P.A.R. Nursing Homes Limited

Atherton Lodge

Inspection report

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22 August 2016

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an inspection on 8, 9 and 22 August 2016. The first day was unannounced. In view of the significant concerns found, we returned to the service unannounced on the 22 August 2016 to check on the safety of the people who used the service.

Atherton Lodge is a privately owned two-storey detached property that has been converted and extended into a care home.

It is registered with Care Quality Commission (CQC) to provide accommodation for up to 40 older people who require personal and nursing care. Some people were living with dementia. At the time of the inspection there were 40 people living at the service.

At the time of our inspection there was no registered manager in place and there had not been one since February 2015. 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. The registered provider had employed a number of managers since February 2015 however they left their post before being registered with the Commission.

At the last inspection on 16 November 2015, we found that a number of improvements were needed in relation to: meeting nutritional people's needs, planning people's care and support, identifying people's health needs and monitoring the quality and safety of the service. After the inspection, we issued requirement actions in relation to breaches of the Health and Social Care Act 2008 which we identified.

Following the inspection the registered provider sent us an action plan stating that they would meet all the relevant legal requirements by 4 January 2016. During this inspection we found that the registered provider had not met these legal requirements and we found further significant breaches of the Health and Social Care Act 2008.

CQC is now considering the appropriate regulatory response to the breaches we found. We will publish our actions at a later date.

People were not kept safe from the risk of actual or potential harm. Risks to people were not properly assessed, reviewed or managed. This included the physical, medical, emotional and mental needs of people who used the service. Staff did not always recognise safeguarding incidents and therefore action was not always taken to ensure that people were kept safe. Accidents and incidents were not always recorded or followed up to ensure people's safety or improve their care.

There were insufficient staff available to meet the needs of people. We found that many of the lounge areas were left unattended and people did not always get the support they required. The registered provider could

not demonstrate how he was assured that the right numbers of skilled and experienced staff were available at all times to meet the needs of the people who used the service.

The management of medicines was not safe which meant there was a risk that people did not get the medicines that they required. Medicines had not always been available and medication which was signed for as given was found on the floor or tables. Medication was not always stored securely or in line with manufacturer's instructions. Records in regards to medicines were not always accurate and did not provide enough information to ensure that the right medication was given to the right person at the right time.

People did not have a choice of nutritious meals and drinks. Some people's diets were very poor placing them at risk of malnutrition but these risks had not been identified. Advice from professionals such as a dietician had not been followed. People had a poor dining experience. Staff did not give some people the option to sit at the dining tables and other people did not get the support they required at mealtimes.

At the time of the visit the service provided support to some adults with functional mental illness which is not in accordance with their Statement of Purpose. Additionally some people were under 60 years of age. Staff did not have the skills and knowledge to support these individuals.

The Statement of Purpose also stated that the service can provide support to people living with dementia who require personal or nursing needs and also people with sensory impairment. We found that the accommodation, adaptations, stimulation and specialised support was not in place to support people with these health conditions. This means that staff could not meet people's needs.

Staff were not familiar with the principles of the Mental Capacity Act 2005 (MCA) when working with people who lacked the mental capacity to make decisions. The CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Some people who used the service were subject to a DoLS but the deputy manager could not tell us if all the authorisations were still valid as some appeared to have expired. Following the inspection, the local authority confirmed they had renewed the authorisations in question.

Whilst people felt the majority of staff were caring and supportive, observations showed that some staff did not know how to manage behaviours which distressed people. Staff responses to this did not always respect people's dignity. People and their relatives commented that they had at times found it difficult to communicate with staff because there had been a language barrier.

People did not receive personalised care which met their needs and some people did not have a care plan in place for their identified needs. Care records lacked detail and some were out of date so did not reflect people's current needs. People had access to health and social care professionals as required, however staff did not always follow advice given by them. People were also at risk of missing health appointments.

Furniture, fixtures and fittings were in need of replacement or repair. Linen and towels were dirty and threadbare. There was a lack of cleanliness throughout the service and a malodour was present throughout the building. There were insufficient bathing facilities available for the number of people who lived at the service. Adequate checks were not carried out on pressure relieving mattresses to ensure that they were working and correctly set.

Staff training was not kept up to date and some staff had not completed training deemed essential for their role. Staff had used moving and handling equipment which they had not been trained to use.

Care staff had been supervised; however supervisors had failed to act upon concerns which staff raised during their supervisions. There was a lack of clinical supervision and oversight of the practices of the registered nurses. This meant that there was risks that people were supported by staff who did not have the skills and knowledge to carry out their roles effectively.

The complaints log could not be located and the deputy manager informed us that no complaints had been made about the service. This was despite family members informing us that they had raised a complaint. There was no evidence of these complaints and how they had been investigated or resolved.

People and their families were not provided with the opportunity to express their views about the service, for example, through meetings or discussions with the registered provider. Staff meetings had not been frequent or well attended.

There was a lack of sustained leadership in the service and staff found it difficult to adapt to ever changing systems, structures and record keeping. The registered provider's governance and auditing of the service had been weak and ineffective. They had been reliant on others and did not demonstrate personal accountability. There had been repeated lack of action where the registered provider had failed to improve or sustain identified areas of improvements.

There was no robust system of quality assurance in place which the registered provider could monitor the safety and welfare of people who used the service. The registered provider did not have a good understanding of the requirements set out in the Health and Social Care Act 2008 and their responsibility to this.

There had been a failure to operate the service in an open and transparent way or in accordance with the law. Significant events which adversely affected people's safety and welfare had not been reported to the CQC as required.

The overall rating for this service is 'Inadequate' and the service is therefore once again placed into 'special measures'.

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

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

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than

12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Poor management of medicines meant there was a risk that people did not get their medication as prescribed.

People told us that they did not always feel safe and adequate measures were not in place to ensure that people were protected from the risks of avoidable harm. The environment was not kept clean and it was in need of remedial repairs.

People received care from staff that had been through a recruitment process but the registered provider had not ensured they had the required communication skills and knowledge to do their job effectively.

Is the service effective?

Inadequate

The service was not effective

Staff were not appropriately inducted into their roles and they had not received on-going training or support to ensure that they were skilled and competent.

People were at risk of having their liberties infringed because staff were not fully aware of the Mental Capacity Act and the associated Deprivation of Liberty Safeguards.

People's nutritional needs were not fully met and they had a poor dining experience. Adaptations and reasonable adjustments had not been made to the premises to meet people's needs.

Is the service caring?

Inadequate

The service was not caring

We observed some positive interactions with staff and people who lived at the service; however staff lacked the required knowledge to provide appropriate care to people.

People's privacy was not always maintained and care records

were not kept securely.

The registered provider had not always taken into account the views of people who used the service.

Is the service responsive?

Inadequate

Care plans did not reflect people's care needs and wishes. Some people did not have a care plan in place detailing their needs.

Staff did not always identify health concerns a timely manner and they did not always deliver care and support to people in the way that was required.

There was a lack of meaningful activities being offered throughout the day.

Where people raised a concern it was not always thoroughly investigated.

Is the service well-led?

Inadequate

The service was not well led.

There was no registered manager in place. The CQC had not been notified of key events within the service.

There was a quality assurance system in place but regular quality audits had not been documented since March 2016. The registered provider had sought the support of a consultant to help identify areas of improvement but there was no evidence of actions taken.

Regular meetings were not held with people who used the service, relatives or staff to ascertain their views and opinions about the service and how it was managed

Atherton Lodge

Detailed findings

Background to this inspection

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

The inspection took place on the 8, 9 and 22 August 2016. The first and last visit to the service was unannounced.

One adult social care inspector carried out the inspection on the first two days and one adult social care inspector and an inspection manager continued with the inspection on the third day.

Before the inspection we gathered and reviewed information held on the service through our notifications and feedback from other professionals. We had been made aware of a number of significant safeguarding concerns by the local authority.

Before the inspection the registered provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with seven people who used the service and seven family members. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us."

We spoke with the new manager, the deputy manager and five other members of staff. We reviewed records held by the service in regards to people who were being supported. This included; care plans, risk assessments, accident records, daily records and medication administration records. The sample of records covered 21 people in total. We also looked at records pertaining to staff and the overall management of the service.

Inadequate

Is the service safe?

Our findings

People who lived at the service told us that they did not always feel safe. Their comments included "I don't go out of my room much now as I am a bit afraid of some of the other people that live here" and "Not all of the staff help me and I am scared to try to do things for myself". Relatives also commented that they were not confident that the service was safe at all times.

People told us that they didn't like being in the lounge as they found it "Noisy" and "Not a peaceful place to sit". We observed that some of the lounge areas were left unattended for long periods of time and due to the nature of their health condition, some people walked around not knowing where to go or what to do. This caused tension and we heard people arguing with each other. Staff told us that one of the lounges was primarily used for people who had behaviours that challenged but were less mobile; so that they could be left without fear of falling for short periods of time. Our observations demonstrated that during these periods people shouted and goaded each other: this caused some upset to others. On one occasion, when the lounge was unattended a person threw a table and drink towards someone sat opposite them. A relative told us that on more than one occasion they had to intervene when people who used the service had an altercation. They said that "I no longer feel [relative] is safe. Records showed that that there had been a number of incidents when people who used the service had harmed or attempted to harm each other. These had not always been witnessed by staff and so indicated a lack of proactive intervention. This meant that people were not protected from the risk of actual or potential harm.

Staff were partly aware of what was meant by safeguarding but we found that some of the incidents recorded or observed had not been recognised as a safeguarding concern. These had not been reported nor any action taken to minimise any further risk. Not all staff had undertaken training in safeguarding.

There was a policy and procedure in place to monitor accidents and incidents. However a detailed and robust analysis of them in order to identify themes and trends had not been carried out. This meant there was no system in place to review this information in order to highlight any improvements that can be made across the service to minimise any future risks to people's safety.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were not protected from the risk of avoidable harm.

All of the people who used the service took medicines and were reliant on the staff to ensure that these were ordered, stored and administered safely.

Medicines were not safely stored. Relatives and visiting professionals had reported to us that the treatment room where medicines were stored was unlocked and unsupervised on a number of occasions. On the day of the inspection the temperature of the treatment room was 25c, which was warm. Therefore, we recommend that this is closely monitored to ensure that this is not exceeded in line with guidance from the Royal Pharmaceutical Society . Supplies of creams, Jevity feeds and food supplements were stored on shelving which was in direct sunlight from the window. This meant there was a risk that medicines would

lose their effectiveness. Medication for disposal was in a box on the floor and loose tablets were in the bottom. This meant that there was a lack of accountability as to who they had been prescribed to. There was an overstock of some items but it was not clear from records if this was due to over-ordering or underuse.

Relatives and visiting professionals reported that they had found tablets on the floor on occasions. However medication administration records (MARs) had been signed to show all medication had been given to people. There was no evidence recorded in MARs to show that people had refused their medication or any other circumstances why it had not been taken. One person was sat in the lounge with two capsules on a table which they had not taken. People who walked about due to living with dementia were at risk of picking these up and taking them. This could have had a detrimental effect on their health. The medication administration record (MAR) had been completed to show that the person had taken their medication. These practices were unsafe and not in line with NICE guidance which states that medicines should be safely stored and a record of medicines given should only be made when the person had taken their medicines.

Some people required medication to be taken via a specialised route, for example, eye drops and injection. Not everyone had confidence in all of the nursing staff that this would be done properly. Concerns were raised by people who used the service and relatives about the competence of some of the nursing staff to administering the insulin safely. This had been highlighted previously to the registered provider who had undertaken an agreement to assess the competency of the nursing staff.

The MAR chart should be clear, indelible, and permanent. It should contain product name, strength, dose frequency, quantity, and any additional information required. We found that this was not always the practice. Information was missing, other records had been completed in pencil and records were not checked for accuracy and signed by a second trained and skilled member of staff.

There was a risk that medication was not being given as prescribed. One person was to take a specific medication every three months but there was no indication on their MAR as to when this was next required. Some medication was instructed to take "As directed": however, staff had not ensured that there was a record from the prescriber of what this actually meant. Another person had been prescribed as required (PRN) medication to be offered at night but on the 8 August 2016 they had been given it in the morning. When prescribing variable doses and 'when required' medicine(s) there should be a care plan in place to advise staff as to why, when and how to offer this. Some PRN records required review whilst others were not in place.

Some people did not have an information sheet alongside their MARs. This meant that staff could not easily identify each person, know what allergies they had or any other key information regarding the management of their medicines. Some people had moved rooms and this information had not been updated on the persons MAR or care plan. This posed a risk that staff may not administer to the right person.

According to their GP notes, one person was at risk of a severe reaction to a specific medication but this information was not recorded anywhere on their MARs. One person had allergies noted within their medical notes but the front sheet stated "Allergies not known".

Nursing notes indicated that sometimes medicines were not available but there was no indication that the reason for this had been investigated or reported. There was no evidence to show that the risks people faced as a result of not taking their prescribed medication on those occasions had been explored.

There was only one nurse on duty and they took on the oversight of all people not just those requiring nursing care. The medication round took them in excess of 3.5 hours each day which meant by the time the round had finished, the next round was ready to commence. This meant that there was a risk that people may not always get their medication at the right time or with the correct time interval. Since the first visit to the service the registered provider has confirmed that two nurses are on duty during the day shift.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider had not ensured the proper and safe use of medicines.

We found the home was not clear and several areas of the environment required attention. People told us that "There are not enough cleaners" and "My bed is always full of crumbs". Relatives commented that the "Cleanliness has gone downhill" and "It has gone to be very smelly in here now". Staff told us that domestic support was rarely available in the afternoon and so they had to try to keep on top of the cleaning during these times.

It was observed we saw that most of the premises was visibly unclean and in need of remedial repair. Carpets and flooring were dirty and in some areas required replacing. Walls, fixtures, fittings and furniture were dirty or damaged: in bathrooms, lounges and bedrooms. Some bed frames were loose, had damaged legs and not all of the mattresses fitted the beds.

Staff informed us that they were only able to use one bath as bath hoists were either broken or not available. New bathrooms had been installed but they could not be used as the necessary equipment was not available. Staff said that one shower was available and sometimes the water temperature was variable. They had resorted to using plastic connectors to use the water from the taps to shower people. This indicated that there were insufficient and unsafe facilities available for the 40 people within the service.

Records showed that there were three days in February 2016 when the passenger lift was out of order for periods of time. No risk assessment was carried out to determine how staff were to safely assist people to access parts of the service.

Whilst call bells were provided, some were not accessible to people as they were trapped down the side of people's beds. Some call bells had long cords and consideration had not been given as to whether these could pose a trip or ligature hazard for some people.

Wall mounted hand sanitizers had been placed in the corridors, but there was no risk assessment carried out as to whether these would be an ingestion risk to some people living with dementia.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the premises was not maintained to ensure that it was safe and clean.

Two recent safeguarding investigations had concluded that the service had taken inadequate steps to keep people safe and had not taken steps to minimise the risks to people. We found that many of the risks that people faced in regards to their physical, mental or emotional health were not identified and there were no risk assessments or management plans in place for these to minimise further risks to people's safety.

A number of people had fallen or were at risk of falls but there were no management plans in place to reduce the risk of further harm. Some people had medical conditions such as diabetes, breathing difficulties, malnutrition or pressure sores; there was inadequate information for staff to be able to monitor and take appropriate actions to maintain people's safety.

Some people had been assessed as requiring a pressure relieving mattress to reduce the risk of pressure ulcers. Where a care plan was in place it did not indicate the type of mattress in-situ or to which pressure it should be set. On the first two days of our visit we found that two mattresses were set at the wrong pressure for the person's weight. A number of the pressure pumps were covered in dust and located right under the beds which indicated that they had not been checked. Staff did not know how to check or correctly set the mattresses and there was no evidence of staff receiving training in their use. One staff member stated "I check by feel" whilst another stated "I know when it is not working as it deflates". This meant that people were at risk of developing pressure ulcers. On the third day of the inspection, the manager informed us they were trying to source the instructions for each of the mattress in order to ensure that the pressure setting was correct.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider had not ensured that the risks to the health and safety of people were assessed and control measures were not in place to make sure that risks were as low as practically possible.

There were insufficient staff available to safely meet people's needs. Rotas indicated different staffing ratio throughout the week. People had differing views on the staffing levels and said that the time that they had to wait for staff could vary from day to day. Relatives commented that staff appeared to take breaks at the same time and, in their opinion, this left staff unavailable to help during some of the busier times.

People and relatives were also concerned that some areas of the service were not adequately supervised: but questioned if this was due to "Numbers or how they are organised". Another relative thought that people were dissuaded from staying in their rooms as staff wanted everyone together. Our own observations supported this view. We found that there were periods of the day when people were not supervised and people were not offered the opportunity of where to sit during the day or at lunch time. The registered provider did not regularly review staffing levels and their mix of skills to make sure they are able to respond to people's changing needs. This is particularly important as the registered provider has stated the service can meet the needs of people with very different health needs ranging from residential care to very complex needs of people living with dementia who require nursing care.

We looked at the recruitment files for two members of staff and saw that the required application forms, references and disclosure and barring checks had been undertaken. However, there were no interview notes kept. This meant that that the registered provider could not demonstrate the robustness of the interview and selection process. There were no other records available relating to employment such as contracts or terms and conditions. We were informed by the registered provider that these were kept at "Head Office".

Inadequate

Is the service effective?

Our findings

People said that they did not have confidence in all of the staff but that some of them were very good. People said that "The food is not very good" and that "I wish we had more choice".

Previous inspections had highlighted concerns with regard to how staff met the nutritional needs of people .This was a breach of Regulation 14 of the Health and Social Care Act 2008. The registered provider subsequently informed us that he would seek advice from the dietetic service. We found that there were on-going concerns and these were confirmed by the dietician.

People who used the service told us that they were not consulted about the menus. Where people lacked capacity, there was no indication in their care plans as to their food likes and dislikes. We spoke to relatives who told us that the person they visited "Would eat soup all day" but did not like sandwiches: we observed that they did not eat their dinner and one of the staff came along and asked if they would like a sandwich as an alternative. On another occasion we saw that a member of staff placed a meal on a table in front of a person in the lounge area. Within five minutes a second member of staff asked the person had they finished and removed the meal. No alternative was offered. The person's care plan stated they needed encouragement with their diet. No encouragement was offered. We raised this to the manager's attention.

Menus did not offer a varied choice for people and a hot meal was available only at lunch time. The chef left before tea; so staff were required to make hot 'snacks' if someone did not want soup or sandwiches later in the day. Where professionals had made recommendations about a person's dietary requirements these had not been followed or recorded in care plans. The poor monitoring and management of people's eating and drinking put them at risk of malnutrition and dehydration.

One family member expressed concern to us that their relative was not eating well and that they had requested staff assist. The family member said that they visited where possible to assist their relative as they were not confident that staff were providing their relative with the appropriate support. The person's nutritional risk assessment had not been updated since the 22 May 2016 and this indicated the person was independent with eating and drinking and had a "usual appetite". Food and fluid charts contradicted this as they showed on some days the person ate or drunk very little. A record of their weight showed that the person had weighed 75.5kg in February 2016 and 69kg in June 2016 but no action had been taken in response to this weight loss. Two people had food charts that showed they had a reduced diet and on some days ate very little. This had not been picked up as a concern.

This was a breach of Regulation 12 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014 because the registered provider had not ensured that a person received appropriate care and treatment.

Two recent safeguarding investigations concluded that the registered provider had failed to address the health needs of people in a timely manner and that this had placed them at risk of further harm. There was a failure by staff to actively seek medical attention or to follow instructions given to them by medical staff. One

person was found to have a letter on file indicating that they had missed diabetic retinopathy appointments: this was despite letters being sent to the person.

This was a breach of Regulation 12 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014 because the registered provider had failed to ensure that care and treatment was received in a safe way.

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 procedure for this in care homes is 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 and found that they were not.

For people who lacked capacity to make decisions about their care and safety, insufficient steps had been taken to assess their ability to make decisions about the care and treatment they received in line with their wishes or best interests. Records did not indicate if people had anyone legally appointed as their representatives to make decisions about the care they received. Whilst care records held some information to identify what decisions people could make themselves this was not consistent and best interests' decisions were not evidenced. Documentation around people's ability to make decisions about their care and treatment was incomplete.
The staff should record a person's informed consent to their medication but this was not in place for all people. Staff did not assess a person's mental capacity in line with appropriate legislation where a person as not able to give informed consent.

Some people were subject to a DoLS at the time of our inspection. These documents were held in a separate file to the care records. Staff were not aware of who had a DoLS in place or who had one applied for. We found that one of the authorisations had expired and the service could not tell us if it had been renewed. We checked following the inspection with the supervisory body who informed us that it had been renewed and the required paperwork had been sent to the service.

At the last inspection, we found that further changes to the environment were required to ensure that it met the needs of those persons living there. Despite the service providing support to people living with dementia and people with sight loss, appropriate adaptions, signage and best practice guidance had not been followed. We found little change to the environment since the last inspection and as previously found clocks were set to the wrong times or were not working. This meant that people were not assisted to be orientated to time and place.

Staff had not received the training and appropriate level of support relevant to their roles and responsibilities. On our last inspection, the registered provider had revised the induction for new staff to meet the new care certificate induction standards. This is an identified set of standards for new health and social care workers. It is expected that registered providers should follow the Care Certificate standards to assess the competence of workers. We found that this had still not been commenced for new staff.

Staff told us that training was undertaken in a variety of ways, including DVDs or "hands on". The training

matrix provided to us showed that not all staff had completed training relevant to their job roles. This included safeguarding, infection control, fire safety, health and safety, first aid, infection control, food hygiene, MCA and DoLS. We found evidence that demonstrated that some staff had not completed moving and handling training until a considerable time after the starting their employment at the service. Staff were not adequately trained and this was demonstrated in their practice and approach to the care, treatment and support people received. Staff did not know about best practice and did not always recognise poor practice.

The registered provider accepted to support some people whose needs fell outside of the remit of its accepted statement of purpose with CQC. Following the last inspection, we made a recommendation that the service found out more about training for staff, based on current best practice, in relation to the specialist needs of people living with dementia. This was to enable staff to understand people's needs and perform their duties more confidently and effectively. There was no evidence that staff had been provided with the necessary training. Records of incidents, care plans and some of the language used in daily records highlighted a lack of knowledge and understanding from staff of people around behaviours that challenged. One staff member told us "I don't always know if what I am doing it right, I just do the best I can". This demonstrated that not all staff had the knowledge and skills to understand and meet the needs of those people at the service.

At the last inspection we highlighted the difficulty that people had in communicating with staff who did not have English as a first language. We raised this with the registered provider as staff employed should have sufficient proficiency to meet people's communication needs in order for them to carry out their job effectively. A number people who used the service and relatives shared an opinion, that on occasions, the language barrier still proved difficult with some staff. We had been made aware, ahead of the inspection, that a number of visiting professionals had concerns in regards to this matter and it was a contributory factor in safeguarding investigations. This had resulted in the care and welfare of people being compromised. The registered provider informed us in July 2016 that he had every confidence that his staff had the required skills; however we found that this was not the case.

Whilst staff had received supervision up until March 2016, there had been no checks undertaken to ensure that any issues identified or concerns raised in those sessions had been addressed. Nursing staff had not received clinical supervision since the area manager left their post in early 2016.

This was a breach of Regulation 12 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014 because the registered provider had failed to ensure that staff providing care and treatment had the required support, competence, skill and experience to do so safely.

Inadequate

Is the service caring?

Our findings

People we spoke to told us that they did not feel cared for. One person was very upset talking about their experience and said "It is awful that this has what my life has come to". Relatives told us that "Whilst staff do their best, they don't have the resources or skills to provide good care".

People's dignity was not respected. At the last inspection we found the some improvements had been made to people's dining experience. This visit showed that these improvements had not been sustained.

A number of people remained in the lounge in armchairs for meals. We did not see people being offered a choice to go to the dining rooms and some care plans did not evidence people's preference. The service was at full occupancy and there were not enough seats available for everyone to sit at the table if this was their choice. Staff assisted some people to eat whilst those that were independent sat and waited for their meals. We saw that some people struggled to eat or cut their food and were in a lounge with no staff available to help. Others sat at the dining tables without table cloths, placemats or condiments. People used plastic beakers and bowls and we were told "That china breaks and needs replacing all of the time". One person required a puree diet and this was served all together in one bowl. The meal did not look appetising or appealing and it meant that people lacked opportunity to experience different tastes.

People lived in an environment that was not clean or well maintained. Linen on some of the beds and towels were thin, stained and threadbare. One relative informed us that they had evidence that their family member's linen had not been changed for over two weeks. On the days of inspection we noted that bed linen was dirty and beds had been made with crumbs still on the linen. We also observed that some people went back to bed but were lying on unmade beds or the plastic mattress covers. This undermined the dignity of those people who used the service.

The use of the lounge in the unit for people living with dementia had been changed into a quiet room/ activities area and at the last inspection; we found the change had been met with mixed views. The registered provider had agreed to monitor the impact of the changes on people. People who used the service and relatives remained unhappy with this change and they told us that their views had still not been sought from the registered provider. From our observations and discussions with people, it was evident that some people did not feel able to go to the communal areas as they found it hard to understand some people's behaviours. Some people spent most of their times in their bedrooms which meant that they were at risk of social isolation.

One person regularly called out in a distressed way or threw objects at others. Staff told us that the person "Always did this". Whilst staff made attempts to support this person at times, there were periods of over twenty minutes when the person was left without supervision. This appeared to be an accepted behaviour which staff did not always respond to.

This was a breach of Regulation 12 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014 because the registered provider had failed to ensure that staff providing care and treatment had the

required skill and experience to do so safely.

People's confidentiality was not respected. On the day of the inspection, correspondence for people was held in the letter rack at the entrance and one of the letters was dated 23 July 2016. This meant that there was a risk that people were not getting timely information but also things of a confidential nature were left in the open reception area.

Inadequate

Is the service responsive?

Our findings

People's views, and that of relatives, about how staff provided supported was mixed. Some said that staff provided the help they required; whilst others felt staff did not understand their needs.

At the last inspection, we found that records for care offered and delivered were not always accurate or sufficient enough to ensure that safe care and treatment was planned for people. Care plans were not detailed enough to enable staff to respond to people's needs. Systems were not in place to identify and assess risks to health and welfare. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities 2014). On this inspection, we found that the registered provider had not made the required improvements they told us they would make by January 2016.

At the last inspection some improvements had been made in how people were protected against the risks of receiving inappropriate or unsafe care and treatment. From information received prior to this inspection and our observations over three days, these improvements had not been sustained.

People's care needs had not been assessed fully prior to their admission to the service and their care records did not sufficiently guide staff on people's current care, treatment and support needs. This put people at risk of inappropriate care.

Staff informed us that they have only been verbally informed of the needs of some people, however they had often found that people's needs differed from the information they were given. For example, a member of staff recalled that they only found out that a person had an infectious condition" Quite a while" after their admission to the service. A senior care assistant had been given the responsibility for completing care plans for people being admitted to the service regardless of the person's level of need. The staff member did not have the required level of clinical skills to carry out assessments and complete care plans for people with nursing needs.

The registered provider provided support to a number of people whose needs fell outside of those that they were registered to support. Staff raised concerns that they did not fully understand two people's needs and how to meet them. The care plans for both people were not fully completed and made no reference to their diagnosis and they were not dated or signed. Staff did not understand the relevance of the powers of the Mental Health Act 1983 that were applicable to the persons care. This meant that people were placed at risk of harm or injury.

Health professionals had made recommendations about some people's care and treatment. This information had not been written into one person's care plan. A dietician visited two people on 18 July 2016 and made a number of recommendations. For one person this information was not incorporated into their care plan around eating and drinking dated 29 June 2016. There was no risk assessment or monitoring tool used to provide oversight of this concern. For the second person the dietician had requested a nutritional plan that would aid in the healing of a pressure ulcer. Despite this there was no care plan in place and no evidence that the foods served was in line with the recommendations. On the 22 August 2016 when we

returned, these care plans had been re-written but they still failed to incorporate the advice and guidance required to meet the person's needs.
On the third day of our visit we requested to see one person's weight records as it indicated in their care plan the need to weigh the person weekly. However the manager and staff on duty were unable to find any record relating to this person's weight. When they further checked they were unable to find any recent records of any person's weight. This meant that people were at risk of not having their nutritional and hydration needs met.

There was a risk that health conditions people had were not appropriately monitored or managed as there were not always appropriate care plans in place. One person who required PRN medication for breathing difficulties did not have a care plan in place for this. This meant staff did not have access to important information in relation to the persons breathing and such as when and why they may require medication. A "Safe Handling Assessment" for the person made no reference as to how this could impact upon their mobility. This assessment stated that no equipment was required; however this contradicted a "Getting about" care plan which made reference to the person requiring a wheelchair when being transferred between floors. The person was deemed at 'risk of falls' but there was no risk assessment or management plan in place to show the level of risk and how it should be managed to minimise the risk of falls. This lack of information put people at risk of not receiving the right care and support.

A number of people had diabetes that was controlled by insulin. For one person, there were no care plans in place around this condition and no guidance for staff. A Nurse Practitioner who visited the service had noted that the person's blood glucose was unstable and had queried why they were getting milk with two sugars every morning. The nurse had requested that this be looked into; however there was no record of any actions taken. Relatives questioned whether a person's admissions to hospital for management of diabetes were always required as it was a service with nursing oversight. Care records indicated that a consistent approach was not being taken by staff to manage this condition and some of the records were illegible. This lack of information and inaccurate recording meant that people were at risk of receiving inappropriate support and treatment.

People's care needs were not appropriately monitored putting them at risk of not receiving the right care and support. Charts were kept for the purpose of monitoring or oversight of people's health and wellbeing such as food and fluid intake, elimination and weights. These were not consistently completed. They were not reviewed by a member of the nursing team in order to identify if there were any new or on-going concerns. Charts for one person indicated from April – August 2016 that they have not opened their bowels for extended periods: up to 21 days. There was no evidence of action taken: despite a past medical history to indicate concern. There was no information in their elimination care plan around the risk of constipation. Another person had a bowel chart in place but it had not been completed for 14 days in July 2016. Recorded entries suggested that the person had not opened their bowels for 15 days in a consecutive period in July 2016 and 11 days running into August 2016: and we noted that one of their medications would place them at risk of constipation. The "Going to the toilet" care plan was blank. One person was prescribed lactulose for constipation but this did not appear to be given during periods where bowel charts suggested they had not opened their bowels.

One person had significant pressure sore upon admission but wound records were not consistently filled in. The last record of a wound assessment was on the 02 August 2016 but daily notes suggested an assessment had been carried out on the 08 August 2016. On the 08 August 2016, the person's skin care plan was blank. On the 09 August 2016 when we returned to copy information from the file, a care plan dated 29 July 2016 was in its place. The person was prescribed a strong pain killer for the related pain but there was no pain charts in place for this. Despite having a complex medical history, the "My health needs" care plan for the

person was blank. Another person was type 2 diabetic but this was not recorded in the persons "Eating and Drinking" care plan and there was no care plan in place for the monitoring of this condition.

These are breaches of Regulation 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities 2014). The registered provider failed to ensure that they assessed, monitored and mitigated the risks to people who used the service. This meant that there was a risk that people did not get the level of support and treatment they required. Staff failed to keep accurate, contemporaneous and legible records.

As on each of the previous inspections, there was very little evidence of activity and stimulation for people. The notice board listed activities available but the person responsible was not available on the days of the inspection. Staff told us that they were not allocated funds towards activities and so were reliant on fundraising and donations. Some people were given colouring books that were not age appropriate. This demonstrates that the registered provider is not meeting the diverse needs of the people who use the service.

We found that complaints were not appropriately responded to in line with the registered providers policy and procedure. The complaints log could not be located. The new manager informed us she was not aware of any current concerns. People we spoke to and their relatives told us that they would go directly to a senior staff member if they had a concern and they were aware that there was a complaints procedure. One person told us that they had raised a concern about their relatives care but we could find no record of this at the service. We asked the registered provider about this and they informed us notes were "Recorded in a notepad; you may be able to find them at Atherton." This does not demonstrate a full and though review and acknowledgment of complaints.

Inadequate

Is the service well-led?

Our findings

People told us that they were disappointed that the managers "Kept on changing all the time" and that they did not know who they were. One person said "I have been told there is another manager now but she has not made herself known to me yet".

Relatives commented that there was a lack of consistent leadership within the service and this had begun to impact upon people's care and treatment. People who used the service and families said that they had not had any opportunity to express their views about the service.

In May 2015 we issued a warning notice to the service for a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because there were ineffective systems in place to assess, monitor and improve the service. In November 2015, we found that whilst some improvements had been made, some actions were still required. On this inspection, we found that the required improvements had not been sustained.

A registered provider is in breach of the conditions of their registration when they do not have a registered manager in place. There was not a registered manager at the service and there had not been one since February 2015. Since that time, the service has had three different managers: the latest starting a week prior to the inspection. Staff told us that they were not happy with all the change as each new manager brought new ideas, new documentation and new ways of doing things: then they moved on and it all started over again. One staff member said, "We are not happy and if we are not happy then it starts to affect the residents".

Some relatives said that they were very disappointed that the registered provider did not take a more active role within the service and come to visit more frequency. One relative said "I would love him to come spend a day here: eating the food my [relatives] eats, sleeping in the bed they sleep in and experiencing the care first hand: I don't think they would like it very much". The registered provider confirmed that they did not meet or seek feedback from people who used or visited the service.

The registered provider demonstrated a lack of knowledge and understanding of the Regulations and their legal responsibility to comply with these.

The registered provider told us that there was a programme of audit and review in place to look at the quality and safety of the service being provided for people. They were unable to tell us what the programme contained or provide information with regards to the audits which had been completed at the service. At the last inspection, the registered provider had told us that they had employed a consultant in order to monitor the quality and effectiveness of the service and that they had been completing an audit on a monthly basis. Only one set of audits completed in May 2016 was available. This highlighted some significant concerns in regards to nursing practices but we found that there was no assurance that appropriate remedial actions or investigations were taken where concerns were identified. We contacted the registered provider who did not recall the audit. They contacted the previous manager for an update but there were no records to confirm

the actions they had taken.

Since the last manager had left, the deputy manager told us that they had not had any time to continue the audit programme. The concerns we had raised during our inspection had not been identified. We highlighted risks associated with people's care, medication, the ability of the service to meet their needs. There were concerns in regards to staff availability to support people on a day to day basis and to keep them safe. There was also a lack of information to support compliance with the regulations.

People had been admitted into the service even though staff did not have the skills or experience to meet their assessed needs. Their needs were complex and their health conditions fell outside those identified as suitable for admission in the Statement of Purpose. There had also been an influx of admissions, up to five in nine days, without due regard to robust pre admission assessments, staffing levels, the skill and ability of the staff available.

The registered provider had accepted to accommodate and support people with a wide range of physical, emotional and mental health needs. However, they failed to demonstrate they had the right mix of staff to support these varied needs. The environment was also unsuitable for some of the people who lived there ; such as those living with dementia, or with a sensory impairment. Best practice guidelines had not been followed in terms of the adaptations or equipment required. The narrow corridors did not lend themselves to promoting the independence of someone in a wheelchair. The building did not support the supervision of people whose behaviours that challenged and way want to constantly walk around.

The accident and incident reports from January 2016 showed a number of serious incidents had occurred at the service. Audits and analysis had been carried out up until July 2016. Despite this care records showed that lessons had not been learned from all of the incidents to ensure the safety of people. The system in place to monitor all incidents, accidents or safeguarding concerns was inadequate as it failed to mitigate risks to people

Records relating to the management of the service were not held securely and appropriately to ensure they could be accessed by authorised people when required. Records and confidential information was held haphazardly and there was a lack of organisation. There was a lack of awareness as to how records should be maintained and provided in line with the Regulations.

These concerns are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider did not have effective governance, including assurance and auditing systems and processes.

Previously, the CQC had not been notified consistently about matters relating to people who used the service or the management of the service. At this inspection, we found that the registered provider had continued to fail to notify CQC about key matters such as safeguarding investigations, serious injury, events reported to the police, or changes to the management. The registered provider had also failed to inform us of events that affected the service such as the issues regarding the passenger lift. This meant that the CQC did not have access to required information in order to determine and address safety concerns about the service through the use of its regulatory processes.

This was a breach of Regulation 15 and 18 of the Care Quality Commission (Registration) Regulations 2009 (Part 4).

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The registered provider did not ensure that people were protected from the risk of avoidable harm. They failed to ensure that the risks to the health and safety of people were assessed and control measures were in place to make sure that risks were as low as practically possible. They failed to ensure the proper and safe use of medicines.

The enforcement action we took:

We issued a notice of decision to cancel the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The registered provider failed to ensure that they assessed, monitored and mitigated the risks to people who used the service. This meant that there was a risk that people did not get the level of support and treatment they required. Staff did not keep accurate, contemporaneous and legible records. The registered provider did not have effective governance, including assurance and auditing systems and processes.

The enforcement action we took:

We issued a notice of decision to cancel the providers registration.