Seahorses Nursing Home

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 3 and 5 July 2018 and was unannounced. The last inspection was in April 2017, where we found four breaches of regulations relating to recruitment, person centred care, staffing, and governance of the service. We asked the provider to complete an action plan to show what they would do and by when to improve the key questions of safe and well-led to at least good.

At this inspection in July 2018, we found the provider had failed to follow their action plan. We identified significant shortfalls in the quality of the care people were receiving and 10 breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found two breaches of the Care Quality Commission (Registration) Regulations 2009.

Seahorses nursing home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Seahorses nursing home accommodates up to eight people in one adapted building. The majority of people in the service were living with Huntington's disease. At the time of this inspection there were eight people living in the service.

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

The provider did not have the financial resources needed to provide and sustain the service to the required standards. They had not informed us about their current financial position which was directly impacting on the care people were receiving.

A system was not in place to ensure there were sufficient numbers of staff on duty to support people and meet their individual care needs. There were not sufficient numbers of skilled, trained and experienced staff to meet people's needs effectively at all times. The provider had reduced staffing levels since the last inspection in April 2017, and this had directly impacted on the care people received placing them at extreme risk of harm.

Governance systems were not operated effectively in order for them to provide an accurate overview of the service. Proper monitoring was not in place to review, identify shortfalls and inform an ongoing plan for improvement. The provider's systems had failed to identify the issues we found during our inspection. Audit and monitoring systems had either not been sustained or were ineffective to ensure that the quality of care was consistently assessed, monitored and improved.

Monitoring systems were not effective to demonstrate accidents and incidents were appropriately analysed to identify hazards, trends or themes, to mitigate the risks of further accidents and incidents.

Thorough risk assessments were not carried out routinely to identify and mitigate risks in relation to people's care and support needs. Risks affecting people had not been reviewed since April 2018.

The culture within the home did not promote a holistic approach to people's care to ensure their physical, mental and emotional needs were being met. Staff spoke abruptly when interacting with people, and did not provide emotional reassurance when people became distressed.

The service was not following the principles of the Mental Capacity Act 2005. Minimal improvement had been made to ensure the way that people's care was delivered did not restrict their freedom more than necessary.

The service did not ensure that safeguarding procedures were followed when there were two significant thefts from people using the service. Systems were not improved to reduce the risk of recurrence.

The provider had not put in place all that was reasonably practicable to maintain the building upkeep, to ensure the premises were safe to use for their intended purpose. The provider had not replaced worn and damaged furniture as required to keep the premises and equipment appropriately maintained.

People were not protected from the risk of infections due to staff not adhering to safe infection control procedures. Many areas of the service were unclean, and equipment such as bed rail coverings and specialist wheelchairs could not be cleaned effectively due to the plastic coverings becoming worn and split.

Systems used to ensure the water system was safe from legionella bacteria were not robust.

People's medicines were not managed or administered safely. People did not always receive their medicines as prescribed. This included prescribed creams.

Care plans for people who had complex health care needs had not been developed to offer guidance to staff on how to maximise people's health and keep them safe.

People did not receive any social activity or stimulation; staff did not have time to deliver this in addition to their caring duties. The provider had not followed our previous recommendation in order to improve this area of people's care.

Following the inspection we urgently raised our concerns with the clinical commissioning group and local authority who responded swiftly to meet with the provider and discuss the concerns. People living in the service were subsequently moved to local nursing homes with the support of the local authority and this service is no longer operating.

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.

Staff were not aware of risks to people's well-being and health and how to effectively mitigate these.

People who were identified at risk of malnutrition and at risk of developing pressure ulcers had not had these risks regularly reviewed.

People were at risk of harm from unsafe medicine administration.

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

People were not protected from the risk of infections.

Is the service effective?

Inadequate

The service was not effective.

Staff were not up to date with relevant training and professional development to ensure good practice. No checks were being undertaken to ensure staff were competent in their role. Training sessions had been cancelled by the provider.

The registered manager and staff were not working within the principles of the Mental capacity Act 2005 Deprivation of Liberty Safeguards.

People's nutritional and hydration needs were not monitored effectively.

Is the service caring?

Inadequate

The service was not caring.

People did not always receive care and support from staff in a kind way.

People's dignity and privacy was not respected.

People were not given the time they needed by staff to express their views.

Is the service responsive?

Inadequate

The service was not responsive.

People did not received personalised care. Care and support was delivered to people in a task orientated way.

Care plans did not contain sufficient information to inform the staff of people's physical, mental, emotional and social needs.

Opportunities were not provided to help people pursue social interests and take part in meaningful activities relevant to their needs; our previous recommendation had not been followed.

People who lived with life limiting conditions did not have plans in place for staff to know their wishes and preferences about the care they should receive nearing the end of their life.

Is the service well-led?

Inadequate

The service was not well led.

The provider had reduced staffing levels placing people at extreme risk of harm. Concerns the provider had about the financial viability of the service had not been reported to CQC or the Local Authority.

The management team was not able to provide us with evidence of an effective monitoring system to ensure the service was safe. Where audits were in place they were not being completed regularly.

No formal process was in place to demonstrate the provider had oversight of the management of the service.

Seahorses Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 3 and 5 July 2018 and was unannounced. The inspection team consisted of one inspector and a specialist advisor in nursing care.

As part of our inspection planning we reviewed all the information we held about the service. This included previous inspection reports and any notifications sent to us by the service including safeguarding incidents or serious injuries. This helped us determine if there were any particular areas to look at during the inspection. We contacted the local authority safeguarding and quality team prior to the inspection.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

At the time of inspection there were eight people living at the service. To help us assess how people's care needs were being met, we reviewed five care records and other information, including risk assessments and medicines records. We reviewed three staff recruitment files, maintenance files and a selection of records which monitored the safety and quality of the service.

During the inspection we spoke with three people who lived at the service, one relative, two health professionals, the registered manager and provider, and two members of care staff.

Inadequate

Is the service safe?

Our findings

At our last inspection in April 2017, we rated this key question as 'requires improvement'. We found the service was in breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to their recruitment procedures. The service also needed to make improvements to medicines processes, staffing levels, and ensure the management of risk was documented more clearly.

At this July 2018 inspection, we found that the service had failed to improve in these areas and there were further significant shortfalls which placed people at risk of harm. The rating in this key question is now 'inadequate'.

At our last inspection in April 2017, we asked the provider to review their staffing levels to ensure they were meeting people's needs. At this inspection we found that staffing levels had been reduced by the provider. A staffing dependency tool was still not being used to calculate how many staff were needed to meet the needs of people safely.

People told us there wasn't always enough staff. One person said, "Staffing at the weekends isn't as good. I cant always get them here when I need them". Another said, "I don't think two staff is enough, but they [staff] come quickly enough when I need them".

Two people required two to three staff to assist them, and there were three staff on duty. However, one of the three staff members was on restricted duties, and therefore only two staff were available. There had been no consideration of finding cover for the staff member on restricted duties, which meant there were less staff available to people than documented on the rota. Due to our serious concerns about people's safety, we asked the provider to take immediate action to ensure that there were sufficient skilled and competent staff on duty at all times.

We observed the lack of staff impacted significantly on the delivery of care. We observed that some people were not being cared for in line with their assessed needs. One person was left in their chair for five hours, when their care plan stated they should only remain in the chair for two hours. We were concerned about the person and therefore raised this twice during the inspection before staff responded. Care was task focussed and not responsive when people required support. Staffing levels observed during the inspection were not sufficient to meet the complex needs of people living at the service, and to provide the required levels of monitoring and support for people either seated in the lounge or in their own bedrooms.

Staff were seen rushing around and there was very little evidence of person centred care being delivered. There was not enough staff on duty to attend to the complex needs of people, which placed them at extreme risk of harm.

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

There was no fire evacuation equipment in the service, such as an evacuation sledge. In the event of an emergency this type of equipment can be used to aid the safe and prompt transfer of people out of the building. Staff had also not received recent training in fire safety. The lack of training meant that staff may not know how to safely support people to evacuate the building in the event of an emergency.

People's records included Personal Emergency Evacuation Plans (PEEPs). These show the support people require to evacuate the building in an emergency situation. However, guidance within the PEEPS advised that people should remain behind fire doors until help arrived. Following the inspection we were made aware that the fire door seals were not safe, and therefore the instruction relating to staying behind fire doors would not have been safe in the event of a fire. A fire risk assessment relating to the premises could not be produced.

There were not effective controls in relation to preventing legionella bacteria in the water systems. One of the ways to reduce the risk of legionella is the effective control of water temperature. At the time of our inspection we saw that hot and cold water temperatures had been taken in June 2018. However, the hot water temperatures were too high in some areas. The service had turned down the temperature of the main boiler to try and remedy this, and had taken off the thermostatic mixing valves (TMV) from the taps which they said was on the advice of a plumber who had visited the service. Removing the TMV's meant that temperatures would not be controlled, and was therefore a scalding risk. Additionally, no evidence could be produced to show that de-scaling of shower heads and taps were being undertaken routinely, which also reduces the risk of legionella.

The risk assessment for legionella did not state who was responsible for any concerns noted or how to escalate concerns. The service had recently sent off a water sample to be tested for legionella. The registered manager contacted the company who tested the water for the result during the inspection. However, the company would not confirm the result as the service had not paid the bill. The provider had not taken sufficient steps to ensure that the water system was safe for people using the service.

We found that risks relating to pressure area care had not been reviewed regularly, and suitable pressure relieving equipment was not always in use. Where people were at risk of developing pressure ulcers, a 'Waterlow' screening tool was used to assess the level of risk. However, we found that four people had not been assessed since April 2018. One person had no Waterlow assessment in place and was at high risk, as they were unable to move independently. The registered manager told us that no one living in the service had been re-assessed since April 2018 due to lack of time. Due to the complex needs of people living in the service and the fact that the majority were unable to mobilise, there was a higher risk of developing pressure ulcers.

Furthermore we found that one person had an area of skin which was vulnerable to breaking down, but they did not have the correct pressure relieving mattress in place to reduce the risk. There was no reference to the vulnerable area of skin in their care plan.

Another person was on a mattress which required a particular setting to ensure their body weight aligned correctly with the mattress. The care plan did not state what setting it should be on. We asked a staff member how they knew which setting to put the mattress on, and they said they just asked the person if it was too soft and turned it up. There was no clear guidance on how often the person should be supported to change position in the care plan, and no Waterlow recorded to determine how high the risk of developing a pressure ulcer was. Repositioning charts for this person showed that on some days they weren't supported to reposition for between eight and ten hours. This could significantly increase the risk of developing pressure areas.

Some people required their weight to be monitored on a regular basis due to the risk of weight loss/malnutrition. However, we found this was not being done. The registered manager told us that no one had been weighed since April 2018 as they had not had the time. This meant the risks to these people was not being adequately assessed or managed.

The majority of people living in the service had swallowing difficulties. Choking risk assessments that were in place contained very basic information, and did not describe the actions that staff should take in the event of a choking incident.

We found that due to a lack of monitoring of medicines procedures and processes, we could not be sure that people were receiving their medicines as prescribed. We checked the Medicines Administration Record (MAR) for the eight people living in the service and found 16 missed signatures overall in the previous three weeks where staff had not signed to say the person had received their medicines. We asked the registered manager if they could give us a copy of the medication error policy but they did not have one. The missed signature errors had not been followed up with individual staff by the registered manager.

We found that one person had missed two doses of a mental health medicine, and the MAR stated that this was 'not available'. The registered manager told us that the medicine was in stock, but the staff member who signed the MAR had not seen the boxed medicine. There was no action taken in response to the error, such as re-training for the staff member or a record of the incident. No further action was taken or considered at this time to see if this person was affected by the missed doses. Other MAR charts also showed that people had missed doses of their medicines but there had been no follow up. One person's MAR chart showed that they had missed eight doses of an eye ointment. These errors presented a significant risk to people's health and wellbeing.

There were additional concerns about the availability and use of prescribed barrier creams. Records did not demonstrate that these were applied in line with the instructions of the prescriber and in one case, no information was available. We asked the registered manager if they could confirm what creams the person was prescribed. They told us they were not sure as they were new to the service. The person had been living in the service for two weeks. No body map was in place to state where any creams should be applied. Additionally there was no photo identification or information about any allergies for this person, which placed them at risk of being given medicines which could cause an adverse effect.

We observed a pot of tablets were left on one person's table unattended, which is not safe practice. Their MAR chart had been hand written by the registered manager who had not signed this, (to avoid errors, two staff should check and sign the MAR chart if hand written). Medicine quantities had not been recorded. There were was therefore no way to audit stock levels accurately, or be sure what medicines the person had taken. One person told us, "Sometimes I only get three tablets. I have to say to staff, I have four in the morning, and they go and get the other one". This demonstrated further that people did not always receive their medicines as prescribed.

Where records included medicines which were taken 'when required' there was limited information on when these medicines might be needed. Some were not dated, so it was not clear if the information had been recently reviewed, or if any changes had been considered periodically.

We observed poor practice in relation to infection control procedures. For example, when staff were assisting people they did not always wear appropriate protective equipment, such as aprons. Some equipment in the service could not be cleaned effectively (such as bed sides and wheelchairs) due to the wipe clean covering having worn away. The service had a cat, and we saw the cat walking across the dining

table where some people ate. The service had not recognised there was an infection risk.

There was a cleaner 12 hours per week, and care staff were also expected to undertake cleaning tasks, which they did not have time to do outside of their caring duties. Infection control audits were given to us, which consisted of a list of rooms with ticks and dates next to each. There was no specific audit in place to demonstrate thorough cleaning was being undertaken. This meant that people were not kept safe from the risk of infection.

All of the above constitutes a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safeguarding procedures were not robust. The registered manager and provider's knowledge of what types of incidents would need to be reported was poor. For example, the medicine errors had not been reported. There had also been two thefts which had occurred in the service which had not been reported to the local authority safeguarding team. The police had been informed, but safer systems had not been implemented by the registered manager or provider to reduce the risk of recurrence. We were concerned that the systems in place did not safeguard people's money, and that appropriate action had not been taken following the incident, placing people at continued risk.

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

Recruitment systems were still not robust since our last inspection in April 2017. We found that one staff member's references had no dates or signatures in place and it was not clear who they were from. Another staff member's file held no references, and there were no risk assessments in place relating to their health (which was impacting on their ability to carry out tasks which were intrinsic to the work for which they were employed). The registered managers' file contained no references or DBS checks. The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions. Therefore we were not assured that the provider was following safe recruitment systems to ensure suitable staff were employed, which put people at risk of harm.

The lack of adequate systems for ensuring staff were safely recruited meant the provider remained in breach of Regulation 19 of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had not developed their practice to ensure that lessons were learned and improvements made when things had gone wrong. Following our previous inspection in April 2017, staffing and management hours had been reduced, which impacted negatively on people's direct care, and all aspects of the service, such as auditing and processes designed to monitor the quality of care. Staff training had been cancelled due to financial restraints. The provider had not learnt from and developed systems and processes which supported improvement. They had not informed CQC or the local authority of their financial position which was directly impacting on the quality of care people received.

Inadequate

Is the service effective?

Our findings

At our previous inspection in April 2017, we rated this key question as 'requires improvement'. This was because training was not sufficient to provide staff with the knowledge they needed to support people effectively. Additionally, many staff were overdue refresher sessions in certain areas.

At this inspection in July 2018, we found that minimal action had been taken to improve this, and we found further concerns. We have therefore rated this key question as 'inadequate'.

The registered manager told us that although training sessions had been booked in 2017, the provider had cancelled these due to financial restraints. Although the training courses were provided at no cost, they were unable to pay staff to attend the training. This resulted in some staff continuing to be overdue in training such as PEG feeds (percutaneous endoscopic gastrostomy; a tube to provide a means of feeding when oral intake is not adequate), medicines management, safeguarding, and moving and handling.

The registered manager told us that six staff had received medicines training in 2017, but when we spoke to the person who delivered the training they told us it was not formal medicines training. Observed competencies were not being undertaken in relation to medicines, which we found was also the case during the last inspection in April 2017. Systems for monitoring staff training were still not robust and it was still not clear what training was periodically required for registered and non-registered staff working in the service. Staff had not been supported to undertake training, learning, and development to enable them to fulfil the requirements of their role. People living in the service had a wide range of complex care needs, and the provider could not be assured that the staff they had employed were fully trained in all aspects of the care they delivered and were competent in this.

We asked one staff member when they had last received supervision. They told us, "That doesn't happen." Supervision provides staff with a forum to discuss the way they work, identify training needs, and receive feedback on their practice. Some supervision sessions had been carried out in November 2017. However, we saw the content of these were basic and did not address what training was needed or any observed practice to identify areas for improvement and ensure staff were working effectively. The registered manager told us that no supervisions had been completed in 2018, as they had not had the time to do so.

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

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).

At our last inspection we found a breach in relation to consent procedures. This was because the service had not considered whether mechanical restraints (such as bed rails, lap belts and chairs which reclined) were depriving people of their liberty, and had not followed the principles of the MCA. For example, some people had bed rails installed on their beds. Bed rails are used to prevent people accidentally falling, slipping, sliding or rolling out of bed but they require formal consent for use, as they are considered a form of mechanical restraint. We found that the decision to install bed rails on people's beds was made without seeking consent in accordance with the MCA.

At this inspection in July 2018, we found that some additional documentation had been added to people's care plans in relation to people's level of capacity, however, it was not clear what was decision was being made which required the test of capacity to be carried out.

DoLS screening checklists had also been used to determine if a DoLS application was required, however, none had been made. The registered manager told us that people were not being restricted of their liberty as they did not attempt to leave the building. This demonstrated a lack of knowledge in what constitutes a deprivation of liberty.

During the morning we noted than one person's feet were dark in colour. we looked through their care plan and could find no information relating to this so we spoke to the registered manager. They informed us that this was due to poor circulation, and that they needed to elevate their legs (which we observed were not elevated). The registered manager then proceeded to go to the person and lift their feet up. There was no interaction with the person before doing this, and no consent was gained.

There were people living in the service who were considered to lack capacity, were under constant supervision, and were unable to leave the service where DoLS applications had not been made. This meant that we could not be confident that the provider was aware of their duties and responsibilities under the deprivation of liberty safeguards and that people's human rights were respected.

This was a repeated breach of Regulation 11 of the Health and Social Care Act 2008(Regulated Activities) Regulation 2014.

People's needs were not holistically assessed before they came to live in the service. We looked at the information for a person new to the service, and found that it contained limited information regarding their care needs. It documented a conversation that the registered manager had with a social worker but there was no specific assessment of needs in place. We were therefore not assured that the person's needs had been properly assessed to ensure the service could support them effectively. Our observations confirmed this. If people moved between services, there was no information or formal processes in place to ensure relevant information about people's care needs was passed on.

We asked people what they thought of the food. One person said, "Could be better", another said, "Its not too bad, but they often run out of mash." We saw that care was not taken to present food in a way that would make it appealing. For example, where people were having pureed food, this was served in one portion, rather than separating the food out on a plate to make it more appetising.

Menus appeared to be repetitive with only one choice of hot meal. Food looked unappetising and people were offered support to go to the dining room to eat, but remained in the lounge. One person was observed

eating tinned spaghetti bolognese on bread at the dining table with the house cat sitting on the table. The meal lacked nutritious content. The table was not laid, there were no condiments, menus were not visible for others to see what was available, and there was lack of choice. Furthermore, no snacks were being offered to people throughout the day.

The registered manager told us that people living with Huntington's tended to prefer sweet foods, so at lunchtime puddings were served, and a savoury meal at the end of the day. We spoke to the dietician about this arrangement, who agreed that offering sweet foods at lunch time seemed reasonable and would increase weight gain. However, there appeared to be no choice in this and people simply received sweet food at lunch time without any consultation on if they wanted something different. This meant people were at risk of not eating as they were not able to choose what they wanted.

People's eating and drinking care plans were not always followed. For example, there was documentation in place that recorded one person's weight, but there was no calculation of their risk of malnutrition or actions to take if weight fluctuated. The care plan recorded that 'regular weights' should be taken, but there was no clarification of what this meant. Another objective in the care plan said to maintain a 'good fluid intake', however it was not specific as to what this meant, and there was no evidence of fluid monitoring found. This meant that we could not be assured that people's food and fluid intake was being monitored sufficiently to ensure nutrition and hydration needs were being met. Risks relating to people becoming malnourished had not been reassessed since April 2018. People's weight was not monitored on a regular basis to minimise any risk of malnutrition, obesity or ill health.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Records stated that people were seen by dieticians, physiotherapists, and speech and language therapists. However, the outcome of their visits was not always recorded so we could not be sure if any recommendations made were being followed. For example, one record stated that fluids were to be thickened as per SALT (speech and language therapy) instructions, and the required consistency. However, the original SALT referral was not on the person's records to cross check this. Records also said that a dietician had carried out a review in December 2017, but there was no further information recorded. Another person had been visited by a physiotherapist, and specific exercises were advised two to three times per day to improve movement in their limbs. However, there was no care plan in relation to this, and the person told us they only received these once a day. This meant that the service was not following recommendations from other professionals.

It was clear the provider had not invested in the service or maintained the premises to provide an environment which was suitable or beneficial for people. They had not considered ways in which to make the environment more visually pleasing for people. The main areas of the service were old and in need of re-decoration and refurbishment. The outside areas did not appear to be used as they were overgrown; outdoor chairs and tables were dirty.

The day of the inspection was very warm, but we observed that no one was asked if they would like to sit in the garden. We asked one person if they would like to sit outside, and they indicated they did. We told a staff member this, and they pushed them to the door of the conservatory, stating that it was difficult to get the wheelchair over the door frame. They said access was possible around the side of the building. However, they did not attempt this so the person could sit in the garden and enjoy the sunshine.

The provider had not put in place all that was reasonably practicable to maintain the building upkeep, to

ensure the premises were safe to use for their intended purpose. The provider had not replaced worn and damaged furniture as required to keep the premises and equipment appropriately maintained.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Inadequate

Is the service caring?

Our findings

At our previous inspection in April 2017, we rated this key question as Good. At this inspection in July 2018, we found significant shortfalls and we have rated this key question as 'inadequate.'

Due to the significant failings in the service, people living at the service did not benefit from a caring culture. The concerns we raised during our last inspection in April 2017 had not been adequately addressed by the provider to ensure people were safe. Staffing levels had been reduced, and training courses cancelled due to financial restraints. This placed people at potential risk of harm, and did not demonstrate a caring approach.

People were not treated with dignity and respect. The inspection team observed poor care practices throughout the inspection. During the day we noted on a few occasions that the staff and registered manager spoke to people in an abrupt and unkind manner. For example, one person was calling out in the lounge and appeared to be agitated. A staff member came into the lounge and said, "If you want a cup of tea you will have to wait until I dry [person's] hair." The person continued to call out. The staff member went to the person and said, "I can't go any quicker, I asked you to be patient." They then gave the person a cup of tea and said, "Right no more shouting, some people haven't had one cup of tea yet." This did not demonstrate a patient, caring or kind approach towards people from staff.

We also observed the registered manager speaking to people in an unkind manner, which included telling one person to, "Shush!" and, "Be quiet!" as they were busy. We were so concerned by what we observed we addressed this directly with the registered manager during the inspection. They apologised and told us they were particularly stressed with everything that was going on in the service. They said that the person did not usually call out as much, and that the presence of strangers (the inspection team) had unsettled them. However, during the inspection we did not observe the person being reassured or comforted by staff at any point.

We received a mixed response from people when we asked if they thought staff were caring. One person told us, "I cant speak as a collective, but I cant speak highly enough of them [staff]. There are two staff that aren't as confident and not as approachable, but generally I think they all care." Another told us that staff were patronising at times, and didn't always wait for a response before assisting with a task such as having a drink.

Care plans and reviews were not always signed by people (or their representatives) to indicate that they had been involved in any of the care planning or subsequent review processes. One person told us, "I've not seen my care plan, no." One care plan said that the next of kin had been invited to visit and comment on the care plan, and this was signed off as 'done'. But there was no other comments or documentation relating to their views. The registered manager told us that reviews of people's care plans had not been carried out due to time constraints.

We observed that people's dignity was not upheld. We saw that one person sitting in the main communal

lounge had a small towel over their lap and appeared to have only a continence pad on underneath. We checked their records as to why this might be the case or if this was their choice, but there was nothing recorded. We also observed one person lying in bed with their top half clothed, but only a continence pad on the bottom half with nothing to cover them to maintain their dignity. We also saw a staff member assisting a person to have a bath, with the door wide open, so anyone walking past could see in. When we questioned staff about this they told us that the bath hoist which they had used to get the person into the bath was too big to allow the door to close. This meant this was regular practice when supporting this person to bathe.

People's privacy needs and expectations were not recorded in their records. Care plans were sometimes worded in a derogatory manner. There were examples of insensitive language used, for example in one person's notes we saw staff had written; "[Person] has been less demanding today". Another person's folder said on the front, "Please make sure all screeching and yelling is recorded on [person's] behaviour chart." These comments observed in the written form, were reflective of interactions we observed throughout the inspection.

We concluded that people were not treated with dignity and respect and staff demonstrated a lack of compassion towards the vulnerable people in their care.

This constitutes a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Friends and families were able to visit people living in the home, and maintain relationships with them. Privacy during visits was taken into account. For example, we saw one person's door was closed as a relative was visiting them and they wanted to speak privately.

Inadequate

Is the service responsive?

Our findings

At our last inspection in April 2017, we rated this key question as 'requires improvement'. This was because people's care plans were not reviewed appropriately, and people were not receiving adequate social stimulation, which we made a recommendation about.

At this July 2018 inspection we found that improvements had not been made, and that recommendations had not been followed. We also found that due to poor staffing levels, people did not receive responsive care in line with their assessed needs. We have therefore rated this key question as 'inadequate'.

Throughout the inspection we identified that due to a lack of adequate staffing levels, people's assessed needs were not being met. For example, one person remained in their chair for five hours when their care plan stipulated only two, as they were unable to support their body weight for a prolonged period. Staff were observed rushing from one person to another, and were unable to provide emotional support when people needed it. The impact of this was that people's needs were not met in a timely or effective manner.

Care plans did not contain sufficient information on people's physical, mental, emotional and social needs. They were written in a clinical, task orientated way, and lacked a person centred approach which took account of people's individual preferences and wishes. At our last inspection in April 2017, we found this was the case, and that care plans were not robustly reviewed to demonstrate that any changes had been considered fully. Information about people's life history before they moved into the service was not available in most cases. Care plans had not been reviewed since April 2018. Previous reviews were lacking in detail. Most just noted to 'continue' which did not evidence that a robust review was carried out. One entry on the daily notes said that one person had chatted about their life living in another town and their musical interests, but there was no social care plan in place detailing this.

Most of the information in people's care plans focused on the tasks that people needed support with as opposed to their preferences and wishes with regards to their care. Some of the information with regards to people's needs was also unclear. The registered manager told us that staff had raised the issue of care plans not being updated, but that they had not had the time to do them.

The service had not considered people's needs in relation to their end of life preferences. We saw that a number of people had Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions in place, however, care plans held minimal information about the scope of people's wishes. For example, if they preferred to go into hospital or remain in the service, which people they wanted to be with them (and those they did not) and how they wished to spend their final days. There was no additional information on how staff could provide comfort during this time. We asked if there was a specific approach or model of end of life care the staff would follow should anyone be approaching the end of their life. The registered manager told us there was no specific approach in place and they were not aware of best practice relating to this area of people's care.

At our last inspection we observed that people were not always receiving adequate social stimulation. It was

not always clear what activities had been tried and whether other options, such as sensory stimulation had been trialled. We made a recommendation that the service explored current guidance in relation to the range of approaches and interventions which could be considered in meeting people's individual needs. No progress had been made on this recommendation. Staffing levels had been reduced, so care staff did not have had the time to deliver meaningful activity or time to people living in the service.

We did not observe any activity taking place on both days that we visited, or any time spent by staff chatting to people. One person had asked to speak to a person of faith. We asked the registered manager if this had been followed up and they told us they were waiting for someone to ring back. The same person had expressed that they would like someone to play a musical instrument for them. We asked the registered manager if this was followed up and they told us it had not been. One person had asked to see a solicitor. It was recorded that the registered manager had given them a number and the person had called but couldn't get through. We asked if this had been followed up and the registered manager told us that the person had told them 'not to bother'. There was no exploratory conversation about why this was important to the person, or additional help they might require to make contact with a solicitor.

All of the above constitutes a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

There was a complaints procedure on display in the reception area, however, it contained incorrect contact details of the provider who was no longer involved in the operation of the service. The registered manager told us they had received no complaints, however, there were two incidents which had occurred in the service which should have been documented to establish the level of investigation required and immediate actions taken to reduce a recurrence. This had not been completed.

Inadequate

Is the service well-led?

Our findings

At our previous inspection in April 2017, we rated this key question as 'requires improvement'. This was because the governance of the service had not been effective in identifying the concerns we raised during the inspection and were not sufficiently robust. The registered manager had also not been given sufficient hours to carry out their registered manager responsibilities which included audits to monitor the quality of the service. This meant that the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

At this inspection in July 2018, we found that the concerns we raised at the last inspection had not been addressed, and there were further serious concerns about people's care. The registered manager's hours had again been reduced. Staffing levels were also reduced, and the use of agency staff to ensure staffing levels were adequate had been stopped by the provider. Staff training had been cancelled due to financial restraints. The high level of concerns we identified at this inspection meant the provider remained in breach of Regulation 17.

In February 2018, we were informed that one of the providers was no longer operating the service. This left one provider who previously had minimal input into the service. At this inspection we found they were working in the service to help staff on shift. They were delivering care to people without the necessary training, for example, in moving and handling. We told the provider during the inspection that they would have to stop providing care immediately as they had not been trained to do so and were therefore putting people at risk. They were aware that one staff member was on restricted duties, but was still permitting them to work in the service with vulnerable people who had complex needs. We observed the staff member carrying out a procedure the registered manager told us they should not be doing.

The provider did not have the financial resources needed to provide and continue to provide the service to the required standards. They had not informed CQC or the local authority that their financial position was negatively impacting on the delivery of care to people, placing them at extreme risk of harm.

This was a breach of Regulation 13 of the Care Quality Commission (Registration) Regulations 2009.

The systems in place to assess, monitor and mitigate risks to people's health, safety and welfare were ineffective. The level of managerial and provider oversight was insufficient to recognise and respond to the concerns we identified during our inspection which should have been picked up and addressed prior to our visit.

We asked the registered manager if they had supervision with the provider. They told us they did not have formal supervision but that they did have informal chats with the provider. This did not demonstrate that the provider had sufficient oversight of the service in order to support the manager in their role and ensure people were receiving a good service.

Systems and processes were not effective in identifying and responding to environmental risks, such as fire

and infection control hazards. The provider had not identified environmental risk factors and poor maintenance of the premises and equipment.

Systems and processes were not effective in responding to accidents and incidents. There was little or no evidence to show what action had been taken to mitigate the risks of further accidents and incidents. Accidents and incidents had not been reviewed or recorded routinely since March 2018. For example, there was a risk assessment in place relating to a person's bed rails. The registered manager told us that an occupational therapist had recommended removing the bed rails as a trial which they did, but the person rolled from the bed and on to the floor sustaining carpet burns. Records showed that the rails were then replaced. The registered manager showed us an accident form which had been completed. However, the form had not been signed, and there was no review or follow up documented. We could not be sure what actions were taken after the incident.

Medicines audits consisted of random stock counts. There was no audit which checked the quality of recording on the MAR charts, which we found was poor. The registered manager had not taken any actions where errors were made, for example, where people did not receive their medicines.

Providers are required by law to notify CQC of certain events which occur in the service. Records we hold, and findings during the inspection indicated that the provider had failed to notify CQC of notifiable events.

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

Staff meetings were held in the service, and we saw that staff had added relevant items to the agenda, such as staffing, cleaning, training, fabric on chairs needing replacement, and fire drills. However the minutes of meetings were not typed up to show what the specific issues were and what actions had been taken to address them.

The service had worked with other professionals, such as dieticians, GP's, physiotherapists and a Huntington's disease advisor. Following our last inspection in April 2017, we advised the registered manager to make contact with the local authority quality assurance team who had visited the service previously to help with documentation and advice. However, they told us they did not make contact with them as they did not feel they needed to. This did not demonstrate that the provider or registered manager valued the input from other professionals to ensure they were providing good quality care.

We asked staff their views in relation to how the service was run. One said, "Its gone downhill, but the nurses in the service are good." Another said, "There have been financial struggles since the providers death. Safety is 'pushed'. If any residents are unwell or palliative they have to try and get another member of staff in".

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had not displayed the report.

Surveys were issued annually to people, relatives and staff as a way of gaining feedback. Generally the feedback was positive.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 Registration Regulations 2009 Financial position except health service bodies and local authorities The provider did not have the financial resources needed to provide and continue to provide the service to the required standards. 13 (1) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not informed CQC of certain events which had occurred in the service. 18 (1) (2) (a) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care plans did not reflect their current needs. Staff did not have accurate and up to date information on people's needs to refer to. The provision of activity was not meeting people's individual and specialist needs. 9 (1) (2) (3) (a) (b) (c) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 10 HSCA RA Regulations 2014 Dignity

personal care	and respect The provider had not ensured that care and treatment was always provided in a respectful and dignified way. Regulation 10 (1) (2) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured that people always consented to the care and support that they received. Regulation 11 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's health, safety and welfare were not managed, monitored or reviewed so as to ensure people's safety and wellbeing. People's medicines were not administered safely or in line with the prescribers instructions. Infection control procedures were poor. 12 (1) (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding procedures were not robust. The systems in place did not safeguard people appropriately, and action had not been taken following an incident, placing people at continued risk. Safeguarding incidents had not been reported

to CQC.

13 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider had not ensured that people's nutritional needs were always being met and monitored. Regulation 14 (1) (2) (4) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had not put in place all that was reasonably practicable to maintain the building upkeep, to ensure the premises were safe to use for their intended purpose. The provider had not replaced worn and damaged furniture as required to keep the premises and equipment appropriately maintained. 15 (1) (a) (b) (c) (d) (e) (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were inadequate systems with ineffective leadership to ensure compliance with the legal requirements. Regulation 17 (1) (2) (a) (b) (c) (e) (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed There were inadequate systems for ensuring staff were safely recruited.

19 (1) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured staff were competent, suitably qualified and skilled to complete their work. Staffing levels were not adequate to ensure people's safety. Regulation 18 (1) (2) (a).