Delicourt Limited

Oaklands Care Home

Inspection report

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15 September 2017

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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?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We carried out an unannounced inspection of this home on 6 and 7 September 2016 and found multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were at risk of social isolation due to the lack of activities on offer to them (Regulation 9). People did not always receive their medicines safely (Regulation 12). The registered provider had failed to ensure the home environment was clean and free from offensive odours (Regulation 15). The registered provider had failed to respond in reasonable time in respect of maintenance requests (Regulation 17). The registered provider had failed to ensure there were adequate numbers of suitably skilled, experienced and qualified staff deployed to meet the needs of people (Regulation 18). Following this inspection we served requirement notices on the registered provider. They sent us an action plan which gave details on the actions they were going to take to be fully compliant with all the Regulations by end of November 2016.

We carried out an unannounced inspection of this home on 14 and 15 September 2017 to check the provider had made the required improvements. At this inspection we found that, whilst the registered provider had taken some steps to address the concerns we found in September 2016, they had failed to be compliant with all of the required Regulations. You will find further information on the breaches of regulation we found in the full version of the report.

The overall rating for this provider is 'Inadequate'. This means that it would be placed into 'Special measures' by CQC. The purpose of special measures is to:

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□□Ensure that providers found to be providing inadequate care significantly improve

□□Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

□□Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures would be inspected again within six months. If insufficient improvements had been made such that there remained a rating of inadequate for any key question or overall, we would take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This would lead to cancelling their registration or to varying the terms of their registration within six months if they did not improve. The service would be kept under review and if needed urgent enforcement action would be considered.

However, on 11 October 2017 following our inspection, the registered provider advised CQC of their intention to close this home. An application has been received to remove this location from our register.

The home provides accommodation and personal care for up to 45 older people, some of whom live with mental health problems or dementia. Accommodation is arranged over four floors with stair and lift access

to all areas. At the time of our inspection 39 people lived at the home and one person was in hospital.

At the time of our inspection the home did not have 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. A new manager had been employed at the home in June 2017 and had begun the process to register with the Commission as the registered manager. However, they left the service the week before our inspection. Another manager, (who had previously been registered with the Commission in this home and knows the home well), had now begun the process to re-register with the Commission as the registered manager for this home.

Whilst there were safe recruitment practices in the home, there were not sufficient staff with suitable skills, knowledge and experience deployed to meet the needs of people. There was a high dependency on the use of agency staff in the home.

Medicines were not managed in a safe and effective manner. Medicines orders were not always managed effectively and people did not always receive their medicines in a timely way to ensure their safety and welfare.

Risk assessments had not always been completed to support staff in mitigating the risks associated with people's care. Care records were poor and lacked up to date information and order.

Whilst systems were in place to support staff in recognising signs of abuse, they had not identified any concerns about the safety and welfare of people in the home as we found during our inspection.

People were not always valued and respected as individuals. Staff did not always know people well and could not always demonstrate how to meet people's individualised needs. Whilst some care staff cared for people in a kind and empathetic way, we observed some very poor practices which did not always show respect and dignity for people. These practices were not challenged by other staff or the registered provider. The training staff had received was not always reflected in the care some staff provided.

People did not always receive care which was person centred and individual to their specific needs. Institutionalised routines were in place which did not reflect people's wishes and preferences. There was a lack of meaningful activities and interactions in the home to reduce the risk of social isolation for people.

There was a lack of leadership and organisation in the management of the home. Staff did not have a good understanding of their roles and responsibilities.

Whilst there was a system in place to allow people to express any concerns or complaints they may have, there was a lack of robust and effective audit in the home to monitor and review the quality and effectiveness of the service provided at the home.

Where people could not consent to their care, staff sought appropriate guidance and followed legislation designed to protect people's rights and freedom. However, care records did not always reflect this information.

People received nutritious food in line with their needs and preferences although care records were not always an accurate reflection of these.

The home was clean and maintenance was completed in a timely way.

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.

There were not always sufficient staff with appropriate skills and knowledge deployed to meet people's needs and ensure their safety and welfare.

People did not always receive their medicines in a safe and effective manner.

Risks associated with people's care had not always been identified and assessments made to reduce these risks for people.

People were not always protected from abuse or improper treatment. Staff had not recognised the concerns we found as potential abuse, so these had gone unreported.

The home was clean and maintenance was completed in a timely way.

Staff recruited to the home had been assessed as to their suitability to work with people.

Is the service effective?

Requires Improvement

The service was not always effective.

Where people could not consent to their care, staff sought appropriate guidance and followed legislation designed to protect people's rights and freedom. However, care records did not always reflect this information.

Whilst staff had received training to enable them to meet the needs of people we were not assured the registered provider had taken steps to ensure these practices were followed and embedded in the home.

Staff did not always know people well and could not always demonstrate how to meet their individual needs.

People received nutritious food in line with their needs and

preferences

Is the service caring?

Inadequate

The service was not always caring.

People said staff were mostly caring and supportive of their needs. Relatives and health and social care professionals said staff appeared to be caring and kind. However we found people were not always valued and respected as individuals.

Staff did not always know people well. Whilst some care staff cared for people in a kind and empathetic way, we observed some very poor practices which did not always show respect and dignity for people. These practices were not challenged by other staff.

People and their relatives were not involved in their care planning.
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Is the service responsive?

Inadequate

The service was not responsive.

People did not always receive care which was person centred and individual to their specific needs.

There was a lack of meaningful activities and interactions in the home to reduce the risk of social isolation for people.

A system was in place to allow people to express any concerns or complaints they may have.

Is the service well-led?

Inadequate

The service was not well led.

There was a lack of leadership and organisation in the management of the home. Staff did not have a good understanding of their roles and responsibilities.

Care records were poor and lacked up to date information and order.

Whilst the registered provider had systems in place to monitor and review the quality and effectiveness of the service provided, these had not been implemented effectively. Audits in place did not identify the concerns we noted at our inspection.

Oaklands Care 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 had made the improvements required following our inspection in September 2016 and was 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.

Two inspectors and an expert by experience completed this unannounced comprehensive inspection on 14 and 15 September 2017. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the home, including previous inspection reports and action plans the registered provider had sent to us since the last inspection. We also reviewed notifications of incidents. A notification is information about important events which the service is required to send us by law. On 8 August 2017 the registered provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR for this home.

We spoke with six people and two relatives to gain their views of the home. Some people who lived at the home were not able to talk with us about the care they received, so we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to understand the experience of people who could not talk with us. We observed care and support being delivered by staff and their interactions with people in communal areas of the home.

We spoke with the nominated individual for the registered provider and an independent care consultant the registered provider had employed to support the changes needed in the home. We spoke with the manager and deputy manager, a senior carer and four members of care staff, two members of kitchen staff and a member of cleaning staff.

We looked at the care plans and associated records for six people and the medicine administration records for 25 people. We looked at a range of records relating to the management of the service including records

of; accidents and incidents, quality assurance documents, five staff recruitment files and policies and procedures.

Following our visit we received feedback from seven health and social care professionals who supported some of the people who lived at the home.

Inadequate

Is the service safe?

Our findings

People said they generally felt safe in the home although two people told us they felt safer in the week when a manager was present in the home. One of these people told us of their concerns living with people who could often display aggression towards them. They also said, "I realise the staff have a heck of a job." Another person told us staff were, "Fairly good at answering", when they called staff for help using their buzzer. A relative told us, "I think they [staff] do their best. They are [at people's] beck and call all the time." Staff told us whilst they tried to keep people safe there were not always enough staff available to meet the needs of people. Health and social care professionals said staff were available to support them when they visited. However, they recognised a high number of agency staff working in the home meant that there were not always enough staff with suitable experience and a good understanding of people's needs available in the home. These views were reflected in our findings in the home.

At our inspection in September 2016 we found the registered provider had failed to ensure there were sufficient numbers of suitably skilled, experienced and qualified staff deployed at all times. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Immediately following this inspection the registered provider sent us an action plan detailing the actions they were going to take to ensure they were complaint with this regulation by end of November 2016. At this inspection we found the registered provider had not taken sufficient action to be compliant with this regulation.

Whilst staff rotas showed there were consistent numbers of staff deployed to meet people's needs, the suitability and experience of staff working in the home was not sufficient to meet the needs of people. There was a high use of external agency staff working in the home. Whilst this increased the number of staff available to meet people's needs, these staff often required extensive support from others to be able to carry out their duties as they did not always have suitable skills and knowledge.

For example, for two members of external agency staff we spoke with English was not their first language and their comprehension of English was poor. This has implications for the safety and effectiveness of the care they were giving to people, particularly those who live with dementia, where clear and effective communication is vital. One member of staff told us they were concerned as some staff, "…aren't good in an emergency. They don't understand enough English". We observed some staff did not always respond appropriately to instruction from other staff as they did not have a good comprehension of the actions being asked of them. During the second day of our inspection an emergency alarm went off and some staff did not understand the need to respond to this immediately.

Staff did not have time to interact with people in a meaningful way. They worked in a task orientated way to complete tasks according to the routine of the day. Much of staff activity consisted of moving people to and from rooms, such as the dining room, toilet areas and lounges at set times of the day. One member of staff told us, "We just have enough time to get straight then we start all over again".

Staff told us there were not enough staff deployed to care for people safely. One member of staff told us,

"No, there aren't. They (staffing levels) are the worst since I've been here". Another said, "It's bad now, especially at weekends because nobody wants to work then. We use a lot of agency staff then". A third member of staff said, "The manager is really good but we're very short staffed. Until that is sorted I don't see things improving".

The registered provider had failed to ensure there were sufficient numbers of suitably skilled and experienced staff deployed at all times. This was a continuing breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed our concerns about staffing levels with the nominated individual for the registered provider. They told us that recruitment in the home had proved challenging over the past year and that they would look at new ways to resolve this including the use of new employment agencies and a recruitment drive for care staff. On 19 September 2017 the registered provider sent information to the Commission of immediate actions they were taking to try to address their staffing issues.

At our inspection in September 2016 we found the registered provider had failed to ensure people's medicines were managed safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Immediately following this inspection the registered provider sent us an action plan detailing the actions they were going to take to ensure they were complaint with this regulation by end of October 2016. At this inspection we found the registered provider had not taken sufficient action to be fully compliant with this regulation.

People did not always receive their medicines as they were prescribed for their individual needs or in a timely way that ensured their safety. People did not receive their morning medicines until they arrived in the dining room area for their breakfast as medicines were stored in this area. During our inspection the morning medicines round was not completed until 11.00am on the first day and 11.50am on the second day of our inspection. Some medicines, such as those for Parkinson's disease or to reduce pain or anxiety, required administration at regular intervals or specific times to ensure they were effective. This did not always happen. For example, for one person who was prescribed a medicine to reduce their anxiety, to be given twenty to thirty minutes before personal care, we saw this was given to them whilst they were in the dining area of the home after they had received their personal care.

Medicines to be given as required (PRN) were not managed in accordance with the registered provider's policy and procedures for the management of medicines. There were no protocols in place for these medicines to show when they may be required, what they were for or the effect the medicines had when they had been administered. We saw people's individual needs to manage symptoms such as pain and agitation were not assessed and these medicines were given routinely. For example, for seven people we saw they had been prescribed medicines for pain relief to be given PRN up to four times per day. Medicine administration records (MAR) showed these people had received this medicine regularly four times per day. We observed that staff administered this medicine without asking whether it was required or assessing people's need for this. They had no pain assessment record in place and staff did not monitor or assess the levels of pain for these people. This is particularly important for people who live with dementia and who may not be able to express their pain. When we asked one person who had been given pain killers what medicines they had taken they said, "I don't really know.' They told us they had no pain.

For three people who were prescribed PRN medicines to reduce anxiety, MAR showed these medicines were given regularly by staff. This regular usage had not been referred to their GP for review. There was no protocol in place for the administration of these medicines and staff had not assessed the effectiveness of these medicines for people which can cause excessive drowsiness. We were not assured staff were

effectively administering and monitoring the use of these medicines to ensure the safety and welfare of people.

Medicines were not always ordered on time or administered in line with the GP prescription. For three people we saw medicines had been omitted or missed for significant periods of time. One person was prescribed a regular medicine to be given twice a day to support their anxieties. Staff had not administered this medicine between 11 September 2017 and 15 September 2017 as there was "No stock". Another person was prescribed a regular medicine to be given twice per day for their anxiety. Between the dates of 28 August 2017 and 15 September 2017 this medicine had not been given on six different occasions due to "No syringe" being available. A third was prescribed a medicine for dementia which had not been given between 7 September 2017 and 15 September 2017 as there was "No stock". People were at risk of harm as they had not received medicines which had been prescribed for their safety and welfare. We spoke with the manager about these omissions and they immediately contacted the GP for further advice.

Two people required the administration of covert medicines. Covert medicines are those given in a disguised form, for example in food or drink, where a person is refusing treatment due to their mental health condition. Records showed the home had taken steps to ensure families and health care professionals had been involved in a best interests' decision making process, in line with the Mental Capacity Act 2005, to ensure the safety and welfare of these two people. However, there was no written pharmaceutical advice on the suitability of covert administration to ensure medicines could be administered safely in this way. The registered provider's policies and procedures and best practice guidelines required this advice to be sought. There was no clear information for staff on how these medicines should be given covertly. For one person their MAR showed they should be given their medicines on a spoon, although their care record identified they should be given covertly. This lack of clear and accurate information was of concern as staff who administered medicines did not always know people who lived at the home. This put people at risk of not receiving their medicines in a manner which ensured their safety and welfare.

Staff who administered medicines had completed competencies in the safe administration of medicines, however we were not assured these staff had the knowledge and skills required to administer medicines safely. Staff had not identified errors and omissions in the administration of medicines for people. During a medicines round we saw a member of staff wore a red tabard which identified they should not be disturbed as they were administering medicines. Throughout the medicines round this member of staff cleared tables of crockery and removed table linens whilst people were waiting for their medicines. We observed poor interactions with people who received their medicines. One person received their medicines from a member of staff and dropped one tablet. The member of staff looked for this medicine which had fallen to the floor under a table in the communal room. They then picked it up and gave it to the person to take. This was not a safe practice.

Medicines were not managed in a way which ensured people received them in a safe and effective manner with regard for the risks associated with them. This was a repeated breach of Regulation 12 of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed our concerns about the administration of medicines with the nominated individual for the registered provider to seek immediate assurances action would be taken to address poor practices. On the 19 September 2017 the registered provider sent information to the Commission of immediate actions they were taking to ensure people received their medicines in a safe and effective manner to ensure their safety and welfare.

Risks associated with people's physical and mental health conditions had not been identified and

appropriate plans of care were not in place to mitigate these risks. For example, for people who lived with diabetes and epilepsy there were no risk assessments in place to identify the risks associated with these conditions or how these should be mitigated.

For people who lived with dementia or mental health conditions and could present with behaviours which may cause harm or distress to them or others there were no risk assessments in place to identify the triggers to these behaviours or how staff should support people to manage these. The risks associated with people's care had not always been assessed to ensure their safety and welfare and that of others.

Risks associated with nutrition and weight loss were monitored but appropriate actions had not always been taken to address any concerns identified in a timely manner. For one person we saw they had lost 22kg of weight in the six months to 25 July 2017. We spoke with the deputy manager about this weight loss and the risks associated with this. They were not clear why this had not been identified in a timely way although did provide information to show that nutritional supplements had been prescribed for the person following a review by the GP in March 2017. During our inspection a full review of weight loss in the home was conducted to ensure the risks associated with this were addressed.

For people who were at risk of falls there was a lack of clear information and assessment of these risks for staff to follow. Health and social care professionals told us, and we saw, there had been a high incidence of falls in the home. Whilst the incidents of falls in the home were recorded, the registered provider had failed to note patterns or themes from these events and take appropriate action to address these. This was being reviewed during our inspection.

Health and social care professionals told us, and we saw, there were a high number of skin tears in the home. Whilst the incidents of skin flaps in the home were recorded, the registered provider had failed to note patterns or themes from these events and take appropriate action to address these. Professionals were concerned that the lack of appropriate moving and handling practices in the home was a factor in this. We observed poor moving and handling practices in the home where staff moved people without the use of appropriate equipment. Some care staff had not assessed the risk of the actions they were taking to support people in moving around the home and they were not acting in accordance with best practice in moving and handling people. People were at risk of injury as the risks associated with poor moving and handling concerns in the home had not been fully identified, assessed and addressed.

The risks associated with people's care had not always been identified and actions taken to mitigate these. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

On 19 September 2017 the registered provider sent information to the Commission of immediate actions they were taking to ensure moving and handling practices in the home were safe and ensured the safety and welfare of people.

The risks associated with moving people in the event of an emergency in the home had been assessed. Personal evacuation plans were in place and readily available in the event of an evacuation of the home. A robust business continuity plan was in place to ensure people were safe in the event of fire or other utilities breakdown such as a power failure.

People were not protected from abuse or improper treatment. Staff were able to identify some types of abuse and they understood the correct safeguarding procedures should they suspect abuse. They were aware that a referral to the local authority should be made, in line with the provider's policy. They were also aware of the provider's whistleblowing policy. Whistleblowing is where a member of staff can report

concerns to a senior manager in the organisation, or directly to external organisations. However, whilst staff had a good understanding of how to report abuse, none of the concerns we identified during our inspection, such as people not receiving their medicines and poor moving and handling, had been identified by staff in the home as potential abuse.

The lack of awareness and recognition by staff of potential abuse and neglect in the home was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following our inspection we informed the local authority of our concerns about this service.

Records showed any safeguarding concerns which had been raised in the service by the local authority of visiting health care professionals had been addressed by the registered provider who had worked with the local authority to investigate and learn from these events. At the time of our inspection the registered provider and manager continued to work with the local safeguard authority on a service action plan written following concerns which had been raised about the home by the local authority and health care professionals.

There were safe and efficient methods of recruitment in place. Recruitment records included proof of identity, two references and an application form. Disclosure and Barring Service (DBS) checks were in place for all staff. These help employers make safer recruitment decisions to minimise the risk of unsuitable people working with people who use care and support services. Staff did not start work until all recruitment checks had been completed. Recruitment checks and information was available for all agency staff who worked in the home.

Requires Improvement

Is the service effective?

Our findings

People who were able to express their wishes felt they were involved in their care and were offered choices and support to maintain their independence. Health and social care professionals felt staff requested their support appropriately and followed guidance provided by them to ensure the safety and welfare of people.

Following our inspection in September 2016 the registered provider had implemented a programme of staff training from an external provider. The registered provider and manager monitored staff training through the use of a training matrix. Staff had been encouraged and supported to develop their skills through the use of external qualifications such as nationally accredited qualifications in health and social care.

Training included the safe administration of medicines, person centred care, safeguarding, challenging behaviour, dementia awareness, moving and handling and nutrition and dementia. Staff told us they had completed this training and records showed most staff had attended these courses. However, we were not assured the registered provider had monitored the effectiveness of this training to ensure best practices had been embedded in the home and people received safe and effective care. For example, staff moving and handling practices were not always safe, medicines were not always safely administered and care we observed was not person centred.

Staff had not received supervision or appraisals for several months with the two previous managers of the home. A member of staff told us, "I don't think it's been a priority. There's been a lot of changes with the management and I haven't had supervision for a few months" Another said, "I haven't had any supervision for about five months." The new manager and an independent care consultant acknowledged there was a lack of supervision in the home and recognised the urgent need for this to be addressed.

The lack of effective supervision and training for staff meant we were not assured people received care from staff who had the right skills and competencies to meet their needs effectively. This was a breach of Regulation 18 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Where people had the mental capacity to make decisions about their care we saw staff respected their wishes and supported them to remain independent. For example, two people preferred to eat their main meal away from the dining room and this was respected. For people who did not have the capacity to make decisions, or their capacity fluctuated, staff were guided by the principles of the MCA and mental capacity assessments had been completed for these people. The manager and staff had an understanding of the processes required to ensure decisions were made in the best interests of people. Whilst records were in place to show these processes had been followed they did not always hold information as to whether a

person had selected a legal representative such as a Lasting Power of Attorney to make decisions on their behalf.

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 application procedure for this in care homes is called the Deprivation of Liberty Safeguards. For nine people who lived at the home an application had been approved by the local authority with regard to them remaining at the home to receive all care or not leaving the home unescorted. A further 21 applications were pending with the local authority or were being submitted at the time of our inspection. Whilst some care records held information on why these safeguards were required, further work was needed to ensure the information relating to safeguards was fully incorporated into care plans. We have addressed this matter in the well led domain of this report.

Most people told us the food provided at the home was good and they enjoyed a variety of foods in line with their preferences. One person said, "The food is very nice." Another told us they enjoyed the food they were given and always had seconds. However a third person told us, "The food used to be very good, the [cook] has now left and the food has gone downhill." Another person said, "Yes it's not what it used to be." They told us they had discussed this with the manager and believed there were plans in place to review the meals available in the home. Some staff sat to eat their own meals with people and tried to create a more social environment for people.

The cook provided three cooked meals a day for people and this was based on a four week rota of menus. There was a choice of meals on offer at each mealtime and kitchen staff told us they would prepare other food for people on request. At meal times care staff presented people with a plate of each of the menu choices at the table so they could choose which they would prefer for their meal. This is good practice, particularly for those who live with dementia and may not remember choices made earlier than this.

We observed good communication between kitchen and care staff, who advised the cook of changes made to people's diets following input from visiting professionals, such as dieticians and Speech and Language Therapists. This was documented and displayed in the kitchen to ensure people received a diet which was in line with their needs. However, care records did not always provide clear information on people's likes, dislikes and dietary requirements, including those who required special diets such as soft or low calorie meals. We have addressed this matter in the well led domain of this report.

Records identified the involvement of health and social care professionals in people's care. These included feedback from GP's, speech and language therapists, community nurses, hospital consultants and NHS Nurse Specialists. This meant people received the most appropriate health care and support to meet their needs. A member of care staff was always available to support professionals who visited the home. Visiting professionals told us some staff at the home knew people very well although there were a high number of agency staff in the home who were not always aware of people's needs.

Inadequate

Is the service caring?

Our findings

People and their relatives said staff were generally caring. One person told us, "I think in the main the staff are very good." Another told us, "The staff are mostly kind and will help me if I need them." Relatives and health and social care professionals said staff appeared to be caring and kind. However we found people were not always valued and respected as individuals.

At our last inspection in September 2016 we found staff did not always display a caring nature towards people. At this inspection we observed care and support given to people throughout both days of our visit. Interactions between people and some staff were excellent. These staff consistently took care to ask people's permission to support them and provided caring and respectful responses to people's needs.

However, some staff members did not treat people in a respectful and courteous manner and these interactions were not always challenged by other staff. We saw several examples of people being treated in a way that was not appropriate or dignified. For example, one person had requested a particular meal for the following day and a member of staff told they might not be able to have it and would have to have fish and chips instead. The person became visibly upset by this and stated, "I don't want fish and chips. I hate fish!" The staff member responded by saying "Shhh. That's tomorrow. We'll sort it out!"

A second person was approached by three staff members who all stood over them. One staff member said abruptly, "Come to the lounge and watch telly. Now, let go of the chair". At no point did any member of staff ask the person if that was what they wanted to do. The person appeared intimidated by the sudden presence of so many staff. A third person was approached by a member of staff who said, "[Person's name], let's go for a walk. Stand up". There was no interaction with this person to ask if they wished to go for a walk and the rationale for moving the person was not made clear.

People's dignity and privacy was not always respected. During breakfast on the second day of our inspection one person became agitated as they wished to prepare themselves for an outing they had later in the morning. They were unable to mobilise to their room independently to do this. A member of staff spoke with this person abruptly to tell them it was too early to get ready and they had to wait until breakfast was finished before staff could help them. This person became distressed about this as they wanted to be prepared for their outing. However staff ignored their continued requests for support for over 40 minutes until we intervened and informed the deputy manager of this person's anxiety. This person's dignity was not respected as staff did not respond to their needs in a timely and caring way.

During a mealtime on the second day of our inspection, we noted one person was brought to the dining table for lunch at 12.15pm. They were placed on a table that was set for one person. They told staff, "Is this just me? Why am I sat here alone again?" Staff did not respond in a meaningful way to this. As staff left the person said, "What a place this is". They sat alone without any interaction with staff or other people for 45 minutes before lunch was served and another person joined their table. They were visibly distressed by this and had their head in their hands on several occasions. This was not noticed by staff. The person was not assisted to leave the table until 1.35pm. At one point a staff member approached the person and said, "I'll

be back soon". The person responded by saying, "So will Christmas". This person was not treated in a respectful and dignified way to ensure their needs were met in line with their wishes. Another person sat for breakfast at 09:00hrs on the second day of our inspection. At 10:25hrs they remained in the same seat with a clothes protector. There had been minimal interaction from staff throughout this period of time.

During mealtimes we observed staff standing over people whilst assisting them to eat; on one occasion a staff member was feeding two people simultaneously. This meant people did not receive effective communications or interactions with staff which were respectful and caring during mealtimes. Staff placed clothes protectors around people's necks without asking the person's permission or communicating with the person. For one person who was sat independently managing their breakfast we saw they were chewing a clothes protector which had been placed round their neck. A member of staff approached them and said abruptly, "[person's name] I think you should be more interested in the toast rather than your apron!"

Following meals some staff attempted to wipe people's hands and faces without seeking their permission or communicating with the person. This showed a lack of respect for people and some people responded to this in a distressed or angry way. For example, a member of staff attempted to wipe a person's hands after lunch without asking their permission. The person became increasingly agitated and eventually pulled their hands away saying, "Get off me!" The staff member responded by moving behind the person and roughly pulling their chair out from under the table. They were stopped by a senior member of staff at this point who told them to leave the person as they were.

Another person was sat in a wheelchair when a member of staff approached them from behind and wiped their face. The person was startled and the member of staff said, "Your face needs cleaning." This person was not treated in a dignified and respectful manner.

Staff supported people to mobilise around the home without interacting with them in meaningful ways. For example, we observed three members of staff move people away from a dining area in the home in their wheelchair without firstly speaking with the person and seeking their permission to move them or explain what they were doing. Another person was led from the dining room by the hand without any interaction from the staff member to encourage them or promote their independence.

When people received their medicines we saw a staff did not always interact with them in a dignified way. For one person who dropped a medicine before they had taken it a staff member proceeded to move their clothes around, lifting layers of clothes to find the medicine without protecting the person's privacy and dignity. The staff member did not appear to recognise they were not acting in a respectful manner in a communal area.

The lack of dignity and respect afforded to people by some staff was a breach of Regulation 10 of the Health and Social are Act 2008 (Regulated Activities) Regulations 2014.

People's rooms were personalised with their own furniture and belongings if they chose and memory boxes at each bedroom door were personalised to reflect people's life, likes and preferences. People did not remain in their rooms during the day but were taken to communal areas of the home and so bedroom doors remained closed at all times.

Care records showed no evidence that people or their representatives had regular and formal involvement in on-going care planning and risk assessment. The registered provider was looking to improve their system of care planning and records and had identified the need to involve people and their families in this work.

Inadequate

Is the service responsive?

Our findings

People and their relatives were not encouraged to express their views and be involved in making decisions about their care. Whilst some staff knew people well and understood how to support them to be as active and independent as possible other staff had a very poor understanding of this. People's care was not always responsive to their individual needs and staff were task orientated in their approach to people's care needs. Health and social care professionals said whilst some staff knew people well and understood their needs, others lacked this knowledge.

At our inspection in September 2016 we found people were at risk of social isolation due to the lack of activities on offer to them. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Immediately following this inspection the registered provider sent us an action plan detailing the actions they were going to take to ensure they were compliant with this regulation by end of November 2016. At this inspection we found the registered provider had not taken sufficient action to be fully compliant with this regulation.

A list of activities which were going on in the home was advertised on a noticeboard in the entrance of the home. This was dated June 2017 and no other information was displayed on activities in the home since this date. An activities coordinator had been employed in the home since our last inspection. However their role involved providing support for people to get up and complete their personal care in the morning before they were able to complete any activities. One member of staff told us, "We don't have time [to do any activities]. There is a co-ordinator but they help out with the care". Another member of staff said, "The activities here aren't very good because the co-ordinator gets called in to work with us when it's busy".

We asked people if there were activities for them to enjoy. One person said, "Not really. I believe they've started doing garden stuff." Another said, "They have singers in sometimes, which seem to be appreciated." A third person told us, "It's boring here. I have read the paper but what else is there to do?" During the first day of our inspection we saw the activities coordinator gave two people a manicure and painted their nails. We did not see any significant evidence of social engagement between staff and people on either day of our visit. On three occasions we observed a member of staff sat in each of four communal lounge or dining areas with people. Whilst a television was on in one area, there were no interactions between staff and people.

The home environment had been improved to provide stimulating areas where people could interact with features such as a garden mural, a wall where people could complete colouring of a mural and feel different textures. However we did not see staff use these to provide interaction or stimulation for people.

People were at risk of social isolation due to the lack of activities and meaningful interactions available to them. This was a repeated breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst people's needs had been assessed prior to their admission to the home, their preferences for how they wished to receive their care and personal history were not always documented. This meant there was

not always clear information available for staff on how to meet people's needs. People's care plans lacked information about how they should receive care in a way which was person centred and specific to their needs. For example, for two people who lived with diabetes we saw their care plans lacked information on how this condition affected them as individuals and how staff should support them with this condition, in particular reviewing the risks associated for the person. For another person who needed medicines prior to them being supported with personal care and mobility, we saw their plans of care did not demonstrate this personalised need and this need was not being met.

For people who lived with dementia we saw their plans of care lacked information on how staff should assess each person's pain or agitation and actions they should take to support these people in a personalised way. There was no information for staff on how they could support people with behaviours which may have been distressing or caused harm to them or others. We saw people were supported to take medicines to manage these symptoms without being monitored and assessed appropriately for these. This meant that people were not always supported in an individualised way to maintain their comfort or distress without the possible undue effects from taking medicines they may not have required. This was clearly demonstrated when we noted one person had not received medicines for their anxiety for over three days in error. The manager told us they were very bright and cheerful despite not having received their medicines regularly. We observed this person was chatty and friendly with staff and on further review by a GP these medicines were stopped. We were not assured people were being supported in an individualised and therapeutic way to ensure their pain and anxiety was manage appropriately.

There were institutionalised practices in the home which required people to get up and attend breakfast in the dining area where medicines were 'given out'. Other mealtimes we observed were at set times through the day in a large dining area which lacked any atmosphere or warm interactions with people. After mealtimes people were moved out of the dining area to sit in other communal areas of the home without any purpose or meaningful reason for them to move. Staff made comments which suggested people were not receiving personalised care which supported them in a meaningful way in line with their preferences and needs. One member of staff referred to a person by their room number rather than their name when they said, "I have to get Room [number] ready then I will be able to help [person] with their breakfast." Another said, "Everyone in that room needs to be taken to the toilet."

The lack of personalised care people that received which was not always responsive to their needs was a breach of Regulation 9 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

The complaints policy was displayed in the entrance to the home. People and their relatives were aware of the policy and felt confident any concerns they raised would be addressed promptly by the manager other staff. Records of three formal complaints received in the home in the past year showed these were responded to in a timely way and in line with the registered provider's policies and procedures.

Inadequate

Is the service well-led?

Our findings

People and their relatives were aware there had been a change in the management of the home recently. One person said, "There has been some changes in the managers, things will improve now." People said they felt able to talk to staff and the new manager if they had any concerns and that these would be dealt with promptly. We asked staff if they thought the home was well-led. One told us, "I think it is now. The previous manager didn't help us at all. I never saw them".
Another staff member said, "There's still a lot of problems and we have a lot of agency staff but I think things are getting better".

At our inspection in September 2016 we found the registered provider had failed to respond in reasonable time in respect of maintenance requests. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. Immediately following that inspection the registered provider sent us an action plan detailing the actions they were going to take to ensure they were compliant with this regulation by end of November 2016. At this inspection we found, whilst systems were now in place to respond to maintenance requests, the registered provider had failed to take actions to be fully compliant with this regulation.

At the time of our inspection the home did not have a registered manager in post. A new manager had been employed in June 2017 and had been supported by the registered provider to address the concerns we had identified and meet compliance with the regulations. However, this manager had left the service the week prior to our inspection. Another manager, who had previously been registered with the Commission in this home, had begun the process to re-register with the Commission as the registered manager. Whilst the registered provider had provided support for the previous manager they had failed to ensure they had effectively managed the home and ensured the safety and welfare of people. They acknowledged to us during our inspection that they required a stronger presence and involvement in the management of the home to ensure it achieved compliance with all the required Regulations.

During our inspection we found there was a serious lack of guidance and leadership to ensure all staff had a good understanding of their roles and responsibilities in maintaining the safety and welfare of people who lived in the home. Whilst the manager and deputy manager demonstrated the skills to support staff and be an integral part of the daily staff team, they were unable to do this. Their roles were overwhelmed with the amount of change required in the systems and practices in the home, which they had recognised was needed, to ensure the safety and welfare of people.

An independent care consultant was available to give support and guidance on the regulatory responsibilities of the registered provider and manager. However, they and the registered provider and manager acknowledged there was a large amount of work required to ensure staff understood their roles and responsibilities within this. Where staff had not received clear guidance and support to understand and recognise their responsibilities, this had impacted on the structure and day to day leadership within the staff team. Senior care staff did not appear to have the authority or autonomy to address concerns consistently or appropriately. For example, poor moving and handling practices went unchallenged by

senior carers and poor interactions were not identified to senior care staff. A senior member of staff reported they were verbally challenged when giving directions to staff to ensure the safety and welfare of people and this had not been addressed by management. There was an accepted culture in the home where some staff had a lack of respect for leadership in the home and this had not been addressed.

We spoke with the registered provider at the end of our inspection. They told us they recognised the need to review and establish a strong leadership team in the home and this would be addressed immediately.

Care records lacked order, were not always accurate, consistent or up to date. There was no consistent format of care records in the home for people. Each of the previous two managers had implemented different systems of care records and neither were complete. Some information was contained on computerised records and had not been updated in paper records available for staff. Other daily care records were maintained on the computer but did not fully inform people's plans of care. We were particularly concerned that the high number of agency staff working in the home did not have access to up to date records on people's needs and preferences, especially as some of these staff administered medicines for people.

We asked the deputy manager how agency or new staff were supported to have clear and accurate information for the people they were caring for, particularly if they were in a senior role. They told us a 'Crib sheet' was available for each person on their daily needs, likes and preferences. However, these sheets contained inaccurate information which lacked details on the risks associated with people's care and did not identify many of their specific needs. For example, for one person who required thickened fluids to reduce their risk of choking their 'Crib Sheet' held no information on their nutritional needs. For another person who lived with epilepsy their 'Crib Sheet' did not identify this risk. People were at risk of not receiving the care they required in line with their needs and preferences especially from staff who did not know them well.

A hand over sheet for staff which provided information on people's daily interventions lacked clear information on people's needs and was not always accurate. There was no information on these sheets on people who required covert medicines or had Deprivation of Liberty safeguards applied for. There was no information about falls risks or recent incidents and accidents. Staff were not always able to access information to ensure they had the knowledge to meet people's needs although during our inspection no member of staff sought to view any plans of care to inform the care they were providing. One member of staff told us they had not read any care plans recently as, "a matter of choice." We were not assured staff had a good understanding of the need for clear, accurate and contemporaneous records to ensure the safety and welfare of people.

The registered provider did not have effective systems in place to monitor and assess the safety and quality of the service they provided. Whilst they had effective and up to date audits of the health and safety in the home, and maintenance and equipment checks were completed, there was a lack of robust and effective audits to identify shortfalls, such as the concerns we had raised during our inspection. For example, skin integrity audits were undertaken monthly. However, these were merely a description of the wounds or skin integrity issues. There was no evidence of the provider attempting to identify the cause of these wounds or common themes emerging. There was no action planning to address issues arising from the audits. Infection control audits were not effective in identifying some areas of cleanliness which required further attention. Care records were not reviewed, audited and monitored for effectiveness and to ensure the safety and welfare of people. Medicines audits were ineffective and meant people were placed at risk of serious harm from the poor management and administration of medicines. The registered provider did not have efficient systems in place to identify the poor staff practices which were evident in the home such as moving

and handling and communication.

The registered provider had formally sought the opinions of people using the service in March 2017. We noted satisfaction surveys were given to people to complete and return. We looked at nine of these which had been completed and returned. Whilst the questionnaires showed a high degree of satisfaction in some areas, such as food quality and cleanliness, four people expressed a degree of dissatisfaction in the flexibility of mealtimes and the lack of activities at the home. We found no evidence of a consistent and concerted effort to address these issues and respond to people's concerns. Our own observations and conversations indicated these areas remained problematic.

The lack of consistent and effective leadership, poor record keeping and poor governance in the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance.