Ranc Care Homes Limited

Park View Care Centre

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 2 and 4 February 2016 and was unannounced. Park View Care Centre provides accommodation and personal and nursing care for up to 88 older people. There are two residential units in the home which accommodate people with nursing needs, and two which accommodate people living with dementia. There were 82 people at the service at the time of our inspection. People were living with a range of care and health needs, including diabetes and Parkinson's. Many people needed support with all of their personal care, and some with eating, drinking and mobility needs. Other people were more physically independent and needed less support from staff.

The service had a registered manager in post at the time of our visit. 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.

Risks to people's safety and welfare had not always been appropriately addressed. There was not a robust system for keeping people safe from harm because staff had not been consistently completing incident reports and the registered manager had not raised safeguarding concerns with the local authority.

Actions to minimise identified risks to people had not been carried out in practice, leaving people exposed to risk of harm. This included people who had experienced repeated falls and those who were at risk of skin breakdowns. Creams had not been stored or recorded appropriately, which created a risk that people might not receive them as intended by the prescriber. Other medicines had been properly managed.

There were not enough staff on duty because data about people's needs and dependencies had been inaccurately submitted to the provider by the registered manager. Staff training was lacking in some areas and ineffective in others. Supervisions by the registered manager had not identified shortfalls in staff knowledge which affected their ability to carry out their roles competently.

Fire drills and testing had been conducted regularly and the premises were well-maintained throughout. Auditing however, was largely ineffective in highlighting where the quality and safety of the service could be improved.

The principles of the Mental Capacity Act 2005 (MCA) had not been properly followed in relation to assessments about people's capacity and decisions made on their behalves. Restrictive practices were observed but staff did not understand that these deprived people of their liberty.

Most staff were caring and considerate but people's dignity was not always considered or protected. Some staff did not always act to meet people's needs and this impacted on people's experience of living in the service. People had not always been protected from the risk of social isolation. There were three activities coordinators working at the service for a total of 118 hours per week. We spoke with one of the coordinators

who worked three days per week. Some people spent long periods without any stimulation or interaction.

Complaints had not always been managed effectively. Care planning was not sufficiently person-centred in some cases, but people's need for independence where possible was considered. People and relatives said they had not been involved in care planning.

The service was not well-led and there was no proper or robust quality assurance processes in place.

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 safe.

Incidents of harm or potential harm had not been consistently reported to the local authority or CQC.

Risks had not been appropriately mitigated to ensure people's health and safety.

There were not enough staff to meet people's needs.

Is the service effective?

Inadequate

The service was not effective.

The service was not working within the principles of the Mental Capacity Act 2005 (MCA).

Staff training was not always effective in helping them to carry out their jobs but they were knowledgeable in some specialist areas.

People were not consistently supported to eat their meals.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's dignity had not always been protected or considered.

Some staff were caring and kind but others did not always act to meet people's needs.

End of life records and training were lacking.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Complaints had not been managed properly.

There was a lack of activities and stimulation for some people.

Care planning was not consistently person-centred.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had not ensured that proper and robust quality assurance processes were in place.

Audits had not been effective in identifying shortfalls in the safety or quality of the service.

Actions in response to feedback about the service had not been implemented successfully.

Confidential records had not been kept securely.

Park View Care Centre

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 2 and 4 February 2016 and was unannounced. The inspection was carried out by three inspectors and two specialist nursing advisors. A specialist advisor is someone who has clinical experience and knowledge of working with older people and those who live with dementia.

Before our inspection we reviewed the information we held about the service including previous inspection reports. We considered the information which had been shared with us by the local authority and other people, and looked at notifications which had been submitted. The provider had 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 met eighteen people who lived at Park View Care Centre. Not everyone was able to verbally share with us their experiences of life at the home. This was because they were living with dementia. We therefore spent time observing their care, including the lunchtime meal and activities. We spoke with nine people's relatives We inspected the environment including bathrooms and some people's bedrooms. We spoke with eleven care staff including nurses, the deputy manager, registered manager and regional operations manager.

We 'pathway tracked 'twelve of the people living at the home. This is when we looked at people's care documentation in depth and made observations of the support they were given. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

During the inspection we reviewed other records. These included staff training and supervision records, staff recruitment records, medicines records, risk assessments, accidents and incident records, quality audits and policies and procedures.

Inadequate

Is the service safe?

Our findings

One person told us told us, "I don't feel safe because I feel cooped up here and I don't like it". Another person said; "The staff are very good to me and they make me feel secure". A relative told us, "I just look at the care and concern they give my relative. She only has to call and someone is there. That's what I call being safe".

There was not a robust system in place for consistently protecting people from abuse or harm. Incident reports had not always been completed following events where people were harmed or there was potential for harm. On other occasions, incident reports had been completed but no further action had been taken by the registered manager. On the second day of our inspection, the regional operations manager told us that 14 such incidents had not been referred to the local authority safeguarding team since 1 December 2015; for their consideration and possible investigation. Following the inspection, the regional operations manager informed us that a total of 22 safeguarding incidents had not been referred since 1 November 2015. The types of event that had not been referred included physical aggression from one person to another, inappropriate behaviour of a sexual nature, and unwitnessed falls. Six of these falls had resulted in head injuries, but people had not been examined by a paramedic or sent to hospital following them. The regional operations manager told us that it was the provider's policy that all head injuries should be assessed in this way; but this had not happened. The registered manager, who is also a registered nurse, told us that she did not know that this was the provider's policy. She said that staff had not made her aware of some incidents, but conceded she knew of others but had failed to follow correct procedures to keep people safe. Staff said they would tell the registered manager about any events which caused harm to people, but not all staff understood that incident reports should be completed. The local authority safeguarding protocol held in the service was dated 2012 and had not been replaced with up-to-date guidance about identifying and reporting incidents. The regional operations manager made referrals to the local authority safeguarding team, in retrospect, during and after our inspection.

The failure to operate robust systems to keep people safe is a breach of Regulation 13 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care files contained assessments of any individual risks that had been identified. These included falls, mobility and skin condition. However, actions to minimise risks to people had not always been followed through in practice. For example, one person had been assessed at very high risk of falling and had been injured in previous falls. Their care plan stated, 'Very poor mobility; needs supervision as at high risk of falls'. We observed this person on two occasions trying to stand up from their chair alone. There were no staff in the lounge to see this happen and intervene. On another occasion, two staff were using a hoist to transfer another person and had to call across the room to say, "Sit down please, X, sit down". The registered manager told us that this person was meant to be supervised at all times, but this did not always happen, leaving them at risk of further falls.

Other people were at risk of pressure wounds or skin breakdowns and had special air mattresses to provide comfort and help to protect their skin. The air mattresses were meant to be set to the person's weight; to

provide the best therapeutic effect. However, we found that none of the mattresses were set correctly, including those in use for people with nursing needs. One person's was set at 90 kg when they weighed 31 kg, another at 120 kg when the person weighed 65.4 kg and a third was set at 100 kg when the person weighed 75.2 kg. Staff showed us a daily checklist which included whether the pump was on and the mattress inflated, but no check to see that the air flow was on the correct setting. The regional operations manager told us that staff had been using the wrong checklist, but we were unable to tell how long the mattress settings had been unchecked or incorrect. The settings were put right during our inspection but people had not received the intended benefits of having air mattresses.

Some people living with dementia showed behaviours that challenged themselves and others. Assessments about the risks associated with this did not always contain enough guidance to help staff manage situations appropriately. For example, one person was clearly very agitated and was walking around the unit banging on surfaces, shouting and pulling at staff's uniforms. Staff removed the person's hand from their clothing but did not offer reassurance or provide any distraction for them. Other people were becoming distressed at the noise, and two people called out for them to "Shut up" and "Just stop it". The risk assessment about the person's behaviour stated that, 'Staff to provide close supervision and understand mood changes'. Another person's care plan recorded that they could become irritated, frustrated and distressed at times. The instruction to staff was, 'Support X's needs to be relaxed and happy'. This did not help staff to understand any triggers to people's behaviour or guide them about the best way to support people and protect others during episodes.

The failure to take appropriate actions to mitigate risks to people's health, safety and welfare is a breach of Regulation 12(2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

There were not enough staff to meet people's needs and keep them safe. There were 82 people in the service during our inspection. People living with dementia were in two units on the ground floor. There were 10 staff in total on the ground floor units; including a supernumerary Residential Care. The regional operations manager told us that thirteen people living on the ground floor showed behaviours that challenge. On the first floor people received nursing care for conditions such as diabetes and Parkinson's. Some people had catheters, special feeding tubes, swallowing difficulties and/or pressure wounds. There were two registered nurses and ten care staff working on the first floor on both days of our inspection.

The registered manager said that staffing levels were based on people's needs and that a monthly dependency tool was used to work out how many staff should be rostered. However, when we asked to see these tools we found that the most recent had been completed in September 2015. The registered manager explained that staff on each unit were supposed to complete the dependency tools each month. These were then passed to the registered manager for submission to the provider through a computer system. However, the registered manager said that staff had failed to complete the tools and she had made submissions about people's needs based on her own knowledge about the care people required. Following the inspection, proper dependency assessments were made and the regional operations manager was able to confirm that this failure to submit accurate and up to date information about care needs had resulted in the service running with four and a half staff short.

We observed the impact of the staffing shortfall during our inspection. People were left unsupervised in the first floor lounge for periods of up to 30 minutes. Some people called out for attention and one person, who was at high risk of falling, tried to stand up alone. The registered manager told us that there should be one staff member in the lounge at all times but this had not happened. People's safety was at risk because of this. One relative told us, "Bells are often ringing for a long time before they stop. People sometimes wait a long time for assistance". Another relative commented, "There aren't enough staff. My relative can't use her

call bell and she often says that she can't get any staff to come to her".

At lunchtime, some people waited 35 minutes to be assisted to eat their meal, while others around them were eating or had finished. Staff said that they tried to help people as quickly as they could but that there was just not enough staff to assist everyone together. One person was constantly rubbing their stomach and making noises while staff helped people either side of them to eat. Staff said, "Just let me finish feeding X and then I'll get to you". The person was able to see and smell the food being served but was unable to feed themselves, which was distressing for them.

The failure to ensure sufficient staffing is a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment systems were not sufficiently robust to provide assurance about staffs' suitability. Four staff files were reviewed but details were missing or incomplete in each of them. Three files had no current photo of the staff member and incomplete work histories on their application forms. Two files held inadequate references; which were either uncomplimentary about staff's aptitude or was a printed reference provided to the staff member some years previously. The printed reference was dated 2011 and the staff member began work in the service in 2014. A second reference for this staff member had been provided by a neighbour. There were no risk assessments in place about employing these staff and the provider had not ensured proper background information had been sought to determine that staff were suitable for working in the service.

The failure to properly operate a robust recruitment procedure is a breach of Regulation 19(3) (a) and Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Prescribed creams had not always been stored appropriately and were seen on window sills and surfaces in people's bedrooms. The registered manager said that there were no risk assessments in place about this or the possibility that people might apply more of their creams than had been prescribed for them. Records for creams did not consistently match up with the items seen in people's rooms. For example; we found two creams in one person's room, but the creams application chart for them only showed one different cream. Staff told us that the two creams in the bedroom were "Probably not being used now", but they were still available and there was a risk they could be applied by staff or the person by mistake.

The unsafe management of some medicines is a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Equipment for use in people's care and treatment was not always clean and in some cases had not been recalibrated in line with the manufacturer's guidelines. On the nursing floor, a hoist and equipment for supporting people to stand were both dirty. A blood pressure monitor and a special device for giving monitored doses of medicine had not been recalibrated within acceptable timescales. The device for medicines had not been used for around two years but there had been no reliable system for routine maintenance of some equipment. The regional operations manager removed both these items from service immediately and checked all other equipment in the service and found it to have been recently calibrated.

The failure to maintain and clean equipment appropriately is a breach of Regulation 15(1)(a)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other equipment such as bath hoists, fire extinguishers and fire blankets had all been serviced regularly and were labelled to evidence this. Electrical testing had been carried out and the service's water system

checked. There was a maintenance book in place in which staff recorded any repairs which were needed. This had been signed off to show that jobs had been completed promptly. The premises were in good condition and decorative order throughout.

People had individual emergency evacuation plans which gave guidance about how they could be quickly and appropriately supported to leave the premises if urgent or immediate need arose to do so. Fire alarms had been tested weekly, and full fire drills recorded how long it had taken to move people to safe areas. There were remedial actions shown to improve on any delays and these had been followed through.

Medicines other than creams, had been managed effectively. Records showed that people had received their medicines as prescribed to them. Controlled drugs had been monitored appropriately and administered in line with best practice, and there were special recording sheets and protocols for other drugs which posed particular risks, such as Warfarin. Medicine administration records held photos of people to help staff ensure that the right person received medicines, and any known allergies were clearly shown to minimise the risk that people would suffer adverse reactions.

Inadequate

Is the service effective?

Our findings

One person said, "The food's ok" but another described it as, "Just edible-not very palatable at all". Relatives said that there were always plenty of drinks available. They also told us that they had faith in the staff and that "They know Mum and they know what they're doing"..."They're certainly on the ball". Our findings however, did not always agree with the feedback we received from people and their relatives.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA). This 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.

Some people living with dementia had stair gates across their bedroom doors. Staff explained that this was to prevent other people going into their bedrooms uninvited. However, the stair gates also had the effect of keeping people from freely moving around the unit. One person shook their gate repeatedly and was calling out to staff for their breakfast. Staff were calling back to this person and passed them their breakfast bowl over the stair gate. Staff could not tell us why this person could not have had their breakfast in the dining room with others, despite the person showing their wish to leave the bedroom. There were no MCA assessments or records of best interest decisions about the use of stair gates, which meant that people's rights and wishes had not been properly considered. We instructed the regional operations manager to remove the stair gates until proper assessments had been made.

One person was receiving their medicines covertly, or without their knowledge. For this to be appropriate, an MCA assessment should first have been carried out to determine whether the person had the capacity to make their own decisions about taking medicines. Although there was clear pharmacy guidance with this person's medicine charts, to confirm that an MCA assessment was required, this had not happened. The provider could not evidence that people's care had been provided in line with the principles of the MCA.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).DoLS applications had been made for some people but the DoLS authorisation for one person had expired on 22 January 2016. This person had therefore been unlawfully deprived of their liberty since that date. There was no system in place to alert the registered manager when the expiry dates of DoLS authorisations were approaching, which meant that reapplications had not been made in a timely way. Following the inspection the regional operations manager confirmed that a system had been implemented to prevent this happening again.

Another person, who was prone to falling, was observed sitting in an armchair with a lap table placed in front of them at a right angle; effectively wedging them into the chair. There was nothing at all on the lap table and there were no staff in the lounge with this person. We asked staff why the lap table was positioned in this way and they told us , "It's for their own safety, to stop them falling when we can't be there". Staff did

not understand that placing the lap table in this way was a form of restraint and could be unlawful. We spoke to the registered manager about this immediately and she told us that the lap tray would be removed and a staff member allocated to be in the lounge at all times.

The failure to act in accordance with the MCA 2005 is a breach of Regulation 11(1) (3) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People were not consistently supported to eat. We observed two lunchtimes and found that some people waited up to 35 minutes to receive support with their meal. On the first floor there were many people who required help from staff with their food. One staff member assisted a person with three mouthfuls of their meal and then left them because the person did not immediately want another spoonful. They did not wait for a while and then try again or provide any verbal encouragement to the person. Another person was seated between two others who were receiving assistance from staff. They could see and smell the food and rubbed their stomach, making sounds throughout. Staff did not pick up on these non-verbal cues and this person waited 35 minutes to be supported to eat. Two people were given drinks and immediately knocked them over onto their trays. Staff did not replace these or mop up the liquid and one person's sleeve rested in this over lunch. People were not offered a choice of drinks with their meal, although we did see that some people had blackcurrant and others had lemon squash. Staff told us that they knew what people liked and just gave it to them. They had not considered that people might like to change their choices.

One staff member stood up between two people with their back against the table and fed a person 'backwards'. This was not a relaxed experience for the person and meant that the staff member had her back to another person seated on the opposite side of the table. Another person was eating using a knife. There was no guard on their plate so food was being pushed off it and the person managed very little to eat. Staff did not intervene to assist this person. The lunchtime was almost silent, with no music and little interaction between people. Tables had no cloths or placemats and there were no condiments on any of them. There were no curtains or blinds in the first floor dining room during our inspection, as the room was being decorated. Bright sunshine streamed through the large windows directly into people's eyes. Staff did not react to this and overall, lunch was not a pleasant or sociable time for people.

Some people's food and fluid intake was recorded on daily charts. The information held on these was generally thorough but we found that prescribed meal supplements were not shown when people had them. The charts where not wholly accurate therefore, as they did not include all of people's intake and would be of limited use in identifying whether people had received adequate hydration and/or nutrition. Although most people's weight was stable, one person had lost eight kgs over eight months and a referral had been made for dietician intervention on 6 October 2015. At the time of our inspection on 4 February 2016, this person had still not been seen by a dietician. Staff told us that they had chased this up once by telephone but had still not received an appointment for the person to be assessed. This person remained at risk due their weight loss, although their food and fluid charts showed that their intake was reasonable.

People had access to dentists, opticians, chiropodists and other professional treatments to help maintain their health. Some people had diabetes and their blood sugar was monitored daily. However, there was no guidance for staff about upper and lower limits and what action should be taken in the event of high or low blood sugar levels. Nursing staff told us that if the blood sugar levels were high then the GP would be informed. One person had high blood sugar levels on several days in the weeks before our inspection. This had not been picked up by staff as a potential problem and the GP had not been contacted, placing the person at risk.

The failure to appropriately meet people's needs is a breach of Regulation 9 (1)(a)(b)(3) (i) of the Health and

Social Care Act 2008 (Regulated Activities) 2014.

Staff had received training in a range of subjects such as dementia care, fire safety and safeguarding people from harm. They told us that they could also access additional training in other subjects if they wished. Most of the training had been delivered through e-learning and had not always been effective in preparing staff to carry out their roles. For example; records showed that 90% of staff had been trained in MCA and DoLS but we found their knowledge and understanding about this lacking in practice. Although 95% of staff had safeguarding training, they had not understood the need to report incidents properly; which had resulted in people remaining at risk of harm. Staff told us that they had no specific training about managing behaviours that challenge. Given that at least thirteen of the people using the service sometimes challenged, this meant that staff were not prepared with the knowledge to respond appropriately.

Staff had not always been properly equipped for their work through appropriate training. Three modules were listed on training records as practical sessions. These were; basic life support, moving and handling and fire safety. Records showed that all staff were overdue to have this training or to have it refreshed. Staff had completed e-learning about each of these subjects but lifting and hoisting people and giving CPR safely would require staff to have hands-on engagement. Staff had received regular supervision but this had not been effective in identifying some of the shortfalls we found in staff knowledge and understanding.

The failure to ensure staff receive effective training and supervision is a breach of Regulation 18 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff were knowledgeable about specialist feeding methods and demonstrated good practice in these areas. Meals seen during the inspection appeared appetising and plentiful and people seemed to enjoy them. One person made a point of telling us, " The fish on Fridays is beautiful". Milkshakes were available and staff said that these helped to "Get goodness into people and build them up". People's care plans included information about how much fluid people should aim to drink each day.There was a kitchen communication book in place which staff used to pass comments to the kitchen staff about meals such as "Residents enjoyed the meal and the nice pudding", "Jelly at suppertime was not set, residents needed to drink it'. Staff told us that this book helped kitchen staff to understand the meals people enjoyed most and to help improve the food provided. Menus were four weekly and there were additional special occasion menus available such as for Valentine's Day.

Pressure wounds had been managed in line with best practice guidelines. Assessment tools were used effectively to identify those people at risk of skin breakdowns; and preventative measures such as frequent repositioning had been put in place. Repositioning charts showed that people had been turned in line with instructions in their care plans. Appropriate dressings had been used to promote healing, and records showed that wounds were regularly monitored and reassessed. Catheter care had been effectively managed by staff, who were well-informed about current best practice.

Requires Improvement

Is the service caring?

Our findings

One relative told us, "It's a fabulous home and all the staff are really brilliant". Another relative said, "Some staff are better than others, the newer ones can be a bit abrupt with Mum and tell her what to do". A further relative commented, "Staff are never demeaning. If Mum has an accident, they just say "Come on, let's sort this out" ".One person said, "I don't like one of them [Staff], but he keeps away from me and I him".

We spoke to people and relatives where possible about their experiences of the service. Many people were living with dementia however and were less able to have meaningful conversations about their care and treatment. We carried out a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

Most staff interacted with people in a positive and kind way. We observed one person asking for an alcoholic drink and staff gently suggested that it was rather early in the day and perhaps a cup of tea would be more refreshing. This staff member encouraged people to laugh and joke with them and there was a pleasant atmosphere while they did. Another staff member reacted in a caring, supportive way to a person who was confused and needing reassurance. One staff member told us, "It makes me proud to see people smiling". Other staff however did not always treat people compassionately. There was a miscommunication between staff and one person and when the staff member had to repeat themselves, their tone became disrespectful and patronising. Another person told us how staff had been short with them because they did not wish to go to bed at 7:30pm. When the person explained that they preferred to retire later, they said staff responded, "We can't be expected to remember what everyone likes".

People and relatives told us that they had not been involved in their care planning. There was no evidence in care plans to show that decisions and choices had been made in consultation and agreement with people and their families, where appropriate. Some relatives were full of praise for the way in which staff cared for their loved ones but others remarked that communication was often poor. One relative said," The only time we get involved is when things go wrong. We haven't been invited to any reviews or anything of that nature".

Although no one was receiving end of life care during our inspection, staff said that they delivered care to dying people as the need arose. Neither the registered manager nor staff were aware of the Gold Standard Framework (GSF). This is recognised best practice in caring for people at the ends of their lives. Staff told us that they had not undergone any training about end of life care. Although there was a section in care plans about advanced care planning, none of those we reviewed had been completed. This meant that staff may not be aware of people's wishes about their care and treatment at end of life and had not been trained to anticipate and manage people's symptoms at that time.

The failure to consistently meet people's needs and involve them in their care planning is a breach of Regulation 9 (1)(a)(b)(c)(3)(a)(b)(d)(f) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff were clearly busy but this sometimes meant they failed to respond to people's needs.One person's relative was observed asking staff for pain relief for their loved one. Staff responded that the nurse was on

their break and would deal with the request on their return, but did not find another nurse to assist so that this person did not have to wait for their pain relief. Another person had a stair gate across their bedroom door and staff passed them their breakfast over the gate. They also carried on conversations with this person across the gate, rather than unfastening it and entering the room to do so. This was not considerate of the person's dignity.

There were other occasions when staff did not act to protect people's dignity. For example; one person was in their room with the door wide open onto a communal corridor. They were lifting their nightdress to waist height and wiping their naked private parts in full view of anyone passing their room. We brought this to staff attention and they initially told us that this person "Is OK", before pulling the door closed.

Staff placed food protectors around people's necks without asking permission to do so. They also approached people from behind while doing this; which seemed to startle some people. People sat for long periods of the day in wheelchairs; including for their meals. Staff wheeled people into the dining room and positioned them at tables without offering people a choice about where they sat. We noticed that the men were all seated together at tables. Staff could not tell us why this was. We saw that people had been lined up in wheelchairs in front of the television in one lounge. The volume had been turned off on the television and people just sat and stared at the screen or slept in their wheelchairs. We asked staff why the volume was off and they said they did not know how to operate it. We checked later in the day and found that people were still sitting like this and that the volume had not been turned up on the television.

The failure to consistently show people dignity and respect is breach of Regulation 10 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Relatives said that they were able to visit the service at any reasonable time and that they were always made to feel welcome. One relative told us, "I feel like part of the family there". Staff commented that, "We just do our very best for people".

Requires Improvement

Is the service responsive?

Our findings

One person told us; "I would speak to staff wearing the dark blue uniforms [Nurses] and I think they would help me if I had a complaint". A relative told us, "I'm not sure how to make a complaint but the administration staff are always friendly and helpful, so I would probably speak to them". Copies of the provider's complaints procedure were displayed in the service. However, not all of these were up-to-date and one copy was not easily accessible because it was pinned to a wall behind some chairs.

Complaints had not always been managed effectively, and records about them were inconsistently maintained. For example; some acknowledgements and final response letters were not dated, which made it difficult to tell if they had been sent within appropriate timescales. We were able to see, however, that final replies to complaints had not always been given within the 28 days stated in the provider's complaints policy. The document used for logging complaints did not allow for full details to be recorded; such as the date a response was sent, the complaint outcome or any resulting actions. There were no records of any investigations made into complaints and we read an e-mail from a relative who said that the written response they had received to a complaint, 'Bore no relation' to the conversation they had had with the registered manager. We asked the registered manager if she had kept a note of that conversation, but she had not. This meant the records about this complaint were incomplete and misleading.

We read two 'Comments and suggestions' from relatives who expressed concern about visiting Jehovah's Witnesses to the service. Both relatives said their family members would not have taken part in the sessions that took place if they had known that they were being delivered by visitors who held those religious beliefs. The registered manager confirmed that these comments had not been treated as complaints; they had not therefore been formally acknowledged and no investigation or actions had been documented. Staff told us that they discussed complaints in general terms, and any learning from them at their meetings. However, they were unable to give us any examples of this. We read notices around the premises reminding staff to speak in English at all times and the registered manager told us this was in response to a complaint.

The failure to operate an effective system for managing complaints is a breach of Regulation 16 (1)(2) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We received mixed views about the activities on offer. One person told us," I like the music people who come in every three to six weeks or so, but no one bothers with the games". Another person said that, "There's not been much on for a week or so". In a survey of relatives conducted in October 2015, one family member responded,' Fantastic activities schedule" but another commented,' Be good if something to occupy their time other than TV'.

There were three activities coordinators working at the service for a total of 118 hours per week. We saw some people on the ground floor engaged in puzzles, games and crafts, but others just sat in armchairs or at tables. One activities coordinator was proactive in trying to gently encourage people to become involved; but not everyone was interested. On the first floor, no group activities happened during the two days of our inspection. People generally sat in wheelchairs or armchairs in communal lounges and there was no

interaction between them. There was no stimulation at all for these people. The television was on, but the volume was switched off. People in wheelchairs were positioned in a line in front of some others seated in reclining armchairs, so it would have been difficult to see the television over people's heads.

We visited other people who stayed in their bedrooms and were nursed in bed. There was little if any stimulation for these people. One person had a radio in their room but this was switched off on each of three occasions when we visited them. There was nothing else for them to do at all. Another person's bed had been positioned in such a way that they could only see the television out of the corner of their eyes. We asked staff about this and they explained that the bed had been moved because the wallpaper was becoming damaged in its previous location. Staff acknowledged that the person could only see the television in their peripheral vision, but nothing had been done to improve this situation for them. A relative told us; "There aren't many activities-it would be nice if someone could just read to Mum".

A monthly activities programme was displayed which included events both in and outside of the service. In-house activities listed were sketching, jigsaws, knitting, skittles, life stories work and manicures. Visiting groups and bands were also included at intervals. The activities coordinator said that activities were held outside of the service when a driver was available. However, these outings had to be cut short in the past because someone had been taken ill during them and everyone had to return to the service. Each person had an activities profile which recorded the things they liked to do; but documents which showed what each individual had been involved in were not all completed fully. There was a sensory room available for people, with a light display and textured objects to touch. However, there was no one using the room at all during the two days we inspected. One staff member said that they did not really have time to take people to the room as they were busy giving care.

The failure to consistently meet people's needs for social interaction is a breach of Regulation 9 (1)(b)(c)(3)(b) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Pre-admission assessments were made by the registered manager before people were accepted into the service. The purpose of these was to ensure that the service was suitable; and capable of meeting people's needs. Three people had been admitted into the service by the registered manager after she had failed to properly assess their needs in line with the provider's policy. During the inspection it was highlighted that these people's needs were not compatible with the care available at the service. Following the inspection, full and detailed reassessments were carried out by the regional operations manager, which confirmed that these people would require placements to be found in services which could adequately meet their needs. This upheaval for people and their families could have been avoided, but the provider had not checked that the registered manager was implementing policy effectively.

The failure to appropriately assess people's needs is a breach of Regulation 9 (1)(3)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Care plans contained detailed information about people's former lives; including their families, jobs, hobbies and interests. People had laminated booklets in their bedrooms, with photos and notes about their memories. Staff were able to tell us about the people they were caring for and their preferences. For example; two people had specified that they did not want to be supported by male care staff and another person liked a jug of water in their room so they could help themselves to drinks. One staff member was able to tell us about the difference between two people's dementia. They said that one of the people was "Forgetful" and the other was, "Living in the past". The staff member described how each person responded differently and that it was important for staff to understand and react to this.

People were encouraged to be independent where possible and care plans showed 'Things I am able to do' and 'Things I would like you to help me with'. One person's care plan noted, 'X likes to choose their own clothing' and another person's stated, 'Encourage to use the toilet as and when needed to maintain independence'.
Care plan information had been regularly reviewed and updated. We read that most people were weighed monthly but if risk of malnutrition was identified, then people were weighed weekly to keep a closer eye on the situation. Care plans were structured to include sections about meeting people's health and social care needs. There was however a lack of detail about the care and support required in some care plans. For example; where people were supported using specialist bathing equipment or hoists, there was no step-by step guidance for staff about how to do so. One person's care plan recorded that 'Extra care when moving and handling' was necessary, but did not document how this could be ensured. It would be difficult for any new member of staff to read the care plan and know exactly how to care for people, based on the care plan information.

We recommend that care plans are reviewed and guidance to staff is expanded and improved where necessary.

Inadequate

Is the service well-led?

Our findings

A relative told us, "The home isn't badly managed, I've seen much worse" and another said," The manager is great, I can talk to her about any concerns I have at any time". A visiting professional commented that," The service is led by example and they take on board the advice they're given".

However, our findings did not match the complimentary feedback that we received from some relatives and professionals. The service was not well-led. We identified a number of failings on the part of both the registered manager and the provider. Although the registered manager was popular with many people, staff and relatives, she had not managed the service effectively; placing people at risk. This had not been recognised by the provider until we inspected. We found many examples of when procedures had not been correctly operated, and observed the impact of these failings. For example; the registered manager had not managed staff appropriately. Important assessments of people's needs and dependencies should have been submitted by staff to the registered manager monthly; for sending on to the provider. This information was used to determine the number of staff deployed and had not been completed by staff since September 2015. However, the registered manager had not taken action to ensure that staff complied with this requirement. As a result, the registered manager told us that she had used her own knowledge about people to submit data to the provider. This had clearly been inaccurate because following our inspection, proper dependency assessments were carried out which identified that the service had been running on four and a half staff short. The impact of this staffing shortfall contributed to people being left unattended in communal areas and waiting for unacceptably long periods to receive assistance with their meals.

Staff told us that they felt supported in their roles and that they were managed well. They said that there was a strong culture of teamwork and that communication between them was "Excellent". Staff felt that the registered manager listened to them and provided opportunities for them to bring any concerns to her attention. One staff member talked of their pride in working in the service and said they were always thinking of ways to make people's experiences better. However, strong leadership had been lacking in the service and this had impacted on the values and vision of staff. We observed situations when some staff did not act to protect people's dignity or treat them with respect. Staff should have been aware that these behaviours were unacceptable, but they had clearly gone unchecked by the registered manager or by colleagues. Staff had used restrictive practice to keep people seated in their chairs but did not understand that this was inappropriate. However, the registered manager had set a poor example for them by permitting the use of stair gates on people's bedrooms. Staff had failed repeatedly to respond to requests for data about people's needs made to them by the registered manager. This had led to understaffing of the service but also demonstrated the lack of management, leadership and staff cooperation which had developed.

The regional operations manager told us there had been at least 14 incidents since 1 December 2015 and 22 incidents in total since 1 November 2015,in which people had been injured or potentially harmed. The registered manager told us that she knew such events should be reported to the local safeguarding body and, in some cases, notified to the Care Quality Commission (CQC). However, she had not consistently done so which meant that investigations into the causes and impact of incidents had not taken place and people

had not been kept safe as a result. The registered manager had knowledge of confidential information about a highly sensitive situation, which she had a duty of care to share with the provider. She had not done so and strategies had not been put into place to protect people and staff in the service. People had not been assessed by paramedics or sent to hospital following head injuries and the registered manager said that she did not know this should happen. The provider had not assured themselves that the registered manager understood and adhered to the provider's policies.

The failure to appropriately notify the CQC of incidents is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Appropriate and robust quality assurance systems had not been put in place by the provider. The registered manager told us that she had been supported in her role by the regional operations manager. However, the regional operations manager told us she had been assigned to another of the provider's care homes from October 2015. Monitoring visits had been less frequent since that time. The quality and safety checks and monitoring which had taken place however, had been ineffective in highlighting the deterioration in the service. This had placed people at considerable risk.

Auditing had been carried out by the registered manager, but we found that this had been largely ineffective in identifying shortfalls in quality and safety. For example; falls audits recorded the number of falls and the time of day they happened, but did not identify which people had fallen or the area in which the falls occurred. This meant that the audit was not effective in highlighting any trends which could require further professional intervention.

A medicines audit dated January 2016 stated that all medicines were locked away securely but we found prescribed creams on window sills and other surfaces in people's rooms. Daily audit forms had been completed by the registered manager, but many of the fields had been left blank. For example; 10 charts should have been checked daily for people whose food and fluid intake was being recorded or who required help to reposition themselves. This had not always been done and the registered manager had not recorded discussions with two staff members as the audit form required. Where issues were identified through the daily audits, there was no evidence of appropriate actions to remedy them. Some actions documented by the registered manager bore no relation to the concerns identified. For example; having highlighted that call bells were sometimes out of reach, the actions shown were, 'Monthly medicines started on nursing floor'. There had been no recent oversight by the provider of the auditing systems carried out by the registered manager; which might have identified that they were not being operated properly.

The failure to establish and operated effective systems to assess the quality and safety of the service is a breach of Regulation 17 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff had been using inappropriate documents to record checks on specialist air flow equipment in use for people at risk of skin wounds and pressure areas. The checks had included testing to see that the air flow pumps were switched on and that mattresses were inflated, but did not require staff to review the pump settings in conjunction with people's weights. This had not been picked up by the registered manager and meant that air flow levels had been set incorrectly on all the mattresses in the service. There was no way of telling in retrospect, how long mattresses had been set wrongly, but the failure by both the registered manager and the provider to check the effectiveness of the recording system in use ,had resulted in people not receiving the proper benefits of this equipment.

Throughout the inspection we observed that private and confidential information about people was not kept securely. On the ground floor, folders containing people's personal details and information about their

care and treatment were kept in clear plastic wall mounts or on small shelves in recesses to the main corridor. These areas were not always attended by staff and the folders were accessible to anyone entering that area. Letters addressed to people from the Department of Work and Pensions were also in the wall mounts and had not been kept securely. These would likely contain personal identifying information such as national insurance numbers, together with confidential financial details. On the first floor, there were nursing stations; but we found that these were unattended for long periods. People's confidential care files were in unlocked drawers there and weights records books and handover sheets had been left open on the desk. There was nothing to prevent people or visitors from reading private and sensitive information about others, which was inappropriate.

The failure to maintain securely; accurate and complete records about people's care and treatment is a breach of Regulation 17(1) (2) (c) (d) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Relatives had been asked for their feedback about the service in a survey that was issued in October 2015. We saw that the results of this had been analysed and an action plan had been produced. However, the actions documented had not always been followed through effectively. For example; comments made by relatives included, 'Dinners allowed to go cold-no attempt to aid feeding'. The action taken was documented as, 'Staff to assist with feeding all the time who requires help', but our observations were that people continued to wait for long periods to receive assistance with their meals.

Another relative had made a comment about a 'Sick bowl' being left on a table for two days. The action in response to this was recorded as, 'All care staff to make sure to cut short finger nails when needed during personal care'. Two relatives stated that their loved ones had often waited too long for call bells to be answered. However, the registered manager had not carried out an audit to check response times and develop a strategy to improve the situation. This had not been an effective use of feedback and meant that relatives' concerns had not been properly addressed.

The failure to consistently act on feedback about the quality and safety of the service is a breach of Regulation 17 (1) (2) (e) (f) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

A further relative told us that they had attended relative meetings and questioned the use of carpets on bedroom floors on the ground floor. They said that following the meeting the carpets were replaced with vinyl flooring, which they felt was more hygienic. There had been some positive comments made by relatives in response to the October 2015 survey. These included: 'Very satisfied with all needs and care' and 'All staff are brilliant in the care of X'.