Cole Valley Care Limited

Cole Valley

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection site visit took place on 20 and 21 August 2018 and was unannounced. At the last inspection completed in February 2017 we rated the service as 'requires improvement'. We found improvements were needed in the areas of risk management, the application of the mental capacity act and the overall governance of the service. At this inspection we found the required improvements had not been made and further improvements were also needed.

Cole Valley 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. The care home accommodates up to 45 people who require nursing care. At the time of our inspection there were 41 people living at the service, many of whom were living with dementia. A registered manager was 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.

People were not protected from the risk of accident or injury due to ineffective risk management processes. Accidents and incidents were recorded but these were not reviewed sufficiently and lessons were not learned to minimise risk and make improvements across the service.

While care staff could describe potential signs of abuse, issues were not always identified and reported meaning action wasn't taken to protect people from potential harm.

Medicines management systems were not consistently safe. People's creams were not stored securely. Staff were administering creams that had not always been prescribed or that had been prescribed for others. People were not always supported by sufficient numbers of staff.

People's rights were not always upheld by the effective use of the Mental Capacity Act. People's capacity to provide consent or make decisions had not been considered in line with the Act. Decisions were not being made appropriately in people's best interests.

People were not always cared for by staff who had the skills and knowledge to support them effectively. People's nutritional needs were met although some improvement to staff knowledge and the support people received was needed. People had access to healthcare professionals but not always in a timely way.

People did not consistently receive care that was kind and caring. People's dignity was not always upheld and their independence was not always promoted. People were supported to receive visits from friends and family without unnecessary restrictions.

People were not fully involved with the planning of the care they received. People's individual support needs

were not always fully understood and met. People's diversity was not embraced and their care needs personalised as a result. People's needs in relation to any protected characteristics were not fully considered. People did not receive access to a sufficient range of leisure opportunities that met their individual needs.

People understood how to make a complaint when required. Some relatives did not feel their complaints had been appropriately addressed.

People were not living in a service where a culture of quality improvement had been developed. Quality assurance systems were either not in place or were inadequate. Areas of improvement needed and risk had not been identified. Action was not being taken to drive improvements and the registered manager had not recognised where improvements were needed.

People were not enabled to be fully involved in the development of the service they lived in. People were not cared for by a staff team who were well supported and consistently motivated in their roles.

We found the provider was not meeting the regulations around providing person-centred care, obtaining appropriate consent, safeguarding, staffing, safe care and treatment and the overall governance of the service. You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

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

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

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 always safe.

People were not protected from the risk of accident or injury due to ineffective risk management processes.

Potential safeguarding issues were not always identified and action taken to protect people from the risk of harm.

Medicines management systems were not consistently safe.

People were not always supported by sufficient numbers of staff.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's rights were not always upheld by the effective use of the Mental Capacity Act.

People were not always cared for by staff who had the skills and knowledge to support them effectively.

People's nutritional needs were met although some improvements were needed. People had access to healthcare professionals but not always in a timely way.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People did not consistently receive care that was kind and caring. People's dignity was not always upheld and their independence promoted.

People were supported to receive visits from friends and family without unnecessary restrictions.

Is the service responsive?

Inadequate

The service was not consistently responsive.

People were not fully involved with the planning of the care they received. People's individual support needs were not always fully understood and met. People's diversity was not embraced. People's needs in relation to any protected characteristics were not fully considered.

People did not receive access to a sufficient range of leisure opportunities.

People understood how to make a complaint when required.

Is the service well-led?

Inadequate

The service was not well-led.

People were not living in service where a culture of quality improvement had been developed. Quality assurance systems were either not in place or were inadequate. Areas of improvement needed and risk had not been identified.

People were not enabled to be fully involved in the development of the service they lived in. People were not cared for by a staff team who were well supported and consistently motivated in their roles.

Cole Valley

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 20 and 21 August 2018 and was unannounced. The inspection team consisted of two inspectors, a Specialist Advisor and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The Specialist Advisor was a qualified nutritionist who looked specifically at how the service met people's nutritional needs.

As part of the inspection we reviewed the information we held about the service. We looked to see if statutory notifications had been sent by the provider. A statutory notification contains information about important events which the provider is required to send to us by law. We looked at information contained in the provider's Provider Information Return (PIR). A PIR is a document the provider completes in advance of an inspection to share information about the service. They can advise us of areas of good practice and outline improvements needed within their service. We sought information and views from the local authority. We also reviewed information that had been sent to us by the public. Prior to the inspection we had received concerns about the quality of care some people were receiving; including support with their food and drink and the approach of some care staff working at the service. We used this information to help us plan our inspection.

During the inspection we spoke with seven people who used the service and nine relatives. Many people living at the service were not always able to share their views about the care they received. To help us understand the experiences of these people we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people living at the service. We also carried out further observations across the service regarding the quality of care people received. We spoke with a director of Cole Valley Care Ltd, the registered manager, the deputy manager, the cook and the assistant cook. We also spoke with 13 staff; including domestic staff, care staff and nurses. We reviewed records relating to 13 people's care and records relating to the management of the service; including

recruitment records, complaints and quality assurance records.

Inadequate

Is the service safe?

Our findings

At our last inspection completed in February 2017 we rated this key question as 'requires improvement'. We found that safeguarding concerns were not always identified and appropriate action taken, including reports not being made to the local safeguarding authority as required by law. We also found risks to people were not always being appropriately mitigated; including people being transferred in wheelchairs without foot plates. At this inspection we found improvements had not been made and further issues had now also arisen putting people at an increased risk of harm.

Care staff we spoke with were able to describe signs of abuse and how they would report these concerns. However, we found as at our last inspection, some incidents were not recognised by the staff team as safeguarding matters where action should be taken to protect people. Therefore, these concerns had not been reported and appropriate action had not been taken. Ongoing incidents that caused people harm had continued. For example; we identified a person who was going into people's bedrooms. One relative told us, the person, "Throws things, turns off the light". They told us their family member could be frightened and made to feel very uncomfortable as they were bedbound and could not respond or react while this was happening. The registered manager and staff team were aware of this behaviour but had not considered the impact on some people living at the service. They had not reported this concern to the local safeguarding authority or to CQC and had not taken any appropriate action to protect people.

The registered manager and staff team had also not recognised how their poor care practices could be neglectful. We found examples's of people's call bells placed out of reach of them. One person was shouting out for assistance as their call bell was out of reach. We found them in their bedroom, distressed with a pillow having fallen and covering their face and alerted care staff and the management team to this concern. We found this person later in the same day with the call bell out of their reach again. We ensured this person was not at risk of immediate harm and notified the local safeguarding authority about our concerns.

The provider's information return stated that safeguarding procedures were in place that ensured appropriate action was always taken to protect people. We found this was not the case.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment

People who were able to share their views told us they felt safe with the support received by staff. One person told us, "I really like being here and I feel safe". Another person told us, "They have to get me out of bed by hoist and they are very good with it". Most relatives also felt their family members were safe, however this view was not always consistent. One relative told us, "I do not feel that my relative is safe here". We saw that people were not always kept safe from harm during the inspection. We saw multiple incidents involving people being transferred in wheelchairs without foot plates. This increases the risk of injury, for example, due to feet potential dragging on the floor. We also saw examples of where care staff had bumped people's legs while transferring either them or other people. We saw bed rails were commonly used and bumpers

were not always well fitting. This can increase the risk of injury and entrapment. We asked the registered manager and deputy manager to show us risk assessments for specific people in relation to the use of their bed rails, the use of a hoist and walking frames and they could not. The provider's information return stated that risk assessments were in place for equipment such as hoists. We found this was not the case. Appropriate risk assessments had not been completed, therefore clear instructions were not available to staff around how to keep people safe.

We found where incidents or concerns had arisen, the registered manager had not ensured they were taking action to mitigate the risk of future incidents arising. We found one person had fallen resulting in a fracture in early 2018. The risk assessment had not been reviewed and no measures put in place to reduce the risk of further falls to this person. We saw they had three recorded falls since this time. We also saw another person who had had 11 falls since November 2017. The risk assessment had also not been reviewed and revised for this person resulting in the ongoing incidents arising. The registered manager could not demonstrate they had taken all reasonable steps to reduce the ongoing risk to these people. We saw where the risk of malnutrition was increased and weight loss identified; insufficient steps had been taken to monitor the risk. For example; one person was noted to have lost 7kg in one month. A member of nursing staff told us; "Her weight loss is terrible- she doesn't look like [person's name] anymore". The registered manager had not ensured steps were taken for this person's weight to be monitored more frequently to ensure the risks could be managed more proactively and intervention from appropriate healthcare professionals sought in a more timely way. We found appropriate investigations were not always completed following incidents. The registered manager was not ensuring that learning could be taken from incidents and used to reduce risks more widely within the service.

People told us they were happy with the support they received with their medicines. One person told us, "I'm on quite a bit of medication and I get it twice a day regularly". A relative told us, "We know [person's name] is getting all their medication on time which is very important to keep them safe". We found that medicines were not always stored securely. We saw a container of a food supplement drink on the tea trolley without the required dispensing label outlining who should receive the medicine and when. Staff were not able to identify who this belonged to. We saw creams were stored in people's bedrooms; some without the required dispensing labels. We saw cream in one person's bedroom that was prescribed for another person living in the service. We saw one person had spat out their medicines and these were left on a plate in a communal area. Staff had not recognised this person had not taken their medicines and they were left in the communal area until we asked for them to be taken away. This posed a risk to the person due to them not taking their prescribed medicine. There was also a risk that other people may have accidentally consumed this medicine while it was left available.

We found protocols to outline when staff should administer people's 'as required' medicines were not in place. A protocol for one person's pain relief medicine wasn't in place. Care staff we spoke with weren't able to clearly describe how they would know this person was in pain and the person was not able to verbalise this. We found gaps in people's medicines administration records had not been identified. This meant the registered manager had not completed checks to ensure these people had received their medicines as prescribed. We found systems were not in place to ensure covert medicines were administered in line with the required law. We also found systems were not in place to ensure record keeping was in line with required best practice guidelines. For example; where MARs are handwritten, two staff members should check the record and sign it to ensure the risk of errors is minimised. This had not consistently been done exposing people to the risk of incorrect medicines or doses being administered.

This was a breach of regulation 12 of the Health and Social Care Act Safe care and treatment

People told us there were not always sufficient numbers of care staff therefore their needs were not always addressed in a timely way. One person told us, "Could do with a few more [staff]. They're rushed off their feet". Another person said, "I have pressed the call button during the day and staff don't come very quickly". A relative told us, "The staff don't have time to do everything so I take my relative to the toilet every day when I come to visit". Another relative told us, "When [person] rings the buzzer, they don't always come straight away". A third said, "I've been with [my relative] on an evening and there's not a care worker in sight". Staff told us there were issues with staffing. One staff member said, "There's enough staff but it's not our staff. There's a lot of agency".

We saw there were periods of time where there were insufficient staff available to support people. We saw situations where people were in communal areas requiring support and staff were not available. We also saw a person struggling to open a door and care staff were not available to provide support. One relative told us, "Today, I've been trying to find a carer for over 20 minutes as my relative needs assistance". We saw the registered manager had not ensured care staff were actively supporting people when they were available. For example; we saw five members of staff in the staff room at one point during inspection. We also saw an example of a member of staff using their mobile phone rather than proactively supporting people. We saw there were high numbers of agency staff in post who did not always fully understand people's care needs. On the first day of our inspection 50% of the care staff on duty were agency staff.

The registered manager confirmed they did not have a formal method of calculating the number of nursing and care staff that were required to support people effectively. They also confirmed they were using high levels of agency staff due to their own in-house 'bank' of staff being insufficient to cover staff absences.The provider's information return (PIR) completed in February 2018 highlighted high levels of agency staff were being used at this time also. This demonstrated the high use of agency staff had been ongoing without any proactive steps being taken by the registered manager to resolve this issue. Despite this the registered manager was not actively recruiting for additional staff. We found there were insufficient numbers of suitably skilled and competent staff available to support people effectively.

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

We looked at how the registered manager had ensured people were protected from the risk of the spread of infection. People and relatives told us they felt the service was kept clean. One relative told us, "They keep it clean, always cleaning around the house". Another relative told us, "The home is really clean with no smell any time we come in". We saw the service was clean and care staff were using appropriate equipment such as gloves and apron to prevent the spread of infection. Domestic staff we spoke with understood infection control practices. The registered manager advised the deputy manager had recently been appointed the lead for infection control and was looking to develop positive practices in this area.

Requires Improvement

Is the service effective?

Our findings

At our last inspection completed in February 2017 we rated this key question as 'requires improvement'. We found issues with the consistent application of the Mental Capacity Act 2005 (MCA). We also found issues with people being served hot meals. At this inspection, we found meals were now being served at an appropriate temperature. However, there were widespread issues with the application of the MCA which resulted in people's rights not being upheld in line with the law. We also found issues with the skills and competency of the staff team.

The 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff we spoke with understood how to obtain consent and provide choices to people who had mental capacity. They did not however understand how to support people in line with the MCA when they lacked capacity to provide consent or make specific decisions. The registered manager and staff team we spoke with were not able to explain the basic principles of the MCA. As a result the MCA had not been considered in relation to specific decisions about people's care as required by law. For example; one person was receiving medicines covertly. Their capacity had not been assessed around the use of medicines and a decision making process had not been made in their 'best interests' as outlined by the Act. We also found this person had been refusing blood monitoring checks and action had not been taken to protect their health in line with the law. We found multiple examples of where decisions were being made on behalf of people without the correct steps being taken. Including one person who staff stated lacked capacity outlining they felt unwell but refusing health checks to be completed. No action was taken to protect this person's health in light of the concerns. Another person was not using their walking frame when needed. The person's capacity to understand the use of the frame may protect them from injury had not been considered. Therefore steps had not been taken to protect the person from repeated falls. The registered manager confirmed to us that they had not applied the MCA appropriately for anyone living at the service despite a large number of people living with dementia and reduced or varying capacity.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Need for consent

We found applications to deprive people of their liberty had been submitted to the local authority where the registered manager felt people lacked capacity. However, due to the registered manager's lack of

understanding regarding the MCA, they did not fully understand the reasons why they needed to apply to deprive someone of their liberty. As a result they had not fully considered the restrictions that were in place for people and if these restrictions constituted a deprivation of their liberty. They had also not shown they had considered if the restrictions in place were proportionate and the least restrictive possible . As a result we could not be sure appropriate applications had been made.

People did not share their views around how competent the staff team were in their roles. Relatives did however state they felt the quality of care provided was good. We observed some good examples of care and support by the staff team. However, we also observed examples of poor care practice; including the unsafe use of wheelchairs and the lack of person-centred care practice. We found widespread issues with the knowledge of the staff team around the Mental Capacity Act 2005 (MCA). We also found issues with the identification of safeguarding concerns and with staff knowledge around supporting people with specific dietary needs, for example those with texture modified diets. We saw staff were given access to training in many of these areas although this had been insufficient in ensuring the staff team had the appropriate skills to support people effectively. We found the registered manager had completed staff supervisions and could provide examples of competency checks completed. However, these had been insufficient in ensuring gaps in the skills and knowledge of the care team had been identified and addressed.

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

People who were able to share their views told us they felt the care they received met their needs. One person told us, "The care I get here is pretty good". Most relatives we spoke with also felt the care provided met people's needs. One relative said, "I can't fault the place". They also said, "It's so nice to see [my relative] up and about, washed and dressed". They told us how the person's health had improved since arriving at the service. This view was not consistent across all relatives. We saw some examples of where people's needs were being met appropriately. We saw that people had access to healthcare professionals such as doctors, physiotherapists, chiropodists and SaLT. However, we saw there could sometimes be a delay in seeking appropriate support due to the poor systems in the service or lack of proactivity. For example; as people's weight loss was not monitored closely, where a risk was present, referrals to the appropriate healthcare professionals were not always made in a timely way. We found the chiropodist was contacted, although the most recent visit was completed due to a relative requesting the visit.

We found people's needs were not always assessed appropriately. We found care plans had been signed as reviewed on a monthly basis but were not always updated in line with people's changing needs. We found some areas of support were being delivered without a thorough assessment of their needs being completed and documented. We saw a handover between staff members was completed between shifts, although the quality of this was poor. There was no written record of important information that needed to be shared with the next staff team. During the verbal handover the staff member was heard to say they were 'not sure' about several specific people and any information that needed to be shared. The quality of care people received could be compromised due to poor assessments of their needs and poor communication between the staff team.

We found the premises to be clean although it was not kept tidy and free from clutter which could pose a risk both in terms of people with poor mobility and also fire. We found some areas of the service were in a poor state of repair. For example; we found a drain cover was missing in a shower room leaving a rough hole which could cause injury to people. This had not been identified as requiring repair until we raised this during the inspection. We found further maintenance concerns such as a broken toilet seat that had not been reported as requiring action in the maintenance book. We saw provisions had not been made for

people to smoke at a safe distance from the building. People were smoking in the garden area with doors to the dining room open resulting in smoke entering communal areas of the building where no smokers were present.

The registered manager had not ensured the decoration of the premises was in line with best practice guidelines for supporting people living with dementia. There was no dementia friendly signage to support people to mobilise independently around the service. There was also signage and the use of rooms that could be confusing and disorienting for people with dementia. For example; a room had a sign for both the bathroom and a hairdressers which was also being used to store equipment. For people with reduced mental capacity, this could be disorientating although the registered manager had not considered this risk. We also saw some people's bed linen was old, worn and in some cases poorly fitting. While we saw concerns with the premises, some people did tell us they were happy with their rooms and the registered manager had supported them to have their own personal items from home. One person told us, "I love my room as I have my furniture from home in it, it is a light room and like having the window behind me open".

People told us they enjoyed the food they ate. One person told us, "The food is great". A relative told us, "It's lovely food here". Another relative said, "The care including food is fantastic I can't fault it". We saw food available to people was of a good quality and alternatives were provided where people did not want what was listed on the menus. One person told us they regularly asked for fish and chips despite this not being on the menu and it was always provided. We saw a range of food choices were offered although people were not fully involved in the planning of menus. We saw people were provided with support to eat while in the dining area although effective use of adaptive equipment such as plate guards and adaptive cutlery was not always in place. We saw people eating in their bedrooms did not receive consistent, caring support that met their needs.

Where people required a specialised diet; such as fortified food to prevent weight loss or texture modified diets due to swallowing issues, we found these people's basic nutritional needs were met. However, we found staff did not always have the skills and knowledge needed to ensure all risks were managed appropriately. For example; food for all people was fortified to ensure weight loss was prevented for certain individuals. However, this approach can increase the risk of weight gain for others. We also found staff had not received sufficient training around the provision of texture modified diets. We found records were not always up to date and care plans did not contain accurate information about people's nutritional needs. This increased the risk of people receiving food and drink that was not appropriate to their needs, especially due to the high levels of agency staff within the service. We saw referrals to GP's and other appropriate healthcare professionals were completed. However, due to monitoring of people's food intake and weights not always being completed frequently enough there could be delays in these referrals being made.

Requires Improvement

Is the service caring?

Our findings

At the last inspection completed in February 2017 we rated this key question as 'good'. At this inspection we found the service provided to people had deteriorated and people were not consistently supported in a kind and caring way.

People who were able to share their views told us they felt care staff were kind and caring in their approach. One person told us, "The care staff are lovely". Some relatives also told us they felt care staff were caring in their approach. One said, "The [staff] are wonderful". Some people told us this was not always consistent. One person told us care staff were, "Mainly" kind and other told us care staff could get, "Shirty" if they did not want a shower when it was offered. A relative said, "I think that most of the carers are very good, friendly and caring but there are some that are not". We observed some warm, kind and caring interactions between people and care staff although we saw this was not consistent. We also saw some interactions and care practice that was not kind and caring. One staff member told us, "[Staff] do the job but don't sit and talk to people. They'd rather sit and talk to each other". We saw this was the case and saw staff members who were 'supervising' lounge areas and making no attempt to interact with people. We also saw a staff member using their mobile phone and ignoring the people in the room with them. We saw the registered manager had not ensured there was a culture in the service that was consistently kind and caring and that care staff could recognise when their care practice itself was not caring. For example; we saw one staff member acknowledging one person wanted to go back to their room. It was also likely from our observations this person required assistance with personal care. The member of staff told the person they would have to wait for the next shift as they finished work in five minutes time. They did not recognise this was uncaring practice. We saw a person shouting from their room distressed with care staff not responding to them. We saw another person becoming very distressed and panting while using the hoist although care staff had not considered how to minimise the person's distress. People were not consistently supported in a kind and caring way.

We saw people's dignity was not always protected and their independence wasn't always promoted. We saw the registered manager had not ensured staff could recognise this in their own care practice. One relative told us people weren't fed with dignity. They said, "You should be interactive with [my relative] and anyone else in the home on eye level to feed them with dignity but there are some carers that stand over people which is wrong". We saw this in practice and saw in some people's bedrooms people weren't supported to eat in a dignified way. We saw one member of staff standing over someone and feeding them with the only interaction being them telling the person to, "Open your mouth…Open for me". We saw the staff member gently stroking the person's hair at one point indicating a warmth but they did not recognise their interaction was not dignified or caring. We saw one person say to agency staff they could see someone's underwear and the agency staff member giggling with the person rather than trying to protect the individual's dignity. We saw the language used in relation to people at the home was not always dignified. For example; people on texture modified diets were called 'feeders' and we saw the registered manager had a folder regarding people's personal finances titled 'pocket money'. We saw the environment within the service and the support people received did not promote their independence in a positive way. We saw staff members did not understand how to support people with dementia or sensory impairment in a way that

enabled them to take control and autonomy over their care choices wherever possible.

Some people and their relatives did however give us positive examples of how people were supported in a positive, caring way that did promote their independence. For example one relative told us, "When my brother got married in [place name] the other month, a carer got our relative dressed and drove them over in their own car so that they could be there. That was so kind and thoughtful and our relative was really touched by that action." This was a good example of care staff supporting someone in a positive way.

People were able to receive visits from their relatives without restrictions. One person told us, "My visitors can come in to see me whenever they want to, at the times it suits them." A relative said, "We can come and visit our relative whenever we want to". One family told us how the registered manager had supported a move to a larger room to assist with family visits. They told us, "As a family we visit daily and the home moved our relative to a bigger room so we could all get in whenever we want to".

Inadequate

Is the service responsive?

Our findings

At the last inspection completed in February 2017 we rated this key question as 'good'. At this inspection we found the service provided to people had deteriorated and people were not consistently supported in a person-centred way.

People told us they did not always feel their needs were understood and met by care staff. One person told us, "Nobody comes to talk to me, they just bring me my food and drink". Another person told us, "I haven't been washed yet as they haven't been to ask me if I want a wash and so I am still in my night dress". It was late morning and the person told us they wanted to be washed and dressed much earlier in the day. One staff member told us, "People exist here". We found care staff did not always understand people's needs and care plans also did not clearly outline people's needs, indicating people had not always been fully involving in planning their care needs. For example; one person was shouting to get out of bed. Staff on duty were not certain if the person could be cared for out of bed. There was no information in this person's care plan around whether they should be supported in or out of bed. The person had not been involved and consulted about this decision and clear plans were not in place. Another person was seen to appear to be in discomfort during the inspection. Care staff we spoke with were not able to outline how they would recognise if this person was in pain and this was not clearly described in their care plan. The needs of these people had not been understood and clear plans put in place to support their individual needs. We asked another staff member about a wound on one person's foot. They were not aware of the person's needs and told us, "The nurses haven't said. I just cut up his food". People's needs were not sufficiently understood.

We found where people displayed behaviours that could challenge or would indicate they were distressed, these people's needs were not fully understood. During a staff handover meeting we heard people's behaviours described as 'interesting' and staff spoke of how some was 'telling [staff member] where to get off'. We heard no evidence of empathy or an attempt to gain an understanding of what the person may be trying to communicate and how to best support them. Assessments had not been sufficiently completed to ensure effective care plans were in place and care provided did not always meet their needs. One person's care plan outlined they had multiple mental health conditions and that they aimed to ensure their behaviour was 'within acceptable limits'. It did not identify this person's needs and the support they needed to assist them in managing their conditions in a dignified way. We found this person had been fed culturally inappropriate food, had been supported by care staff of the opposite gender against their wishes and had been distressed due to the actions of another person living at the service. The registered manager had not ensured this person's needs were fully understood and steps taken for care staff to meet their needs.

We found people's communication needs were not considered to ensure they were able to take control of choices around their day to day care. One relative told us choices were poor and said; "[My family member] has a wardrobe of clothes and always wears the same things". They told us care staff make choices without fully consulting with the person. The provider's information return stated they followed the Accessible Information Standards. However, the registered manager when asked, was not aware of the requirements of these standards which require them to make sure people with sensory loss or disability are given information in a way they can understand. We saw during the inspection people were not given information

in accessible formats with consideration to how conditions such as dementia may impact on their memory and decision making capacity. For example; we saw food choices were offered verbally from a list. There was no use of pictures or other aids to assist people. One person was unable to recall their choices 15 minutes after they had been made. Staff were not able to explain alternative methods they would use to obtain someone's choices if they were not able to respond. They told us they would use their knowledge of the person to make a choice but did not outline methods such as using pictures or written communication to enable the person to independently make choices for themselves.

People did not have access to a range of leisure opportunities that met their individual needs. One person told us there was always something to do at the service but they didn't always enjoy what was available. A relative told us, "[People] just don't get any interaction to stimulate them…No one comes to talk to [my relative], they are just lying here but they know what is going on and will respond if someone talks to them". A staff member said, "There's bingo and karaoke and that's about it". People and relatives told us how a staff member did karaoke for them and this was enjoyed by many. We also saw some games being played with people during the inspection. However, steps had not been taken to understand people's individual preferences and needs in terms of activities and leisure opportunities. Care staff also did not interact with people sufficiently on a day to day basis. As a result people's needs had not been recognised and met. Insufficient leisure opportunities were available for people to enjoy.

The registered manager had not ensured that the service was a place that people who identified as lesbian, gay, bisexual or transgender (LGBT) were able to speak openly about their life history and current needs. The registered manager, told us one person had previously had a long term relationship with a same sex partner. Care staff we spoke with were not aware of this person's history and there was no reference to this in their care plan. We also saw people's needs in relation to their culture and religion were not always understood and consistently addressed. One relative told us, "A nun comes in every Sunday to see [my relative] which is important to my relative and me". Another relative however said, "I have raised asking a priest to come in weekly to give communion to [my relative] but I don't think that is happening and my relative would like that to happen as their faith is important to them." A third said, My relative is catholic and their faith is important to them but I am not sure if the home has organised for a priest to visit yet". We found one person did not eat beef due to cultural reasons although we saw care staff feeding them a beef dinner. We also saw another person had some cards with religious pictures on them in their room. We asked a member of staff about this person's religious needs and they told us, "I'm not really sure. I don't know him… He might be catholic as there are some catholic cards on his shelf. I haven't seen a priest. They haven't told me".

The provider's information return stated a key worker and named nurse was linked to ensure people were being effectively cared for and their needs were met. It also stated that care plans reflected any changes in people's needs. We found this was not the case during our inspection. We found care plans were signed by staff to say they had been reviewed on a monthly basis although these reviews did not recognise if care plans did not reflect people's needs or if people's needs had changed. The registered manager told us, "A lot of the care plans don't even change". This demonstrated a lack of understanding around people's needs and the need for an ongoing assessment of people's changing support needs.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person centred care

We found care plans did not contain detailed information about people's wishes when they reached the end of their life. We were however given some positive examples of how the registered manager had supported people in a kind and caring way. One relative told us the registered manager had sat with people and read to them. They also told us how the bedroom doors were closed to enable a person to be taken out of the

home after they had passed away with dignity and without causing distress to others.

People who could share their views told us they understood how to make a complaint if needed. One person told us, "If there were any issues then I am confident that I could ask/ raise the matter with the manager". A relative told us, "I have no complaints or concerns but would raise them if necessary". Some relatives told us they felt their concerns weren't taken seriously by the registered manager. One relative told us, "I may as well have a cloak of invisibility on when I raise concerns". Another relative told us they did not feel their concerns had been addressed. We saw the registered manager kept a record of complaints received and sent a response. They were not keeping records of any investigations that were completed around complaints raised and needed to ensure that complainants felt an appropriate response had been sent even where the issues could not potentially be resolved.

Inadequate

Is the service well-led?

Our findings

At the last inspection completed in February 2017 we rated this key question as 'requires improvement'. We found quality assurance systems had not always identified areas of improvement required in the service. We also found the registered manager was not always aware of their legal obligations. At this inspection we found improvements had not been made and further issues had now also arisen which had exposed people to the risk of poor care and harm.

Providers and registered managers have a legal obligation to inform CQC about specific incidents such as allegations of abuse and serious injuries. They do this by submitting a 'statutory notification'. The provider's information return (PIR) stated the management team ensure that these legal obligations are met. We found this was not the case and not all required statutory notifications had been sent.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 Notificationi of other incidents

The PIR stated that all previous issues identified by CQC had been addressed and the required standards were now being met. We found this not to be the case during the inspection. The PIR stated that the registered manager and owners completed regular audits of the service. During the inspection, we found the registered manager was not completing sufficient, regular audits. Where audits were completed they were not identifying areas of improvement required and issues within the service. For example; care plan audits were completed but had not identified inaccurate or incomplete information about people's care needs. Medicines audits had also not identified gaps in people's medicine administration records (MAR). As a result issues were not identified and steps to make improvements and to ensure people were not at risk were not taken. The provider was completing quality visits to the service although these were completed against historic regulations and not the current legal requirements. This being despite the PIR stating the management team remained abreast of all changes in legislation. We found further examples of where the registered manager was not aware of current legislative requirements; for example they had failed to implement the Mental Capacity Act 2005. We found the deputy manager was in the process of reviewing audits completed in order to take action to implement a more effective quality assurance system. At the time of the inspection, this work had just begun.

The registered manager had failed to ensure sufficient systems were in place to review incidents such as accidents and safeguarding concerns. This resulted in people being exposed to unnecessary ongoing risk and repeated incidents which may have otherwise been prevented. For example; we found there was no audit of falls, accidents or any other incidents to identify trends and potential causes. As a result, steps had not been taken to minimise the risk of any likely reoccurrence. We saw examples of two people that had experienced repeated falls with no action taken to minimise the risk to them. The registered manager also did not ensure lessons were learned from these incidents in order to make improvements and minimise risk across the wider service.

The registered manager had failed to develop sufficient supervisory systems to ensure that gaps in the

conduct or skills of staff members was identified and addressed. As a result we saw examples of uncaring practice and poor quality support exposing people to unnecessary risk. Many of these issues had been raised previously either by CQC or internally yet the registered manager had failed to take sufficient action. For example; we had raised at prior inspections concerns about people being transferred in wheelchairs with no footplates. We saw this practice was still continuing during our inspection although the registered manager was not aware of this. We were told by staff members that some staff used their mobile phones when they should be supporting people. We saw this raised during staff meeting minutes yet the practice was still continuing and we saw this during the inspection. We saw numerous concerns with staff not recognising care practice was unsafe or uncaring. These issues had not been identified by the registered manager and therefore no improvement plan was in place.

The registered manager had not developed systems to ensure that accurate records were kept regarding care delivery and staff members. For example; records had not been kept on a staff member's right to work in the UK after their prior work permit had expired. The registered manager made contact with the staff member to request they brought this into the service during the inspection. We found care plans had not been updated in line with people's changing needs, even where staff had changed the care delivered. For example; one person required feeding through a tube into their stomach and updated instructions had been provided by a dietician. Staff members were delivering the appropriate care but records did not reflect this. The registered manager updated training records during the inspection as these had not been maintained. When we reviewed the records we identified errors, despite this only having just been completed. We found records relating to people's medicines administration were not always accurate and had not been completed in line with best practice guidelines. For example; when staff had created a written administration record these had not always been checked and signed by two members of staff to reduce the risk of errors as recommended.

Most people were not able to share their views about the manager. We did not see the registered manager to be visible within the service during our inspection. We found relatives who were visiting the service did however know who the manager was. Most relatives gave positive feedback about the management of the service. One relative told us, "I have found the manager very friendly, very helpful and approachable, so if I did have any concerns then I would be happy and confident to raise them with them". This view was not held by all relatives. For example; one relative said, "They need someone who is more hands on, proactive, more approachable". We found people were not always actively involved in the development and improvement of the service. Systems were not in place to ensure people's views were sought in a proactive way and used to drive improvements.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance

Some staff told us they felt well supported by the registered manager. Others told us they did not and that, "There was no leadership" within the service. One staff member told us communication was poor and the registered manager had not developed strong team working amongst the staff team. This reflected what we saw during our inspection. They also said, "I can't remember the last time there was a staff meeting". We saw staff meetings were held infrequently with very few staff members in attendance. We found a culture of accountability and continuous improvement had not been developed within the service. Staff were not encouraged to recognise and question poor practice with the confidence this would be addressed and managed appropriately. One staff member told us they didn't feel comfortable raising concerns with the manager. They told us, "The manager has got no confidentiality".

We saw some steps were being taken to make links with external organisations who could provide support.

For example; we saw a relatives group was being set up to provide support to family members. Links have been made with the Alzheimer's Society regarding a talk for relatives to provider information and support.

Duty of Candour is a requirement of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 that requires registered persons to act in an open and transparent way with people in relation to the care and treatment they received. We found the registered manager was not always open to identifying areas of improvement required within the service. Their failure to identify and accept where improvement was needed had resulted in poor standards of care remaining not addressed.

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 18 Registration Regulations 2009 Notifications of other incidents
Treatment of disease, disorder or injury	Statutory notifications had not always been submitted as required by law.

The enforcement action we took:

We imposed a condition on the provider's registration restricting any further admissions without the prior consent of the Care Quality Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	People's individual needs were not fully assessed and understood, therefore were not always met.

The enforcement action we took:

We imposed a condition on the provider's registration restricting any further admissions without the prior consent of the Care Quality Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	People's rights were not upheld by the effective use of the Mental Capacity Act 2005.

The enforcement action we took:

We imposed a condition on the provider's registration restricting any further admissions without the prior consent of the Care Quality Commission.

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	People were exposed to the risk of harm due to unsafe risk management systems, poor moving and handling and unsafe medicines management.

The enforcement action we took:

We imposed a condition on the provider's registration restricting any further admissions without the prior

consent of the Care Quality Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems were not in place to ensure all potential safeguarding concerns were recognised and reported. As a result action had not always been taken to protect people from harm.

The enforcement action we took:

We imposed a condition on the provider's registration restricting any further admissions without the prior consent of the Care Quality Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems were inadequate. Potential risk and areas of improvement were not identified. Action had not been taken to make required improvements. Records were not always complete and accurate.

The enforcement action we took:

We imposed a condition on the provider's registration restricting any further admissions without the prior consent of the Care Quality Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing People were not always supported by sufficient numbers of suitably competent and skilled staff members. Training was not always effective and further training in some areas was required.

The enforcement action we took:

We imposed a condition on the provider's registration restricting any further admissions without the prior consent of the Care Quality Commission.