Homebeech Limited

Homebeech

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Homebeech on the 19 and 26 June 2018 and 25 September 2018.

In February 2016, we undertook a comprehensive inspection of this service and found breaches of regulations in relation to safe care and treatment, dignity and respect and person-centred care. We asked the provider to submit an action plan on how they would address these breaches. An action plan was submitted which identified the steps that would be taken. We undertook an unannounced comprehensive inspection of this service on 28 February and 30 March 2017. At the inspection we found that insufficient improvements had been made in relation to these three breaches of regulation. The service was rated as Requires Improvement in each domain and overall. As a result of our findings at the inspection, we took enforcement action and issued three Warning Notices on 4 April 2017, against each regulation, to the provider and to the registered manager.

Details of each breach were stated to the provider and registered manager in each Warning Notice. Regulation 12: Risks to people had not been identified or assessed adequately to ensure staff received guidance on how to support people safely. Records were not always reviewed consistently to ensure people's most up to date needs were met or communicated to staff. Premises were not always managed to keep people safe. Regulation 10: Not all staff displayed a caring attitude and several instances were observed when staff ignored people. Some people and relatives gave negative feedback about the care and support from staff. Regulation 9: Activities on offer to people had not been organised to reflect people's interests or to provide mental stimulation. Systems were not in place to ensure that records relating to people's care were accurate or contemporaneous.

We also found that the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because we identified concerns that the provider had not ensured that effective systems and processes were in place to assess, monitor and improve the quality and safety of the service. The provider's audit systems were not effective in demonstrating action had been taken regarding identified shortfalls. In addition, systems were not in place to demonstrate the service operated effectively to ensure compliance with the Regulations.

We undertook a focused inspection on 30 July 2017 to check that the provider had met their legal requirements and the provider and registered manager had met the Warning Notices served under Section 29 of the Health and Social Care Act 2008. We found that improvements had been made and the requirements of the three Warning Notices were met. However, further work was needed to sustain the improvements already implemented and to drive continuous improvement.

We undertook this unannounced comprehensive inspection to look at all aspects of the service and to check that the provider had sustained the improvements and to confirm that the service now met legal requirements. We found the provider had not sustained improvements and were in breach of Regulations.

Homebeech is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Homebeech is situated close to the seafront in Bognor Regis and within walking distance of the town centre. It is registered to provide accommodation and nursing care for up to 66 people with a variety of health conditions, including dementia, physical disability and frailties of old age. On the day of our inspection there were 50 people living in the service, who required varying levels of support. Homebeech is arranged into three units. The main part of the home called 'Oakside', but commonly referred to as 'Homebeech,' supports people who have health care needs. Daffodil unit is for people under the age of 65 years who have a range of physical disabilities. Beechside unit accommodates nine people living with dementia, it has a locked door with a key pad entry / exit system. The main part of the home has a large sitting room and dining room, with an adjacent conservatory. A further sitting room is available to people on the ground floor. The Beechside unit has separate facilities, including a lounge and dining area. All bedrooms have a toilet and sink en-suite. Accommodation is provided over three floors and lifts enable easy access. People have access to outdoor spaces.

There was a manager in post, who began their employment at the service approximately two weeks before the first day of this inspection. At the time of our inspection, they were not registered with the CQC. However, since the conclusion of our inspection they have begun the process to register with the commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People's safety was sometimes being compromised as people commented they had to wait for care and assistance.

People told us that they were happy with the care. However, care was not personalised to the individual. People's preferences were not followed when they had personal care. For example, people did not always receive assistance getting into bed at the time they wished. Care was task driven, meaning that staff did not routinely meet people's preferences in relation to how their care was delivered.

There were some arrangements in place to meet people's social and recreational needs and in response to the previous inspection, the service now employed a part-time activities co-ordinator. However, we could not see that activities were routinely organised for everybody or for people who remained in their rooms. Staff did not engage socially with people, due to the care delivery being task centred. We observed occasions when people were ignored by staff.

The provider had a range of quality assurance audits. However, action had not been taken in response to shortfalls identified by the audit systems. Therefore, the audits had not ensured that people received a consistent and good quality service that met individual needs. The provider had also not met all of the required improvements set out in their action plan identified at the previous inspection. Systems were not in place to demonstrate the service operated effectively to ensure they met the Regulations.

Staff had received training in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service did not support this practice.

Accidents and incidents were recorded appropriately. Risks associated with the environment and equipment had been identified. Emergency procedures were in place in the event of fire. There was a nurse who was responsible for managing an evacuation in the event of a fire. However, they had not received any training specific to the geography of the building.

When staff were recruited, their employment history was not always completely checked and valid references were not always obtained. Recruitment checks did not ensure new staff were safe to work within the care sector.

Medicines were stored safely and in accordance with current regulations and guidance. However, medicines were not always given in line with safe practice. Medicines prescribed to be taken 'as required' were not given in accordance with people's needs.

Staff had not received training specific to the needs of the people living at the service. Only two staff members had received training on, 'Working in a person-centred way' and only one had undertaken training in dignity and respect.

People were not always enabled or encouraged to eat and drink well. Special diets were not always adequately catered for. People requiring soft diets told us they received very little choice. We have made a recommendation about staff training on the subject of meeting people's nutritional needs. Health care was accessible for people and appointments were made for regular check-ups as needed.

People were not able to express their views and had limited opportunity to feedback about the service they received.

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 consistently safe.

Care and treatment was not always provided in a safe way for people. We saw unsafe care practices taking place.

Staff did not respond to people's needs in a timely fashion.

Staff were not always recruited in line with safe practice. This placed people at risk.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff were not always appropriately trained to safely support people's care needs.

Staff did not understand the importance of monitoring people's food and drink intake.

Staff did not always obtain people's consent before acting.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always involved in the planning of their care. They were not routinely offered choices in relation to their care and treatment.

People's privacy and dignity was not always respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive the care they required at the time they needed it. The delivery of care often suited staff routine, rather than people's individual preferences and choices.

There were some arrangements in place to meet people's social and recreational needs. However not all people were occupied in a meaningful way and in line with their interests. Activities were not routinely organised for people at the weekend or in the evening.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Quality assurance processes were not effective and did not improve the quality and safety of the service. Systems were not in place to demonstrate the service operated effectively and in compliance with the Regulations. Action had not been taken to rectify the issues identified at previous inspections.

The culture was task driven. Staff did not recognise people's individual needs.

There were no effective systems to gain feedback from people.

Homebeech

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection site visit took place on 19 and 26 June 2018 and 25 September 2018. It was unannounced.

One inspector and an expert by experience in older people's care undertook this inspection. 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 service. We considered information which had been shared with us by the Local Authority and Clinical Commissioning Group, and looked at notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. 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 observed care in the communal areas of the service. We spoke with people and staff, and saw how people were supported during their lunch. We spent time observing care and how staff and people interacted. We spent time looking at records, including eleven people's care records, five staff files and other records relating to the management of the service, such as training records, meeting minutes, accident and incident recording and audit documentation.

During our inspection, we spoke with fifteen people living at the service, five visitors, four care staff on duty, a member of ancillary staff, one of the agency nurses on duty, the manager, the deputy manager and the area manager. We also 'pathway tracked' the care for some people living at the service. This is where we check that the care detailed in individual plans matches the experience of the person receiving care. It was an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

Inadequate

Is the service safe?

Our findings

At the inspection in February / March 2016 we found that the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there was a risk that people may not receive appropriate support to mitigate the risk of weight loss and malnutrition. At the inspection in February / March 2017, we found the provider remained in breach of Regulation 12. We issued a Warning Notice to the provider which required them to take action. We undertook a focused inspection on 30 July 2017 and found that improvements had been made and that the Warning Notice was met. However, further work was needed to sustain the improvements already implemented and to drive continuous improvement.

At this inspection we saw that the premises were not purpose-built as a care home. The layout was such that it could present significant difficulties in evacuating people in the event of an emergency. We saw that regular fire alarm checks had been recorded. There was a fire safety policy dated 1 January 2016 which had been signed to indicate it had been reviewed in 2018. This policy listed the actions to take in the event of a fire and detailed who was responsible for carrying out each action. It stated that, 'The nurse in charge will assume responsibility for managing the evacuation' and that senior management will 'Assist under the guidance of the nurse in charge'. The registered nurse we spoke to was not aware that this was their responsibility. The registered nurses at the home were almost exclusively from an agency. This was confirmed in records. As the nurses were not employed directly by Homebeech their training had been conducted by the agency. This meant that the nurse responsible for managing any evacuation, in the event of a fire had not received any training specific to the geography of the building and may have poor geographical knowledge of the building. The nurse we spoke to told us that they knew their way around the building as they had worked there before. They told us that it had taken them a while to get to know the building. The manager told us that they were, "Still getting to know their way round," and the layout of the building was confusing.

Risks associated with the safety of equipment were managed appropriately. Health and safety checks had been undertaken to ensure safe management of electrics, gas, the passenger lift and moving and handling equipment.

Accidents and incidents were reported and monitored. The manager told us that measures were put in place to reduce risks to people. They said that a member of staff was always present in communal areas, such as the lounge and dining room, to reduce the risk of people falling. However, the manager was not able to provide any evidence that this had reduced the number of falls. We observed several times when staff were not present in the lounge. This meant that people at risk of falls were left unsupervised as the measure put in place to reduce the risk was not being followed.

Risks to people had not always been identified or assessed appropriately, risk assessments were insufficient. A risk assessment is a document used by staff that highlights a potential risk, the level of risk and details of what reasonable measures and steps should be taken to minimise the risk to the person they support. Guidance to enable staff to understand the actions required to support people safely was not always

adequate. For example, we saw unsafe care practices taking place. We saw staff transferring a person from an armchair to a wheelchair. During this transfer we saw that the brakes had not been used on the wheelchair, which meant that it moved backwards into the legs of another person. We shared this information with the manager who assured us that immediate action would be taken and all staff would be spoken to. We saw that the same hoist sling was used for all people in the lounge, irrespectively of people's size. The manager told us that people had individual hoist slings that were fitted according to their size. However, we saw that these were not always used. This meant people were at risk of harm due to incorrectly fitting hoist slings.

We looked at the management of medicines. People were happy with how they received their medicines. Medicines were stored correctly and securely in line with legal requirements. They were ordered correctly and medicines which were out of date or no longer needed were disposed of appropriately. The registered nurses had received training in the administration of medicines from the agency that employed them. The manager told us that staff training in medicines did not include observation of practice. Observation of practice is required to ensure that staff are competent to give medicines. Following the inspection, the Nominated Individual sent us a copy of a medication competency check for one registered nurse which included evidence of observation of practice.

We saw a nurse giving people their medicines. Some people were prescribed medicines to be taken 'as required'. We saw that these were not given in accordance with people's needs. People who were prescribed 'as required' pain relief were given them routinely and not asked if they needed them. We saw that some people were prescribed medicines that contained a, 'Not to be taken with alcohol' warning. This warning was clearly recorded on people's medication administration records. However, we saw that these medicines were routinely given to people who were having a lunchtime glass of wine. No conversation took place regarding the medicines alcohol warning and there was nothing documented in people's care records to evidence that a conversation had previously taken place. The manager told us that this had been risk assessed, however there was no documentation to support this. There was no evidence that this had been discussed with people's GPs. There was no evidence that people were aware of the warning associated with their medicines. This meant that people were at risk of harm due to the unsafe administration of medicines.

The above evidence demonstrated that the provider had not ensured that care and treatment was provided in a safe way for service users, including assessing and mitigating risks to service users and ensuring safe premises were maintained. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People at Homebeech told us there were not enough care staff on duty to support people at the times they wanted or needed. For example, one person told us, "There's not enough staff. If I want to go to the toilet I've got to wait for a carer. It's no good saying you've got to wait. If I want to go I want to go there and then. I can't hold it in". Another person said, "At times there's not enough staff, especially at night". A third person said, "I usually go to bed at around 9:30pm. If they're short staffed it can be later, 10pm, even 11pm, that's too late for me". People's relatives also told us that there were not enough staff. Comments included, "There's not always staff around and I worry that situations could arise". Another visitor told us, "They're short in the mornings. One of us comes in most days to feed mum to free up the staff".

Throughout the inspection we heard call bells ringing repeatedly. We were told and records confirmed that the provider had audited how long it took staff to answer call bells. This audit had taken place over one weekend in April 2018. The records demonstrated that on 22 April it took staff between 10 and 17 minutes to answer call bells on 16 different occasions. Eight of these occasions were recorded in the audit as, 'No action required'. On 23 April it took staff between 10 and 18 minutes to answer call bells on 12 different occasions.

The audit had not been repeated and the manager was not able to provide any evidence that the call bell response times had improved.

People told us that they thought that there were, "Not enough staff" and spoke of, "Regular delays receiving assistance." People said they could sometimes, "Wait for 20 minutes or longer after ringing their call bell for assistance". We were told that, "Staff could be thin on the ground," at weekends. People also told us that, "The carers are carers. That's what they do. They're busy and don't really have time to stop and talk to you."

Our own observations supported the feedback we had received. During our inspection we viewed care delivery at different times throughout the service. Several people had requests unanswered. For example, we heard one person ask to use the toilet at 12.05. Their request was not adhered to until 12.25. During this time the person repeated their request several times. The response from staff included, "I can't do it on my own, you must wait". The current staffing levels were not sufficient staff to ensure people's needs could be met safely.

The above evidence demonstrated that staff were not always available to safely support people's care needs. We found the staffing levels to require improvement and placed people at risk. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection we found the physical environment of Homebeech required improvement. We saw that some areas of the home were not clean. There was an offensive odour in the main dining area. A visitor told us, "It's cleanish. It could really do with a deep clean. The whole place is tired. It smells of wee in places". Another visitor said, "It's better than it was. It has its moments. The lounge is better than I've seen it for a while. Hygiene on the whole is not too bad. There was an incident over the weekend [Name] had an accident and wet the floor, there seemed to be no urgency to understand it had to be cleaned up."

The manager told us and records confirmed, that they had cleaning schedules and regular audits of cleaning. We saw that an environmental audit had taken place on 24 April 2018. This audit had identified that several areas of the home were dirty and smelt unpleasant. This included faeces on a toilet wall. It was recorded that the required action was, 'Wall to be cleaned'. This was not recorded on the audit as having been completed until 2 May 2018, over a week after the shortfall was identified. However, following the inspection the Nominated Individual sent us a copy of a cleaning schedule that showed that the area had been cleaned the same day. The audit had identified an additional 14 areas in need of improvement. For example, a room was described as, 'Room and sink are filthy'. None of these areas had any record of actions being taken.

Recruitment records did not ensure that staff were safe to work with people. Some checks had been completed before staff starting work. For example, the staff files contained disclosure reference numbers to indicate that checks through the Disclosure and Barring Service (DBS) had been carried out. These checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. We looked at five staff files. One file only contained one page of their application form and their file did not contain a full employment history. The provider had not obtained evidence of satisfactory conduct from the staff members previous employer. The file contained a handwritten letter from a friend and not an employment reference. Another staff file contained an undated handwritten letter from the staff member's partner. This was discussed with the manager who told us that no one had noticed that the referee had the same address as the staff member. Their file did not contain any evidence of satisfactory conduct from their previous employer.

The above evidence demonstrated that staff were not always recruited in line with safe practice. We found

staff recruitment required improvement and placed people at risk. This was a breach of Regulation 19, Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

At the inspection in February / March 2017 the service was rated as Requires Improvement. We recommended that the provider put a system in place that ensured staff received regular supervision opportunities, in line with the provider's policy, together with an annual appraisal as appropriate. At this inspection the manager told us that she had not yet implemented an on-going programme of supervision. The manager had been in post for approximately two weeks at the time of this inspection. She told us that she was aware of the benefit of regular supervisions and that she was observing staff and still getting to know them. Supervision is a formal meeting where training needs, objectives and progress for the year are discussed.

Staff told us that they received adequate training and they felt they had the skills they needed to carry out their roles effectively. Registered nurses at the home were almost exclusively from an agency. As the nurses were not employed directly by Homebeech their training had been conducted by the agency. The manager told us that the training was online and included a quiz to check staff understanding and competence. Training schedules confirmed some staff received essential training, such as moving and handling and safeguarding vulnerable people. Not all staff had received training in relation to the MCA and DoLS. The staff training records showed that only four staff had received this training. However, the majority of staff had not received training that was specific to the needs of the people living at the service. For example, only one staff member had received training in caring for people living with dementia and only three staff had received training in diabetes awareness. The training record showed that only two staff members had received training on, 'Working in a person-centred way' and only one had undertaken training in dignity and respect. However, following the inspection the Nominated Individual sent us a different copy of the training matrix. This showed that additional staff training had taken place which was not recorded on the records maintained at the service. For example, staff had received training in relation to MCA and DoLS. Our observations demonstrated that staff did not always put this into practice, this meant that people did not receive appropriate care.

The provider had an induction programme which allowed new members of staff to be introduced to the running of Homebeech and the people living at the service. Staff told us they had received an induction which equipped them to work with people. We saw that some staff files contained induction work books, however, these were not consistently completed. This meant that people were at risk of inappropriate care from staff who had not completed the providers induction programme.

The above evidence demonstrated that staff were not always appropriately trained to safely support people's care needs. We found the staffing training to require improvement and placed people at risk. 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

take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At this inspection, we checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Mental capacity assessments had been completed for people living at the home. The MCA code of practice clearly states that capacity must be presumed unless proven otherwise and assessments are time limited and decision specific. A 'blanket' assessment of people's capacity is not appropriate, nor is presuming their incapacity without a robust assessment of people's ability to make certain decisions. People who needed them had DoLS assessments and the conditions of these were being met.

During our visit we saw that staff did not involve people in decisions or respect their choices. We saw that staff did not demonstrate an understanding about consent or establish what people's wishes were. We saw staff acting without gaining people's consent. Staff members did not recognise that people had the right to refuse. We saw a staff member offer a person a drink, "Do you want some more juice?" The person clearly replied, "No." We then saw the staff member put a straw in the persons mouth and tell her to drink.

One person told us, "I feel restricted. I can't get around without them carers. They took my wheels away from me and told me I need assistance. I didn't before I came here. I've got to the point where I can't be bothered now, you just put up with it."

A visitor told us that, "[Name] told me the staff didn't come in to check on her last night, the morning staff completed the checks." The visitor also complained that, "This morning when they dressed [Name] they put night pads on. [Name] said she didn't want them. I don't want her to have them either. They are supposed to be toileting her. They didn't get her consent and I don't think that this is respectful to her dignity at all… I wouldn't choose this place again."

People had access to health care relevant to their conditions, including GPs and chiropodists. Referrals for regular health care were recorded in people's care records. However, one visitor said they were not happy with having to wait. They told us that, "[Name] has a pressure sore at the base of her spine and we had real trouble getting a pressure cushion. It took a good few weeks, we kept asking before they finally got it. I think they could have done more to get it quicker. It's all sorted now."

We observed lunch in the dining room and lounge. We saw three staff supporting people to eat. The staff did not engage with the people they were assisting. We saw that one staff member was totally disengaged from the person they were supporting. We saw that the staff member barely spoke to the person and spent a lot of the time staring blankly into the air, moving the food on the plate around with a fork. We saw a staff member bumped a person's hand whilst clearing the table. This caused the person's wine to spill over their arm. The staff member did not speak to the person or offer any assistance, they walked off.

A visitor told us, "I think the food is quite good. [Name] needs a soft diet and there's not a lot of choice." Their relative agreed that there was a lack of choice and told us that she, "Had baked potatoes with cheese for last two days." Another visitor told us that, "[Name] is on a fork mashable diet and there's not much variety for supper. They are trying to change the menu, there's a new manager. We'll see." The manager acknowledged the choice of food could be improved. They told us that the menu was being reviewed to address this.

Our observations showed that staff did not understand the importance of monitoring people's food and drink intake. We saw that a member of staff cleared a person's plate despite them not having eaten any of their lunch. A different staff member then cleared the same persons pudding which had also not been eaten. During the lunch time the person did not eat any food and only consumed a glass of wine. No action was taken by staff. Staff did not ask the person why they had not eaten and they were not offered alternative food. This was discussed with the manager who was not aware that the person had not eaten. It had not been recorded in the persons care records. This meant that people were at risk of inadequate nutrition. We recommend that staff receive training, based on current best practice, in relation to meeting people's nutritional needs.

Requires Improvement

Is the service caring?

Our findings

At the inspection in February / March 2016 we found that the provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people were not always treated with dignity and respect. At the inspection in February / March 2017, we found the provider remained in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a Warning Notice to the provider which required them to take action because some staff did not display a caring attitude to people, in some instances, ignoring them. We observed an incident within the Beechside unit where staff did not treat people with dignity and respect. Care delivered by staff at the home was task orientated rather than person-centred. Following the inspection, the provider sent us an action plan which showed what steps would be taken to meet this regulation and the requirements of the Warning Notice. We undertook a focused inspection on 30 July 2017 and found that improvements had been made and that the Warning Notice was met. However, further work was needed to sustain the improvements already implemented and to drive continuous improvement. We found the principles of privacy and dignity were not embedded into every day care practice.

At this inspection we looked at the arrangements in place to protect and uphold people's confidentiality, privacy and dignity. Staff did not always show kindness and respect when speaking with people. During our observations we heard a staff member refer to a person as, "Darling." The person's response indicated that they did not wish to be referred to in this way. One person told us that, "They [staff] all do their job well enough and I can't complain that they're unkind to me or anything like that. It's just that they don't actually spend time to talk to you. You press the bell and it's 'What do you want?'" Another person told us that, "They [staff] do knock before they come in. I don't understand why really, as they just come straight in after knocking." We saw that a member of staff took a glass of juice, with a straw in it, and placed it on a table out of reach of a person and walked off. The person was not spoken to.

Staff members had very little understanding of the principles of privacy and dignity despite them having received training and it being covered as part of staff's induction. Throughout the inspection, we observed staff moving people using a hoist. On two separate occasions we saw that people were hoisted in communal areas of the home in a manner that did not respect their dignity. One person's trousers fell down and another had their undergarments on display. No attempts were made by staff to cover the people.

We saw that a staff member moved a person's wheelchair so that he was in front of the television to watch football. The person was not spoken to, no warning was given that his wheelchair was going to be moved. The person told us that he, "Did not like football". We saw that another person was trying to watch the football, but had been seated so that she could not see the television. On several occasions she called out to ask what the score was and if anything was happening. Staff did not respond to her and repeatedly walked in front of the television. On one occasion staff left the mobile hoist in front of the television meaning that no one could watch it.

Staff did not ensure that people remained in control and received support that centred on them as an individual. A relative told us that, "They're not encouraging her to be independent, especially putting the

night pad on against her wishes."

Care records were stored securely. Confidential written information was kept secure and there were policies and procedures to protect people's confidentiality. Staff had an understanding of confidentiality of care records and written information and had received training pertaining to this. However, during our observations we found that staff did not respect people's confidentiality with regards to spoken information. For example, a staff member was heard to call, "You want to go to the toilet?" to a person across the lounge / dining area. Staff discussed the person's request to go to the toilet across the room on several occasions.

The above evidence demonstrated that the provider had not ensured that people were treated with dignity and respect. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were able to maintain relationships with those who mattered to them. Visiting was not restricted and guests were welcome at any time. People could see their visitors in the communal areas or in their own room. A person told us that, "Sometimes when my son visits we'll go to my room, there's nowhere else to sit really that's what I'd call private. There's the conservatory out the back that's not really used, except by the staff who are often in there."

Requires Improvement

Is the service responsive?

Our findings

At the inspection in February / March 2016 we found that the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people were not consistently supported to follow their interests and take part in social activities. There was a lack of activities or opportunities for people to be occupied in a meaningful way and in line with their interests. At the inspection in February / March 2017, we found the provider remained in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a Warning Notice to the provider which required them to take action. Following the inspection, the provider sent us an action plan which showed what steps would be taken to meet this regulation and the requirements of the Warning Notice. We undertook a focused inspection on 30 July 2017 and found that improvements had been made and that the Warning Notice was met, although further work was still required to embed and sustain these improvements.

In response to the previous inspection, the service now employed a dedicated activities co-ordinator, and we saw there were some arrangements in place to meet people's social and recreational needs. However, activities were not routinely organised for everybody or for people at the weekend or in the evening, and staff did not make time to engage socially with people. Providing people with meaningful interaction and stimulating activities is an important part of improving their quality of life. Having companionship and someone to talk to assists with maintaining people's mental and physical wellbeing, and is an integral part of providing person- centred care. One person told us, "I get on well enough with the staff but there's just not enough staff, especially in the lounge. They don't have a lot of time to sit and talk to people about their life and what they've done. They just don't get to know people. I also think that they need to think more about how they phrase things. If you ask someone who has difficulties processing thoughts to make a decision, they may not know the right answer."

On the first day of the inspection, we saw an activity taking place in the afternoon. We observed a visiting entertainer organise a singing activity session. The activity was popular and people who took part clearly enjoyed themselves. However, we saw that no formal activities took place for people in the other areas of the home or in people's rooms. People spent this time sitting in their bedrooms or armchairs in the lounge or dining room watching television or listening to music. Apart from the delivery of care, there was little meaningful interaction with people in terms of stimulation and engagement.

A visitor told us, "I think it is probably pretty boring here, for somebody compos mentis it must be a nightmare. [Name] joined in with the exercise though which I'm pleased about." Another visitor told us that, "The activities are picking up. There's a varied programme. It's getting better but there's still room for improvement."

A visitor told us that, "We've had no input to anything about the home. There's no difficulty getting [Name] in and out. We've taken her out in the car and they [Staff] have taken her out along the front." Another visitor told us that, "It would be nice for [Name] to sit at the porch in the fine weather but the staff smoke out there. As soon as they open the door to come in the smell comes straight in, it's not nice. I don't want to be

inhaling their second-hand smoke." During the inspection we saw that some staff were smoking outside on the patio, directly in front of the lounge / dining area.

People commented they were happy with the care. However, care was not always personalised to the individual. For example, people did not always go to bed when they wished. We observed another person being told several times that they needed to wait before they could be taken to the toilet. Staffing levels at the service did not allow staff to routinely meet people preferences in relation to how their care was delivered. Staff did not display a good understanding about the people they were caring for, for example, in their preferences for food and drink. We saw that one person was given blackcurrant to drink, despite them not liking it.

People's care plans were brief and did not give staff sufficient detail for staff to be able to ensure consistent care. For example, the care plan for a person with diabetes stated that they need to have their blood sugar level monitored, but there was no information recorded regarding the frequency or what the blood sugar level should be. This meant that the person was at risk of inconsistent care as the care plan was open to each member of staff's own interpretation. One person's care plan described them as having, 'Unpredictable behaviour'. There was no information as to how this may present, or any guidelines for staff to follow. A care plan for a person with a wound stated that they had a skin tear, but there was no description of the wound and the date of its' occurrence was not recorded. We found that care plans contained contradictory information and were not updated to reflect people's current needs. For example, a care plan stated that the person's wife visited daily, however she had died earlier this year. This meant people were at risk of inconsistent and uncoordinated care.

The above evidence demonstrated that there was a lack of activities or opportunities for people to be occupied in a meaningful way and in line with their interests. Care was not person-centred. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service well-led?

Our findings

At the inspection in February / March 2017, we found the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because we identified concerns that the provider had not ensured that effective systems and processes were in place to assess, monitor and improve the quality and safety of the service. The providers audit systems were not effective in demonstrating action had been taken regarding identified shortfalls. In addition, systems were not in place to demonstrate the service operated effectively to ensure compliance with the Regulations. After the inspection, the provider sent us an action plan which showed what steps would be taken to meet legal requirements to ensure compliance with the Regulations. At this inspection we found that the provider had not met all the required improvements set out in their action plan created in light of the concerns identified at the previous inspections. We found repeated breaches of Regulations.

The service has been without a registered manager since April 2018. The current manager had been in post for approximately two weeks. The area manager was visible within the service to support the current manager. The manager told us that she found the senior management team very supportive. She told us that she was still getting to know the service.

Staff felt there was good communication within the home. They attended daily handovers to kept them informed of any developments or changes to people's needs. We saw that a daily allocation sheet was completed detailing which staff were working in which area of the home. Staff told us that they found this useful. Staff told us that they got on well with each other. Feedback regarding the manager was limited as she was new in post.

The provider had a range of quality assurance audits. The manager showed us audit activity which included health and safety, medication, care planning, cleanliness and call bell answering times. The information gathered from these audits had identified shortfalls. However, there was no evidence to demonstrate that these audits were used to improve the quality of the service or the care delivered. They had not fully ensured that people received a consistent and good quality service that met people's individual needs.

One person told us, "I think it's a very closed atmosphere. Maybe that's my fault and I don't help because I keep to myself." Another person said that, "It's fairly relaxed but a nothing environment, quite a sad state. I wouldn't choose this place again or recommend it."

There was very little opportunity for people or their relatives to feedback about the quality of the service they received. None of the people we spoke with said they had completed an annual questionnaire, survey, feedback form or been asked for their opinion. One person told us that, "They have residents' meetings. I went to one but there wasn't much to interest me." Another told us, "Yes, they had a meeting earlier in the month. You don't get any feedback."

The above evidence demonstrated that the provider had not ensured that effective systems and processes were in place to assess, monitor and improve the quality and safety of the service. Systems were not in place

to demonstrate the service operated effectively to ensure compliance with the Regulations. This is a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were able to make suggestions and report any problems or concerns. Regular staff meetings took place. The manager told us that she was looking at the benefits of the current staff meetings. She was planning to make the staff meetings departmental, so that staff could discuss information relevant to their role. Staff were aware of the whistle blowing policy and when to take concerns to appropriate agencies outside of the service, if they felt they were not being dealt with effectively. We saw that policies, procedures and contact details were available for staff to do this.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The manager had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken. The manager was also aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent and it sets out specific guidelines providers must follow if things go wrong with care and treatment.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured there were activities or opportunities for people to be occupied in a meaningful way and in line with their interests. The provider had not ensured that care was person-centred.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had not ensured that people were treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that care and treatment was provided in a safe way for service users, including assessing and mitigating risks to service users and ensuring safe premises were maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not recruited staff in line with safe practice. Staff recruitment required improvement and placed people at risk.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider had not ensured that staff were available to safely support people's care needs. The staffing levels required improvement and placed people at risk.
The provider had not ensured that staff were appropriately trained to safely support people's care needs. The staff training required improvement and placed people at risk.