records relating to this incident confirmed no actions had been taken by staff to ensure a medical review had been sought. Where support was required by one person we saw staff responded in an inappropriate manner to deal with their behaviours and support them safely. We also witnessed a number of incidents that occurred during our inspection whilst people were not supervised adequately by staff. This placed people at risk of harm or potential harm.

A system was in place which enabled any investigation of potential abuse to be recorded. However, we noted not all of the allegations that had been raised had been recorded in the records and the Care Quality Commission had not been notified of all of the allegations as required by law. We spoke with the home manager and regional manager about our concerns who told us they were taking action to ensure records were detailed and reflected all allegations of abuse. They also told us all notifications would be submitted to the Care Quality Commission. This would support an analysis of themes and lessons learned could be implemented.

We saw a memorandum to advise staff on dealing with allegations of abuse as well as a whistleblowing (Reporting bad practice) helpline poster for staff to access if they had any concerns about staff practice. There was an up to date policy in place on the provider's computer system. This provided up to date information about how to deal with allegations of abuse. However, the policy we saw in the safeguarding file was dated 2010; therefore it did not reflect the new regulation and guidance that was recorded in the up to date policy.

We checked staff training records. The home manager provided a copy of the most recent training matrix. Not all staff had completed safeguarding vulnerable adults training. This meant not all staff had been updated with the up to date knowledge and skills to act appropriately on any allegations of abuse.

Systems and processes were not established and operated effectively to prevent or investigate abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection we identified a number of serious concerns as a result of the inadequate staffing numbers in some areas of the home. These included an altercation between two people who used the service, one person was seen inappropriately dressed, one was seen requiring support with their continence care, another person was observed eating their lunch in an undignified manner and we saw a chaotic, disorganised lunchtime experience for some people who used the service.

Staff we spoke with raised concerns about the numbers of staff in place to deliver safe care to people. They told us, "We are short staffed we use a lot of agency", "They'd phone us at all hours to come in [due to staff shortages]" and "[There is] Not enough staff. I am expected to do everything, medication, care plan updates, care and help with meals." We were told that staff had been called in to bolster to numbers due to the inspection. One staff member told us they had reported their concerns in relation to the staffing to the manager. They told us, "I said it's not safe. I was told, look at the DICE [Dependency Indicator Care Evaluation] tool and that's what [staff] you can have. It was very stressful." However some staff felt that recent changes in management and further discussions surrounding staffing levels throughout the home had started to show improvements in this area.

We asked how the home ensured they had enough staff in place to ensure people were safe and well cared for. The regional director told us they used the DICE tool to calculate the numbers of staff required to support the needs of all the people. They said care files for all people had DICE assessments that were reviewed regularly. On the fourth day of our inspection we were told that the service was no longer using the DICE tool to calculate the staffing needs for the home. This meant that there was no system in place to calculate appropriate staffing numbers in order to meet people's needs and keep them safe.

We checked a number of care files. Whilst we saw DICE records were in place not all of the evaluations had been completed recently. Where reviews of the DICE had taken place we saw some of these did not reflect people's current needs. This would prevent an accurate assessment of the staffing requirements, which could have put people at risk of unsafe care. One example was where a DICE assessment identified a need in relation to seven areas of a person's care; however we saw no evidence of care plans to reflect this need. Another DICE assessment identified a change in a person's condition; however the risk rating had not been reviewed to reflect this and a third had been completed not reflecting a person's high needs. Two of the staff we spoke with did not express confidence in the use of the 'DICE' tool used in relation to staffing levels.

As a result of the first two days of our inspection the regional director confirmed an increase in staffing numbers on one of the units to ensure people were protected from any risks associated with inadequate staffing in the home. However, on the fourth day of our inspection we saw records in people's care files that confirmed staffing levels to support people's individual needs had not been achieved. We were told by professionals undertaking reviews of people's care that appropriate staffing levels continued to be problematic in the home due to agency staff failing to attend allocated shifts.

We asked people who used the service and visiting relatives about the staffing levels in the home. Some people told us there was enough staff to meet their needs. They said that the recent changes in management and further discussions surrounding staffing levels throughout the home had started to show improvements in the staffing. However, the majority of people on both units said there weren't enough staff and that they had to wait for assistance both during the day and night. Comments we received included, "No, not really [enough staff] you have to wait for tablets when I'm in much pain. They are all very busy", "No, I have to wait for someone to answer the buzzer at night time, I can't tell you how long I have to wait. I sometimes have accidents because they don't answer the buzzer. This morning I said if you don't come I'm going to wet myself, but they're not too bothered. They have quite a few agency staff" and "There are times when we have to wait especially at night, I have to wait ten to forty five minutes."

Relatives told us, "[Name] is supposed to be on a one to one the other night there wasn't much evidence of it; they left [name] with the activity coordinator. On Wednesday me and my [relative] were here, so I don't know if they [the staff] fell back, but the one to one wasn't evident." Another told us, "I am sure there's not, [name is] very vulnerable [name] can't communicate or move" and "A really good nurse who was wonderful to [name] left even without another job to go to. [Name] told us [name] was overloaded working here." We were told by relatives that the home was nice on the surface, but people who used the service were not well cared for due to inadequate staffing levels.

A professional we spoke with also raised concerns about the staffing levels in the home. They told us, "They are constantly very short staffed. It can take ten minutes to identify a member of staff."

During our inspection we asked staff how they ensured people received appropriate and timely care that met their needs. It was clear from the feedback we received that some staff did not understand people's individual needs and were unable to demonstrate an understanding of how to keep people safe. Where we saw people with complex needs had been supported by agency staff they told us they had not received a handover and did not have the required knowledge about how to support them safely. Staff did not have the appropriate knowledge and information to support people's individual needs.

There was insufficient numbers of suitably qualified, competent and skilled staff deployed to meet the needs of people who used the service. This was a breach regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home produced duty rotas which identified the staffing allocation for each shift which was split into each unit. This ensured staff were aware of their shift patterns as well as where they were working on any given day. The home manager discussed their plans for the duty rotas. These provided staff with an over view of a number of weeks duty rotas that would help with planning. Where changes were required we saw notes on the arrangements made for these shifts. It was clear from the duty rotas that a high proportion of agency staff was utilised to support staffing numbers in the home. We noted from a regional directors quality visit which identified a high number of agency hours had been used in January 2018. The home manager told us they aimed to block book the same agency staff to support consistency in the staff team.

On 27 February 2018. We looked at the arrangements for managing medicines and found they did not keep people safe. The home manager and deputy manager had recently made improvements to the storage and management of medicines and this was seen at the inspection. However, we found issues with medicines administration and documentation.

We observed staff administering the morning medicines. Staff gave medicines in a kind and patient way and signed the records after the person had taken their medicine. However, the nurse was interrupted on several occasions by staff members and phone calls. Disruption and interference of staff whilst administering medicines increases the risk of a medicines error, lengthens the time to taken to complete the medicines round, and is not good practice. Medicines that should be given at specific times to be effective were not administered according to recommendations. For example, medicines required before or after food were given together with other medicines during breakfast.

We reviewed the medicines administration records (MAR) for thirteen people who used the service and compared records with current supplies. We found that medicines were not always given as prescribed by the doctor. One person had two medicines missing from their current record, and had not received these medicines for four days prior to the inspection. In addition, the evening dose of a twice-daily medicine had been omitted on twenty one occasions in the previous four weeks, as the person was sleeping and staff had

not considered giving the medicine earlier in the day.

Some people were prescribed one or more medicines to be given "when required". Additional information to help staff give the medicine safely was not always available. For example, one person was prescribed three medicines for constipation and there was no clear guidance about how or when these should be used. Some people were prescribed pain-relieving medicines to be taken when needed, that had a variable dosage and it was not clear what dose staff should give. Staff did not always record the amount given to a person.

We looked at the records for a person receiving their medicines covertly, hidden in food or drink. The person had a medication support plan and a decision had been made in their best interest to give medicines covertly. However, the records lacked sufficient detail to administer the medicines properly and a pharmacist had not advised how to disguise each medicine without reducing its effectiveness in line with the homes management of medicines policy. This person had continued to refuse medicine demonstrating the plan was not effective.

One person required a thickener added to drinks because they had difficulty swallowing. There was no clear information available to care staff who might prepare drinks about the consistency required and staff did not keep records of when and how much thickener had been used. People who used the service were at risk of choking if drinks were given that are the wrong consistency.

We asked to see recent documentation of staff competency training and medicines audits. We saw that one monthly audit had been done in the three months prior to the inspection. Audits (checks) should be regularly carried out to ensure that medicines are used safely, and in accordance with the home's medicine policy. Issues had been identified but actions had failed to prevent the issues we found during the inspection. The provider had a comprehensive medicines competency tool for assessing staff who administered medicines. All staff should undergo an annual competency assessment following the medicines policy. We saw evidence that three staff had undertaken a medicines competency assessment in the last twelve months and these assessments were incomplete. There is a greater risk of errors occurring if staff have not been regularly assessed.

During our inspection the regional director made us aware of a serious incident that had occurred in relation to the administration of covert medicines for one person who used the service. We saw a record had been completed by the GP in relation to covert medicines that stated the family were aware of the covert medicines. However, the family member of this person had not been made aware of the covert medicines administration. We were told that the staff member responsible for the administration of medicines had not ensured this person had taken their medicines safely. This was despite the provider's medication policy which states, 'Witness the person taking the medicine.' The regional director told us of the actions taken immediately to keep people safe from any unsafe medicines administration.

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

During our inspection we undertook a tour of all the units of the home. The home was split into four units with lounges, dining areas and communal bathrooms available for all people who used the service to access. Whilst we saw some areas were clean and tidy others identified potential risks for people who used the service. Examples seen were a trolley that had been left on one unit with gloves, aprons, wipes, towels and continence products on it. We also saw a strap had been left in a bathroom and some batteries had been left on a window sill on one of the units. These items could pose a choking risk to people.

One communal bathroom we saw had numerous items stored in it. These included a chair, mattresses, commode, wheelchair footplates and a pair of slippers. We brought this to the attention of the regional director and clinical lead who told us they would ensure these items were stored appropriately and an interim measure of displaying an out of order sign would be used to prevent people using the bathroom. However on a return visit we checked the bathroom and saw none of the items had been removed and signage had not been displayed to advise people not to use this bathroom. We also saw a number of items stored in a sluice room. These included a walking trolley, pressure cushions and positional cushions. We brought this to the attention of the staff who gave assurances these would be moved immediately.

We looked at how the service managed risks in the home. We identified a number of concerns in relation to people's individual risks and how these had been managed. We saw some examples where risks assessments had been completed and reviewed appropriately. However some records we looked at identified gaps in individual risk assessments for people. For example, one person's records we looked at had no risk assessment in place to safely manage their behaviours or their personal safety. We also saw that where scoring had been completed for risks, the calculations for one person did not reflect their current needs and the risk that had been identified. We saw two care plans with evidence of reviews taking place recently however these did not reflect a change in risk where guidance was in place to reduce their risk of choking. Where another person had risk assessments in place to manage falls and dementia we saw these had been completed however no actions had been recorded on how to manage these safely. This placed people at risk of harm as records did not reflect people's current and individual needs and risks.

We checked the systems in place to record and act on incidents and accidents in the home. We noted a large number of falls and altercations occurring between people who used the service. We saw some evidence that incidents and accidents were being recorded on incident reporting forms. However the records were disorganised and were not stored centrally. When asked for up to date copies of incidents staff found it difficult to locate them. Some records were stored in an incident and accident file however others were left loose in the manager office. This would prevent analysis of patterns or trends and implement measures to keep people safe.

The home manager we spoke with told us they were developing systems to ensure all incidents and accidents were stored centrally. We looked at a number of incident and accidents records. Records indicated the circumstances surrounding the incidents however we saw some examples where the home failed to take appropriate actions as a result of incidents. For example, one person had sustained an unwittnessed fall, which resulted in facial bruising that had not been referred for a medical opinion to confirm no injuries had occurred. Another record we looked at identified a near miss event that had occurred in the home. We could see no record that confirmed the management had shared these risks with the staff team to prevent any future risks. This placed people who used the service at increased risk because staff failed to ensure appropriate actions were taken as a result of accidents or incidents in the home. Of the accident and incident records we looked at we noted that information recorded in accident and incident records was very brief.

The home manager told us a daily walk around of the home was conducted to ensure the environment had been checked and safe for people to live in. We saw evidence in the regional directors quality audits that daily walk arounds had been completed on some occasions but not all days had been documented. This meant we could not be confident regular checks were taking place to ensure the home was safe and monitored for people to live in.

People were at risk of unsafe care and treatment. This was because risks for people were not managed safely and the provider failed to ensure the environment was safely maintained and monitored for people to

live in. This was a breach regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw some evidence of environmental risk assessments and checks taking place in the home. However, on one of the units in the home we saw a broken window restrictor in a public area. We brought this to the attention of the home manager and regional director who gave assurances they would take immediate actions to repair it.

Maintenance logs were in place, which demonstrated actions taken to ensure maintenance work was ongoing in the home. Checks included, water checks, window restrictors, pest control, hoist, wheelchairs, bath aids and sling checks. Service certificates demonstrated relevant service and checks had taken place for gas, electrical and kitchen appliances safety, portable appliance testing, lift and legionella testing. Guidance had been developed in the homes contingency plan that provided staff with the information about how to respond and manage an emergency situation safely.

Records we looked at confirmed an up to date fire risk assessment had been completed by an external company. We saw actions and recommendations had been recorded; however we could see no record to confirm these had been completed. We spoke with the home manager about this who confirmed the appropriate actions had been taken in response to the actions. Relevant servicing was taking place on fire equipment, the fire alarm and emergency lighting. This would ensure staff were alerted to and had access to monitored equipment if required in an emergency. We saw evidence of regular fire drills and fire alarm tests taking place in the home. We checked people's care files and could find no evidence that personal evacuation plans had been developed to guide staff about how to support them in the event of an emergency.

We looked around the home. Whilst some areas of the home were clean and tidy not all areas protected people from the risk of infection. For example cleaning equipment such as a mop, bucket, brush and wet floor signage had been left out in the kitchen area in one of the units on the first day of our inspection. We brought this to the attention of a senior staff member who provided assurance that these items would be moved. On the second day of our inspection we saw these items were still in the same place. We saw three pairs of discarded dirty gloves left on the counter top in two bathrooms on one of the units and a care trolley on another unit. We looked in a communal toilet on one unit and saw a dirty stained bed pan had been left unattended as well as clothing that had been left on top of the bin.

We checked one of the sluice rooms and saw pressure relieving cushions, a walking trolley and a large amount of cardboard had been stored inappropriately. Some relatives we spoke with told us about some concerns in relation to the cleanliness of the home. They said, "One issue I have is cleanliness", [Name's] room and toilet aren't cleaned properly" and "I have to chase after the cleaners sometimes." Others told us the home was of an acceptable standard of cleanliness and that staff always wore PPE when administering personal care.

We saw in one of the bedrooms we looked in a dirty sheet had been discarded on the floor and another bedroom had wound dressings stored next to the toilet in the ensuite facilities. We checked a number of bathrooms on one unit and saw no soap or paper towels were available to people to protect them from the risk of infection.

Whilst we saw some evidence of daily cleaning records being completed we saw no record to confirm an infection prevention audit had been completed that would identify any areas for improvement and reduce the risks of infection. We checked the staff training matrix and saw that whilst some staff had completed

infection control training not all staff had completed this to ensure they had the knowledge and skills to protect people from the risks of infection.

This was a breach regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider failed to have systems in place to protect people from the risks associated with infection.

During our observations we observed staff using personal protective equipment such as gloves and aprons when undertaking personal care and kitchen duties.

We saw safe recruitment procedures were in place that supported new staff working in the home. Records we looked at included appropriate checks had taken place. These included completed application forms, references from previous employers, proof of identity and Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and helps to prevent unsuitable people from working with people who use care and support services.

The training matrix showed most new staff had undertaken induction training on commencement to their role; however not all staff had completed this.

We recommend the provider seeks relevant guidance to ensure newly recruited staff receive an appropriate and timely induction to their role.

Inadequate

Is the service effective?

Our findings

We asked people who used the service and relatives about the knowledge and skills of the staff team. We received mixed feedback. They told us, "They're always here when you want them and they work very hard" and "Some seem to be alright." However others said, "Some of the really good staff left about twelve months ago", "In the main. If they are short staffed agency staff don't know routines" and "It depends, some have no idea of time." A relative told us "[Name] had to tell agency staff where things are."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best 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 whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We looked at mental capacity assessments and best interests decisions in people's care files. We identified a number of serious concerns. One record confirmed the involvement of professionals and family members in these assessments. However, none of the other ten records we looked at where assessments had been completed identified any involvement of either family or professionals in their development. We only saw that these had been signed by the registered manager and one other employed staff member. We looked at information relating to DoLS application in people's care files. We saw only one record that demonstrated relevant information had been forwarded to the assessing authority. We asked management about how many applications had been submitted. None were able to provide accurate, up to date information that demonstrated appropriate applications had been submitted to ensure people were not unlawfully deprived of their liberty. This prevented people who used the service from being protected from unlawful and inappropriate restrictions.

The provider failed to ensure people who used the service were protected from unlawful restrictions. This was a breach of regulation 13 the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment.

We checked to see if people had signed and agreed to their care. Only one care file we looked at had consent for a photograph signed. There was no formal consent recorded in any of the care files that would demonstrate people or their nominated representative had been involved in and agreed to their care. Not all of the care files demonstrated people had been consulted about decisions in relation to their care.

There was very little written evidence to show that people had been actively consulted about their decision

to move into the home. People and relatives we spoke with provided mixed feedback about their care plans and reviews. One person said, "No nothing at all, I have nobody sitting down with me, I'm not that lucky". Only one relative confirmed their records had been reviewed but could not confirm how often this took place.

The provider failed to ensure relevant consent had been obtained to deliver people's care. This was a breach of Regulation 11 the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent.

We asked staff about the training they received to provide them with the appropriate knowledge and skills to deliver effective care to people who used the service. Not all staff we spoke with confirmed they had received the relevant training to support the delivery of care to people who used the service. One person said they received online training and additional training if they requested it. They told us topics covered included moving and handling and first aid. Another said, "It is a mixture of face to face training and some E-learning. I still have bits to finish. The E-learning I haven't finished." One person told us they had not received essential training in relation to medicines management. A member of agency staff we spoke with told us the home did not ask them what training they had undertaken to ensure they had the knowledge and skills to deliver effective care. A professional we spoke with raised some concerns in relation to the knowledge and skills of the staff team to deliver the specific needs for two people. They said, "It took a lot of my time to sort out [the concern] and liaise with the [professional team]. The home should check that the nurses here have the skills."

The staff files and training records we looked at identified not all of the staff team had undertaken training to ensure they had the knowledge and skills to meet people's individual needs. Gaps in the training included evacuation drills, basic life support, infection control, dysphagia and choking. This meant that people were at risk of ineffective care because staff had not received the relevant training to support the delivery of their care.

We asked whether staff received supervision and support in their roles from the management. We received mixed feedback. One person told us they had not had any supervision since commencing at the home several months earlier. One staff told us, "I have not had my last two supervisions that were planned as the manager was busy". Another told us, "The manager was always busy." The training matrix we looked at identified a number of gaps in records relating to staff supervision and annual appraisals. There was some evidence of completed supervision records in the office however there was no consistent system of storing the records to ensure that monitoring of regular supervisions took place. Supervision records we looked at included a review of actions from the last meeting, any issues raised, future actions and any areas of learning identified.

One record we looked at had not been completed in full and gaps were seen relating to actions from any previous supervisions. An individual matrix in this persons file indicated they had only received four supervisions in 2016 and one in 2017. We saw some evidence of practical supervision taking place that covered topics such as completion of food and fluids charts, choking risk and personal care. However, one staff member we spoke with told us they had not undertaken a competency check for medicines administration since they commenced working at the home. It was clear from our observations during the inspection that staff were undertaking their duties with little oversight and supervision from senior members of the staff team.

The provider failed to ensure staff had the required knowledge, skills and competence to deliver appropriate care to people who used the service. This was a breach of regulation 19 the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014. Fit and proper persons employed.

We looked at how people were supported with their food and fluids in the home. Some units in the home supported people in a timely manner; however not all people's dining experience was positive. For example, on one unit we saw people were waiting for very long periods of time to receive their meal. This was because staff told us they had other duties that also required completing before meal service could begin. On another unit we identified some serious concerns. For example, we saw one person was asleep when staff gave them their meal. Staff failed to wake this person up to eat their meal. We saw staff failed to respond in a timely and appropriate way to support one person with their appearance during meal time. We saw another person had spilt their soup. Staff failed to respond appropriately to ensure this person ate their meal safely and no injury occurred. We requested further staff were allocated to one of the dining rooms during our first day of the inspection to ensure people were safe.

We raised our concerns with the management of the home. They provided assurances that measures would be taken to ensure people were safe during their meal time experience. However, we were informed that a similar incident had occurred following the first day of our inspection, which resulted in injury. We observed a chaotic and disorganised meal service for people on one of the units. People were observed shouting and vocalising across the dining area. We observed that one person who was very vocal on the first day of our inspection was eating their meal alone in the lounge on the second day. The rationale was not clear as to why this person was dining in the lounge alone.

We checked the records for food and fluids and identified some gaps in their recording. This would make it difficult to confirm if people who used the service had received sufficient nutrition to meet their needs. Where care files identified people required a specialised diet it was not evident that all people received appropriate meals to ensure a risk of choking was reduced. For example, one person's record identified they required a pureed diet; however food charts recorded that they had eaten cornflakes for breakfast. We asked staff about this who told us this person refused to remain on a pureed diet; however there was no guidance for staff in their records relating to this persons choice of meal consistency. We saw another person who had been reviewed by a speech and language therapist. This specialist had directed staff to provide a special diet. We saw they had not been provided with this. We checked the records relating to their diet in the kitchen and saw these had not been updated to reflect their needs. This put them at risk of choking due to the meals being provided.

Where people had been referred to professionals we saw not all of these referrals had been followed up appropriately. A dietetic referral had been made on behalf of one person. However, there was no evidence within the records we saw to show this had been followed up by the home. Other records we looked at identified weights and nutritional scores were not consistently being monitored. Where waterlow scores have been recorded these had not been updated to reflect a significant weight loss for one person. People were not appropriately monitored to ensure any changes in their conditions were acted upon appropriately by the home.

People were not protected from inadequate and unsafe nutrition and hydration. This was a breach of Regulation 14 the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Meeting nutritional and hydration needs.

We saw some improvements in the dining experience on the fourth day of our inspection and an increase in staffing levels during meals times was seen. However, we still saw some concerns relating to how people were supported effectively to eat their meals. We observed people eating their meals in all of the units within the home. Whilst some of the dining rooms were nicely set with table cloths, mats, napkins and condiments,

not all dining areas had been prepared in this manner for lunch.

There was a rolling menu for people who used the service. We checked the kitchen and saw plenty of supplies of fresh food and vegetables and there was evidence of regular cleaning and temperature checks taking place. This ensured the environment was safe for food to be prepared in. We saw people had access to a choice of meals during meal times. These included three course menus. Snacks were available for people to eat during the day if they so wished. We saw the chef preparing homemade biscuits and cakes for people who used the service. We received some positive feedback about the food served. . Examples of comments included, "I am quite happy with the food here", "It is not the grand hotel but the foods not bad", "I can't complain about the food" and "They will always get you a snack if you don't fancy the dinner." One person said, "Meal times are a testing time, I have to wait." The home manager told us they ensured people who used the service received snacks, milkshakes, fresh fruit and chocolate bars in between meals. We saw people had access to hot and cold drinks throughout the day, however we did receive feedback that snacks were not always provided.

Most people we spoke with told us relevant professionals were involved in their health care reviews, when needed. They said they were seen by a GP if they required it. People confirmed other professionals, such as a chiropodist visited the home to deliver care. We saw a chiropodist and district nurses attending to people's needs during our inspection. Records we looked at identified some evidence of referrals being made to professionals. However, we saw some of these were not always done in a timely manner to ensure people received relevant and up to date individualised care, in accordance with their needs. We recommend the provider seeks nationally recognised guidance to ensure timely and appropriate referrals to the wider professional team are made.

The home had been purpose built and had been split into four units. The home was over two floors and a lift was available for people to use. There were evacuation sheets available on stair wells for people with limited mobility to use in the event of an evacuation. All of the units had accessible lounges and dining areas with satellite kitchens for staff to access during the day. Lounges had TV and DVD players for people to watch DVD's of their choosing. Corridors were large and accommodated people easily where wheelchairs were required. However, we did raise some concerns in relation to the length of some of the units and the risks associated with the lack of oversight by staff for people who used the service. There was a communal area in the entrance to the home with seating, tea and coffee facilities as well as access to a secure outside space for people to use. Gardens had raised planters, a greenhouse and an old fashioned telephone box. This would support reminiscence therapy for people who used the service. We saw one person making use of the facilities in the green house during one of the days of our inspection. Staff told us this person regularly undertook basic garden duties in the greenhouse.

We looked in a number of bedrooms all of which were large and supported people where the use of moving and handling aids were required. All of the bedrooms in the home had ensuite walk in shower facilities. We saw some of the bedrooms contained personal possessions and mementoes of people's choosing. This would promote a feeling of home for the people living there. There was some evidence of basic signage on people's bedroom doors to assist them in identifying which room was their bedroom.

Requires Improvement

Is the service caring?

Our findings

We asked people who used the service and relatives about the care they received in the home. The comments about the treatment by staff were positive and everyone said the staff were kind. They told us, "I am quite happy. I feel well looked after. I have no complaints staff are trying to do a job", "The staff are nice", "The staff are very good, it is not easy to look after [name]. No one is not caring" and "They are very caring, nobody ever walks past [name] without speaking. The staff are really good at managing [names] distress." However others told us, "They are very nice to me, but nobody sits and talks to me. They're not sympathetic. It's a home but it doesn't feel like a home" and "Sometimes I need more attention, but I don't always get it."

None of the people we spoke with said they had a choice when they received their care and told us they just 'accepted what was offered to them.' During our inspection we identified some concerns in relation to the care people received and how this impacted on them. For example we saw staff speaking in an inappropriate and unacceptable manner to one person. We also saw some people had been dressed in clothing that was clearly inappropriate for them. For example, we saw one person had trousers on that were too small for them. This exposed the continence aids they were using. And another whose clothing was clearly far too large and we saw their trousers fall down whilst they were mobilising. We were told that staff did not always respond in a timely manner or spend quality time to support people's individual needs. One comment from a relative was, "It would be good if they could help [name] walk more often and sit and chat to [name]." A staff member we spoke with told us they provided, "Good care, but if we have more staff we would be able to meet their needs."

Most people we spoke with told us they were supported to be as independent as possible and were encouraged to follow their own routines. However, not all people confirmed this. We saw people's individual needs had been recorded in care files. There was evidence that records guided staff to deliver care in a polite and respectful way. However, a number of the care files did not demonstrate the involvement of people or relevant others in their development. This meant that records could not confidently be relied upon to reflect people's individual needs, choices and preferred routines.

There was ineffective systems to ensure people who used the service received appropriate care, met their needs and reflected their choices. This was a breach of Regulation 9 the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care.

Whilst some units in the home appeared disorganised and chaotic during the inspection other areas had a calming atmosphere that supported the delivery of care to people who used the service. During our inspection we saw some staff being caring and compassionate towards people who used the service. Staff were observed being kind, caring and respectful during their interactions with people and their families in some areas of the home. We saw people smiling and demonstrated their appreciation of the engagement of the staff with them. During an incident on one of the units where one person had suffered an injury we saw all staff involved responded in an appropriate way to deliver timely care to them.

The home had policies and procedures in place for autonomy, independence and choice. This would

provide guidance and knowledge to the staff team. We saw some examples of positive meaningful relationships between people who used the service and staff. We saw some evidence that staff understood the needs of people. For example one staff member was observed supporting one person patiently, engaging in conversation and supporting them to eat their meal how they chose. However, feedback from one relative was that staff did not sit and talk with their relative.

A number of people we spoke with told us the privacy, dignity and respect was maintained. Examples of comments included, "Very well, they treat her with respect", "Quite often I find staff sitting and talking to [name]" and "[The staff are] Lovely, they're so nice, really friendly". Relatives told us, "It varies, but there's always respect and care". Another said staff were "Very friendly and [people were treated] with respect." However others we spoke with raised some concerns about the way staff responded to them. They said, "One kisses me every morning and I don't like it, I don't say anything because I don't want to hurt [staff members] feelings", "One or two [staff] will have a chat" and "[Name] has a walking frame but I don't think they're offering it to [name] and [name] doesn't want to upset them by asking."

We saw some people were treated with dignity and respect and some staff we spoke with told us they felt people were treated with respect. However, not all people received the same quality of care. For example we observed several occasions where people were demonstrating challenging behaviours shouting and swearing. Whilst several staff members were witness to this behaviour none of the staff provided support or reassurance to any of the people. Another example was where one person required support to maintain their dignity by supporting their personal care. No staff supported or encouraged this person this was despite inspectors making the staff aware of this need.

There were ineffective systems to ensure people who used the service received appropriate care and treatment. This was a breach of Regulation 9 the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care.

Other examples we saw identified staff speaking with people in a kind and caring manner, talking quietly to people in a respectful way. We saw some staff referring to them by their names and knocking on bedrooms doors before they entered. Another example was where staff spoke kindly to one person and supported them to access treatment from a professional who had visited the service.

We looked at how the home supported people's equality, diversity and human rights. Whilst we saw some evidence that people were consulted about their preference and choice not all staff respected people's diverse needs. None of the people we spoke with told us they were given a choice of the gender of staff to support them.

Where a choice of gender for staff was identified by one person we saw this was not always achieved. We observed personal care for this person was provided by a male staff member despite their gender preference of female staff being recorded in their care file. And we saw a number of occasions where this person was supported throughout the inspection by male staff. This prevented their choice and needs being respected.

There were ineffective systems to ensure people who used the service's individual needs and choices were met. This was a breach of Regulation 10 Dignity and respect.

We saw some examples of people's choices being respected. We saw one person being offered support by a male staff member, but this was refused by them. Staff told us this was respected and the staff member was moved to another unit to ensure female staff were available to deliver personal care to people where it was

required. The home had policies and procedures in place for equality, diversity and inclusion.

We saw no evidence in the home to guide people who used the service, visitors or staff about how to access advocacy support. Advocacy seeks to ensure that people are able to have their voice heard on issues that are important to them. Some of the staff we spoke with lacked appropriate knowledge about the use of advocacy services and how this related to the delivery of care to vulnerable people.

Inadequate

Is the service responsive?

Our findings

We asked people who used the service and their relatives about the development of care files to support their delivery of care. Very few people we spoke with told us their care plans had been reviewed regularly. Examples of comments included, "They have discussed my mobility with me" and "No, but their [relatives] are always speaking to the nurses." We asked staff about how to ensure people received individualised care that met their needs. They told us, "I read [name's] care plan" and "I go through the care plan."

We looked at a number of care files across all of the units in the home. We saw evidence of completed preadmission assessment in the care files we looked at. Areas covered included mobility, nutrition, communication and any specific health conditions. This information was used to inform subsequent care plans. There was some evidence of personal histories and important family members noted in care files.

Some of the care files had some good evidence of care planning in relation to people's specific needs. For example, one record we looked at had good evidence in relation to falls management and professional involvement in the planning of their care. Another care file had information in them in relation to how to support a particular medical condition in the event of a medical emergency. However we identified significant concerns in relation other care files. A number of care plans did not reflect the needs of people who used the service. For example, one care file we looked at contained guidance in relation to actions for staff to follow if there was a deterioration in their skin condition. However, we saw further entries that confirmed this person had an ongoing concern with a pressure sore. This meant out of date and inaccurate information was provided. Another care file we looked at had no reference about how to support the person's mental health needs, despite a medical diagnosis that would necessitate guidance for staff. One persons care file directed staff in the use of mobility aids to support their moving and handling. However when we spoke with staff about this they told us the person did not require the use of a hoist. This meant that records were incorrect and failed to reflect people's current needs.

We spoke with the home manager and regional director about our concerns with the care plans and risk assessments who provided assurances that immediate actions would be taken to rectify the deficiencies in people's care files. However, on 23 February and 9 March 2018 we rechecked a random sample of these. Whilst some areas of the care files had been improved we still identified gaps in the records. For example, one care file we looked at failed to guide staff about how to support and protect people from the risks of their behaviours. Another record we looked at had no care plan or risk assessment to guide staff about how to maintain the person's personal safety. We also saw one persons care file had no care plan to support their continence needs. This was despite inspectors identifying some concerns to staff during our inspection in relation to their individual continence needs. This meant care files failed to reflect people's individualised and current need.

A number of care plans had been completed using a blanket statement about people's capacity and directed that care planning was in the person's best interests. A number of the care files we looked at failed to identify that people who used the service or their representatives had been involved in the development of them. This meant we could not be confident care plans reflected people's individual likes, needs and

choices. We saw information in one person's care file relating to another person who used the service. This meant that accurate and up to date information about this person was not accessible to staff.

Daily records we checked had a number of gaps in their completion. Food and fluid charts had a number of gaps and identified people's intake of food and fluid was poor. We saw no actions had been taken to either act on or report the lack of food and fluids taken by people who used the service. One person's care file identified a medical condition that required regular monitoring of their condition. We saw however that staff failed to ensure this was undertaken as directed. Daily entries had been completed however we noted these were brief and lacked detail about the care that was delivered to people. We noted in another record that staff had recorded where wound dressings were required for them however they had no stock of the dressing. This meant that the directed care this person required was not delivered to them.

We asked about whether people were in receipt of end of life care. We saw records relating to Do Not Attempt Resuscitation (DNAR). One record we looked at had been completed accurately and had been signed by the relevant people relating to these decisions. Two records were seen where people were diagnosed as palliative care however end of life care plans had not been completed.

There were ineffective systems and processes in place to ensure people who used the service had up to date, accurate, complete and contemporaneous records. This was a breach of Regulation 17 the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

We asked people who used the service and relatives about the activities on offer. We received mixed feedback. Examples of comments included, "I read and walk around. I don't want to join in the activities", "I read, I do the activities and they try hard to keep us amused", "Dream, if the activities are interesting I'll go" and "They don't sit and talk on a regular basis, but the activity coordinators do." However others told us, "In the last year they haven't taken [name] out once despite them having a minibus", "If it wasn't for me and my husband taking [name] out [name] would be stuck here", "I do nothing", "Mostly watching TV, I do go for walks, but we don't seem to do activities much anymore" and "They have no time to chat." A relative told us, "They sit [name] in front of the TV and take [name] to watch music. A lot of the time, [name's] left in front of the TV in the main lounge."

Staff we spoke with were unable to provide examples of any activities or trips that had taken place to support residents outside the home, in order to maintain a connection with the wider community. People told us if they went out this was usually organised by family members. Some people told us they were looking forward to sitting out in the enclosed garden during the warmer months of the year.

We saw photographs and details of the activities on offer in the home on display. However, throughout our inspection we saw very few activities taking place and where we saw some activities; people didn't engage in them. We observed on one of the units none of the people were engaged in any meaningful activity by staff. On one of the days of the inspection we saw staff had put on musical DVD for people to watch. We noted that once this had finished the DVD was left on a loop system on the menu setting for a long period of time. This continued until the inspectors brought this to the attention of staff and it was switched off. A relative also told us about one person who utilised an audio book to assist them in engaging in a pastime of their choice. However, they told us there had been a number of occasions where staff had failed to ensure this was available to them. This prevented people from engaging in meaningful activities of their choice. Records relating to activities contained limited information about people's like and choices. However, we saw not all of the records have been completed in full and one record we saw was blank.

On one of the days of our inspection we saw a member of staff was supporting one person in a one to one

activity of their choice. We noted that this staff member was asked by the management in the home to stop undertaking this activity and to engage in group activities for people. The staff member was clearly upset by this direction and told us they were the only staff member who could undertake this activity with them. We spoke with the home manager about this who told us they wanted activities to be offered to all people in the home and not just small groups of individuals.

The provider failed to ensure people who used the service were provided with appropriate care that reflected their individual preferences. This was a breach of Regulation 9 the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care.

We asked people or their relatives if they knew how to complain. People told us they would talk to the nurse in charge first and then if not satisfied they would go to the manager. Some people said when they had raised concerns these had been resolved to their satisfaction. However, a relative told us where concerns had been raised they felt the home had not resolved their concerns in a timely manner.

Staff we spoke with were aware of how to deal with complaints and confirmed they would be confident in raising any concerns with the management. One staff member was able to discuss an episode where they had raised a concern that had been acted upon appropriately by the management.

We saw a complaints procedure in place to guide people, visitors and staff. This provided up to date information for them to follow if they had any concerns or complaints. We noted that some complaints were dealt with in line with the provider's guidance. However, we saw a number of complaints had not been acted upon appropriately. Records had been left out on the desk in the manager's office and we could not see evidence of the actions taken by the management to deal with them. There was no log or system in place that would support the audit and monitoring process of complaints. Following our inspection the provider told us, 'We have a company wide electronic system for capturing complaints and recording outcomes.'

We recommend the provider seeks nationally recognised guidance to ensure complaints are handled responsively.

We saw thank you cards had been received about people's experiences in the home. Comments included, 'Thank you for the love and attention', 'Thank you for caring for our [name] keeping her safe and well', 'You all work so hard and that was always appreciated by me' and 'Just wanted to say how very much we appreciate all you have done to make the move easier.'

Care files we looked at had information in them about how to support people with their communication needs, for example the use of glasses and hearing aids. We saw some information in them that provided staff with the knowledge about how to support their diverse needs. We saw some evidence of people using aids such as glasses during our inspection. One care plan provided guidance for staff about the person's vision and how this impacted on the support they needed. However one relative we spoke with told us, "[Name's] reading glasses went missing despite a label on them with [name's] name." We also saw a pair of glasses left unattended on a care trolley.

We saw all areas of the home utilised computers as part of the daily work. Relevant documentation was submitted via electronic systems to professionals and the Care Quality Commission. This would enable information to be shared in a timely manner.

Inadequate

Is the service well-led?

Our findings

We asked people who used the service and relatives about the leadership and management in the home. We received mixed feedback. Examples of comments included, "I really don't think the management care about the staff as they don't seem to keep the good ones", I have only seen the manager two to three times", "There has not been a settled manager in our time. There had been three managers. The area managers are firefighting." Another told us the management didn't seem to want any input from care staff and let good valued staff leave.

Very few people we spoke with knew there was a new manager in post and could not confirm they had seen the new home manager and as such could not confirm if [name] was approachable. During our inspection the presence of the management in all of the units of the home was mixed. We saw some evidence of the management on one of the days of our inspection; however other days we saw no evidence of any of the management undertaking walk around of the unit unless it was as a result of requests from the inspection team.

We received mixed feedback from staff about the leadership and management of the home. Comments included, "I feel supported", "It has been more organised in the last few weeks. The staff morale is OK it would be better if there was more staff", "The manager to be fair is fine. She doesn't take sides, is around and regular", "[Home manager] is brilliant she has tried everything. I can't say anything bad about her. She is on top of everything and goes around pointing things out that need doing. She is visible on the units", "[Name] as a manager has brought some changes in. I feel supported by the nurses. I don't get supervision", "The manager is visible, I have had more feedback regarding the changes."

The home manager told us they provided out of hours support when they were not in the home. However others told us, "The manager never told us what was happening." We saw feedback in the regional director's audit from a staff member that recorded, 'Feels the management team does not, listen and feels undervalued as a staff member'. Some of the staff we spoke with felt that their concerns surrounding low staffing levels had not previously been responded to as they had hoped by the registered manager impacting on staff morale. Staff also told us the new manager didn't introduce themselves to staff, people who used the service or family and visitors.

There was a registered manager in post during our inspection; however following the first day of our inspection we were told a new manager had taken over the overall responsibility for the home. The service was not well led. There was a lack of strong leadership and a lack of provider oversight. During our inspection we asked for information relating to the needs of people who used the service. The management of the service was unable to provide up to date information. An example was when we asked how many people required the use of a hoist or two staff to provide care.

We found systematic failings in the home that had impacted on the care that people received. This placed people who used the service at risk of harm or potential harm. The risks for people were not managed safely to protect people from harm. The provider failed to ensure the premises and environment was safely

maintained and monitored for people to live in.

Systems failed to protect people from the unsafe management of medicines and failed to protect people from the risks of infection. There were inadequate systems; and processes were not established and operated effectively to prevent or investigate abuse.

People who used the service were not protected from unlawful restrictions. There were ineffective systems and processes in place to ensure people who used the service had up to date, accurate, complete and contemporaneous records and there was insufficient numbers of suitably qualified, competent and skilled staff deployed to meet the needs of people who used the service.

Effective systems were not in place to ensure people who used the service received appropriate care and treatment. There were ineffective systems in place to ensure people who used the service were provided with appropriate care that reflected their individual preferences.

Systems were ineffective to ensure people who used the service's individual, diverse needs and choices were met. Relevant consent had not been recorded as obtained to deliver people's care. People were not protected from inadequate and unsafe nutrition and hydration. Staff did not have the required knowledge skills and competence to deliver appropriate care to people who used the service. Statutory notifications were not submitted to the Care Quality Commission without delay.

There was evidence of the regional director quality visits, taking place, topics covered review of action plans, complaints, clinical meetings, conversations with residents (People who used then service) relative and professionals, staff management, staff rotas, meetings and training. We saw a number of concerns had been identified in the audits that demonstrated systems and process had not been followed. Examples seen were; audits had not been completed for December, lack of reviews of all incidents and accidents, lack of regular resident meetings in all areas of the home, no evidence of any staff meetings, (The home was) behind with supervisions and appraisals. This meant the management team had failed to ensure the home was monitored and managed safely for people to live in.

We saw very little evidence of detailed audits taking place consistently. There was no evidence that confirmed systems and processes were being checked and any gaps were acted upon appropriately. There was some evidence of audits recorded in people's individual care files. We saw notes on the actions required to address the shortfalls identified. However, the audits had not been held centrally to ensure actions were completed and there was no signature to confirm these had been checked and signed off. There was no evidence that call bell audits had been completed in the home. This would ensure people received timely support when they required it, as equipment was working effectively. The regional director told us they would ensure this was completed. We also saw a fire risk assessment had been completed in November 2017. Actions had been recorded; however we saw these had not been addressed. Where records had been completed for incidents, accidents and safeguarding we saw no log sheet had been developed. This would support oversight and monitoring of incidents to prevent future risks and ensure lessons were learned.

We saw information on display advertising resident meetings and a drop in session to meet the area manager. However very few people knew about residents meetings. Some relatives we spoke with told us if they, 'Knew when they were they would attend.'

Staff confirmed that staff meetings took place usually "Every two months" and "Daily at 11am." There was information in the staff room with planned dates of meetings for staff as well as clinical meetings planned in the home.

We saw some minutes from team meetings. Topics covered included, clothes, meals, maintenance and audits. There were minutes from the daily, 'stand up meetings' which the management held with the senior staff team. Topics covered activities, infection control, staffing and recruitment. Whilst there was evidence of these meetings taking place were noted that these had not been completed every day. The home manager told us they had commenced a walk around every morning looking at the environment, care planning and delivery and as a result of the finding she will make changes to ensure people's needs were met. However we were not confident as to the effectiveness of these walk arounds as we identified a number of concerns on all of the days of our inspection.

Systems and processes were not established or operated effectively. This was a breach of Regulation 17 the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

As a result of inspection we wrote to the provider and asked them to advise us of their plans to make improvements in the home. The provider developed an action plan that demonstrated the actions taken by them. They told us they had undertaken a voluntary suspension of admissions until the improvements had been made. The nominated individual was also undertaking regular visits to the home to ensure the improvements continued and were maintained. The home was also working closely with members of the wider professional team as part of a quality improvement process. These included the local authority commissioners, the NHS clinical commission group and the local authority safeguarding team.

We asked about how the service obtained feedback from people who used the service and family members. There was a centralised system where these were recorded. We saw some positive feedback had been obtained about the standards and facilities, care, support, cleanliness, food and drink, staff, safety, security and values for example. Some comments in the feedback included, 'Staff are wonderful' and "Would recommend the home.' Some visitors to the home told us they had received questionnaires and that they had received feedback from them.

The home had developed a welcome pack and information leaflet for people who used the service and their relatives. These provided information relating to the services on offer, contact details as well as information about the provider. We received positive feedback about the changes that had taken place since the new home manager had commenced in their role.

During our inspection it was clear statutory notifications had not been submitted to the Care Quality Commission as required without delay. These included incident, serious injury and allegations of abuse. When we asked the management of the service about statutory notifications they were unable to provide us with accurate information about how many notifications had been submitted.

Statutory notifications were not submitted to the Care Quality Commission without delay. This was a breach of Regulation 18 of the Care Quality Commission (Registrations) Regulation 2009. Notification of other incidents.

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 failed to ensure statutory notifications were submitted to the Care Quality Commission without delay. Regulation - 18. (1) (2) (a) (b) (e)

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 There was ineffective systems to ensure people who used the service received appropriate care and treatment. The provider failed to ensure people who used the service were provided with appropriate care that reflected their individual preferences. Regulation – 9. (1) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect There were ineffective systems to ensure people who used the service's individual diverse needs and choices were met. Regulation – 10. (1) (2) (c)

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 The provider failed to ensure relevant consent had been recorded as obtained to deliver people's care. Regulation – 11. (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People were not protected from inadequate and unsafe nutrition and hydration. Regulation - 14 (1) (2) (b) (4) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to ensure staff had the required knowledge skills and competence to deliver appropriate care to people who used the service. Regulation - 19. (1) (b)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks for people were not managed safely to protect people from harm. The provider failed to ensure the premises and environment was safely maintained and monitored for people to live in. The provider failed to protect people from the unsafe management of medicines. The provider failed to protect people from the risks of infection. Regulations - 12. (1) (2) (a) (b) (d) (g) (h)

The enforcement action we took:

A notice of proposal was issued to impose conditions on the providers registration

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 Risks for people were not managed safely to protect people from harm. The provider failed to ensure the premises and environment was safely maintained and monitored for people to live in. The provider failed to protect people from the unsafe management of medicines. The provider failed to protect people from the risks of infection. Regulations - 12. (1) (2) (a) (b) (d) (g) (h)

The enforcement action we took:

A notice of proposal was issued to impose conditions on the providers registration

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 There were ineffective systems and processes in place to ensure people who used the service had up to date, accurate, complete and contemporaneous records. Regulation – 17. (1) (2) (a) (c)

The enforcement action we took:

A notice of proposal was issued to impose conditions on the providers registration

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 There were insufficient numbers of suitably qualified, competent and skilled staff deployed to meet the needs of people who used the service. Regulation - 18. (1)

The enforcement action we took:

A notice of proposal was issued to impose conditions on the providers registration