The Grange Care Providers Limited

The Grange

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 24 and 26 October 2016. The first day was unannounced and the second day was announced.

The Grange is a residential care home for older people. It is registered to provide accommodation and personal care for a maximum of 24 people. There were 15 people living at the service on the days of our inspection, and one person was in hospital. Some of the people were living with dementia.

The service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.' The registered manager had left the service on 28 May 2016. A new manager was in post on 16 June 2016, but was not intending to register with us.

At our previous inspection on 19 and 26 May 2016, we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe care and treatment, the need for consent, responding to complaints and good governance. As a result, we issued requirement notices due to the concerns we had identified. The home was also placed into special measures meaning significant improvements were required, or further enforcement action could being taken. Following this inspection, the home sent us an action plan, detailing the improvements they intended to make.

The provider and manager were still not proactive in identifying and managing risks to the people who lived there. Risk assessments for people living at the service were not individualised and staff did not know how to effectively support people safely.

Accidents and incidents were still not thoroughly investigated or audited. The provider had not changed their practices to ensure open and transparent consideration of the facts. As a result lessons had not been learned from these incidents, and similar incidents continued to occur.

Staff were not trained or supported to provide safe care and support to the people living at the service.

People could not be assured they would be supported to take their medicines as the doctor had prescribed for them.

People's ability to consent to their treatment was not respected. People were not actively involved in decisions about their care and treatment. Where people lacked capacity to make decisions, they were not protected under the principles of the MCA 2005.

People's dignity and privacy was not always respected by the staff as they provided care and support.

People's human rights and diversity were not supported because staff didn't know their individual needs. People did not always receive care that was planned to meet their assessed needs and there was a lack of social activity for a number of people who lived at the home.

Complaints were not managed well and people could not be assured that their concerns would be listened to and acted upon.

The registered provider had some quality audits in place, but this system was not robust enough to identify and address the multiple risks and problems we found.

The overall rating for this service remains 'Inadequate' and the service, therefore, remains 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.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

During the inspection we found continued and new breaches of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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.
Risks to people's health and safety were not identified, managed, reviewed or updated to ensure people's safety.
Systems in place to identify themes with accidents or to learn how to prevent further accidents were inadequate.
People could not have as required medication through the night because there were not always enough suitably trained and skilled staff to do this.
The service did not always have enough staff to meet people's needs

Is the service effective?

Inadequate

The service was not effective.
Staff training was not consistent and staff were not supervised or supported to put learning into practice.
People's capacity was not considered when decisions needed to be made in line with legislation and guidance.
Healthcare professionals did not have confidence that their instructions for the support of people would be carried out.

Is the service caring?

Inadequate

The service was not caring.
People's dignity and privacy was not always respected by staff.
People did not receive a caring service because of a lack of involvement in their personal care planning. Staff tried to provide kind and caring support but did not know the people well.

Is the service responsive?

Inadequate

The service was not responsive.
People did not receive care that was responsive to their needs.
People were not enabled to take part in pastimes which they enjoyed. The registered provider failed to act on concerns received by the service.

Is the service well-led?

Inadequate

The service was not well led.
The registered provider had failed to provide safe and

appropriate care to people using the service. The culture of the service was not positive, open and inclusive.
People who used the service, relatives and staff were not consulted regarding the quality and safety of the service.
Leadership in the home was inadequate, staff were not supported. A lack of effective governance meant quality was not considered and improvements were not made.

The Grange

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 24 October and 26 October 2016. The first day was unannounced and the second day was announced.

The inspection team consisted of two inspectors.

We carried out this inspection in response to concerns we had received and information that was shared with us from the local adult safeguarding team. These were in relation to the quality and safety of care provided to people in the home. We also were made aware of concerns from other agencies such as the ambulance service and GP. We completed a comprehensive inspection and looked at all five key questions.

As part of our planning we reviewed the information we held about the service and the provider. This included statutory notifications received from the provider about deaths, accidents and safeguarding alerts. A statutory notification is information about important events which the provider is required to send us by law.

During the inspection we spoke with three people who lived at the service and four relatives. We spoke with eight staff which included care staff, assistant manager and domestic. We also spoke with the manager and the registered provider. We also spoke with the GP and other healthcare professionals.

We reviewed four care records which related to assessment of risk and people's needs, including mental capacity assessments. We also viewed other records relating to staff training, complaints, accidents and incidents.

We observed people's care and support in the communal areas of the home and how staff interacted with people.

Inadequate

Is the service safe?

Our findings

At our last inspection in May 2016, the provider was not providing safe care and treatment to people living at the service, because risks to people's health and safety had not been identified, managed, reviewed or updated to ensure people's safety. The provider did not have systems in place to identify themes with accidents or to learn how to prevent further accidents. The provider had not maintained the building safely to protect people from avoidable harm. The provider did not have systems in place to check equipment in the service on a regular basis. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to make improvements and to send us an action plan outlining what action they intended to take to meet the regulation.

At this inspection, we found that the provider had failed to implement systems and processes to identify and respond to areas of risk that could expose people to the risk of harm. People had been involved in incidents that had or could have affected their health, safety and welfare. We found examples of accidents and incidents, which had resulted in serious injuries to people. The provider had recorded accidents and incidents as they happened. However, they were not thoroughly investigated and did not assist the provider in identifying areas for improvement that should have reduced the risk of injury to people. For example, one person had recently returned from hospital recovering from a serious injury after a fall. No reassessment of their needs had been completed by the provider or manager and staff were unaware of the changes in the person's care and support needs. The person had sustained another fall three days after their return to the home, which resulted in a serious injury that required hospital treatment.

At the last inspection, people were not involved in the risk management process. At this inspection we found that no effective improvements had been made. The manager had introduced new risk assessments for people. These assessments were generic in nature and did not always reflect people's individual needs. For example, one person was living with diabetes, but the information in their risk assessment was incorrect. This placed them at risk of poor care and treatment.. This was confirmed by a health professional we spoke with. They told us that if staff followed these instructions, then the risks to this person, who had a low blood sugar, would be increased.

We saw in another person's risk assessment they needed help to move from one position to another, because they could not weight bear. The risk assessment guided staff to use a piece of equipment called a 'stand aid' hoist. This type of hoist should not be used with people who cannot weight bear and could place the person at risk of injury. The manager told us that information regarding risk assessments was shared verbally with staff at handovers. However, when we spoke with one member of staff they told us, "I'm not sure what individual risk assessments are in place for people." Staff also confirmed that they had not seen the risk assessments for people. One staff member told us, "Risk assessments are amended, but need to be looked at more often. People's needs change so quickly." We asked the staff member what they did if they felt the risk assessments were not up to date. They responded, "I make a calculated decision on the needs of the people as and when we are helping them."

One person was seated in their room on both days of the inspection. They had bruises on their face as the

result of an unwitnessed fall. Their bedroom floor was covered in padded mats. Staff told us this was to give the person a 'soft landing' if they fell. The person had impaired vision and used a walking frame to help them move. We found information in the person's risk assessment was contradictory in that it guided staff to make sure the floor was 'clutter free'. The padded matting on the floor posed a significant trip hazard to the person, because there was no space for them to walk freely.

At the previous inspection people did not have a Personal Emergency Evacuation Plan (PEEP). These plans should have demonstrated how each individual's evacuation needs had been assessed in the event of fire or other emergencies. This information would be used to assist staff and emergency services in the safe and rapid evacuation of people living at the service. At this inspection we saw that PEEPs had been put in place in people's care files. However, they were all identical and did not address people's individual needs. This meant that staff and emergency services still did not have the required information to safely evacuate people in an emergency. The provider had not taken sufficient action to keep people safe in their planning for evacuation in the event of fire breaking out.

We saw evidence that some environmental concerns had been rectified since our last inspection. However, we remained concerned that the registered provider had not ensured the premises were safe to use. For example, we saw that the new windows in the service had restrictors in place, which could be opened very easily by people. This placed people at risk of falling out of the windows. We discussed this with the registered provider who agreed to make these windows safe immediately. We have received confirmation from the manager that these windows had been made safe following our visit.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection, we had been notified of a number of falls resulting in people sustaining serious injuries. Many of the falls were unwitnessed and occurred during the night when there was reduced staffing numbers. The provider told us they intended to review night time staffing levels.

At this inspection, we saw the provider had not reviewed night time staffing levels as they had stated. The provider told us "We are looking at increasing the staffing at the beginning and end of the nightshifts." We saw people's needs were not safely met, because sufficient numbers of staff who were suitably skilled and experienced were not employed. On the days of our inspection there were 14 people living at the service. Three of the people lived in the rooms in the annex. These rooms were situated across the car park from the main building. The registered provider told us that the staffing levels were sufficient to provide the required level of care for the number of people living at the home. They could not tell us how they determined the number of staff they needed on duty to meet people's needs. They told us they did take people's dependency into account, but were not able to tell us or demonstrate how they did this.

Staff told us that the staffing levels made it difficult to care for everyone safely. They told us, and we saw that the nights were very short staffed due to the complex care needs of people living at the home. One staff member said, "Staffing levels have not changed since the last inspection, which we hoped they would. Last week we had a resident who fell in the night. [Person] had a history of falls. They fell when my colleague and I were answering a call bell. With an extra member of staff that fall could have been avoided." Another commented, "I work with my heart in my mouth. People are so frail and vulnerable. There are not enough staff to care for people safely." A third staff member said, "Most people need two staff for everything. I worry about what we would do if there was a fire." Another staff member said, "Staffing levels have not been good, with not enough staff on occasions. We rely on agency staff to cover." They also commented, "New staff are coming in now so it may get better."

One relative said, "They use a lot of agency staff who don't know [person's name]. The staff turnover has been high. I don't think they are watching [person]. I worry that they are not getting enough fluids when I am not here." Another relative said, "In my view there is not enough staff on duty. If people want to go to the toilet they have to wait."

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

We looked at how people were supported to take their medicines safely. The provider did not have appropriate arrangements in place to manage medicines safely. During our visit we were informed by staff that medicines were not administered after 8pm and not until after 8am in the morning. One staff member said, "We don't give medicines at night. They get their last medicine before the night staff come on." They also said, "I can't give pain relief at night if somebody needs it." This meant people could not receive pain relief when they required it.

We saw that one person had a specific health condition that required medicines to be given at certain times to help them move. These times included during the night shifts. These medicines were not given at the required time. This meant this person did not receive the medicines in line with their prescription and it may have affected their ability to move more freely.

During our inspection we identified some people who required the administration of PRN medication. This is medicine that is given 'as and when' it is required such as Paracetamol to relieve pain. We found that a number of records we looked at contained at least one medicine to be taken 'when required.' We found that all medicines prescribed in that way did not have adequate information available to guide staff on to how to give them. It was important that this information was recorded to ensure people were given their medicines safely and consistently at all times. We also found there was no information recorded to guide staff as to where to apply prescribed creams to ensure people were given the correct treatment. We saw two medicated creams belonging to people in other people's rooms, staff we spoke with could not tell how this had happened or that people had not been given creams that were not prescribed for them.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home was not clean and had an unpleasant odour. One person's bedroom had a strong odour of stale urine. We saw that many bathrooms and people's bedrooms did not have soap or paper towels. We saw in one communal bathroom that there was a waste bin which did not have a lid. It contained used continence products, which were not in separate bags. We saw beds, which had been remade by staff with fresh urine stains on the sheets, brown stains on skirting boards and dirty commodes. We saw that records were in place for staff to complete when rooms had been checked. However, these were not completed on most days throughout October 2016 and so did not provide a record of staff oversight of the conditions of the rooms. There were not enough domestic staff employed to maintain the cleanliness of the service on a daily basis. We spoke with the domestic person on duty. They told us their responsibilities on the day was to undertake the laundry and clean rooms. However, they had been asked to assist the care staff in providing care. This meant that they were not able to complete their allocated tasks. This demonstrated that the cleaning of the home was not being routinely completed and people were living in a home that was dirty with unpleasant odours.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

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

At our last inspection, the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider did not have systems in place to work in accordance with the requirements of the Mental Capacity Act 2005, and did not have processes in place to protect people's rights and gain consent. They sent us an action plan describing the action they intended to take to meet the regulation. . There was now an update log on all Deprivation of Liberty Safeguards (DoLS) applications, which was reviewed regularly by the home manager."

We saw at this inspection that, although there was information about DoLS applications and authorisations, the provider had still not assessed people's capacity to consent to their care and support. Training for staff had still not been undertaken. We found that people were not supported in making decisions about their care and treatment. Best interests decisions were not recorded in care plans. We also found decisions made about restricting people's liberty were not recorded appropriately.
Staff were unable to say which people they supported were subject of an authorised DoLS and had no knowledge of the restrictions in place . We discussed the current number of DoLS authorisations for people in the home with the provider and manager. They told us that two people currently had authorised DoLS restrictions in place, however, both the provider and the manager appeared unsure as to who should be subject to the DoLS.

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

Staff were not provided with training and support to ensure they were able to meet people's needs effectively. We found a large number of new staff had been employed since the last inspection. The provider had not taken steps to make sure these staff had taken part in an induction programme or to assure themselves that staff were competent in carrying out their roles. We spoke with one staff member about their induction. They said, "I shadowed other staff for two half-days and one night. Then I stayed on nights. I felt my own lack of experience so asked to have the day shifts to get to know people while they were awake." We spoke with another new staff member about their induction to the service. They said, "I had a health and safety 'walk and talk'. I felt that was adequate for me, because of my background." Another said, "I had two

half days shadowing and read care plans." We spoke with a staff member who worked as a bank staff member. They told us that all their training had been done with the agency they worked for. They said that they had not received any induction or training with the provider, including medication.

We found that staff had not received training that was essential to their role such as moving and handling training, first aid and dementia care. One member of staff we spoke with told us, "I use my common sense when deciding how to move someone, people need two staff so I have no choice, but I am sensible." Another new member of staff told us they felt they had been 'chucked in at the deep end'.

The service cared for people who were living with dementia. One new staff member told us, "Because I know nothing about dementia I have taken it upon myself to find out about it. I have not had any training." We saw some staff had difficulty supporting people when they became increasingly anxious and unsettled. We saw that some staff were currently undergoing an on-line dementia awareness course. Most staff had not received any training on how to support people living with dementia.
The provider could not show us their plans for making sure staff had training or that there was a system in place to support staff with learning after training had taken place. Staff were not supervised or given the opportunity to sit and discuss learning with a senior member of the team.

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

We saw that the physical environment was still not conducive to the improvement of people's quality of life and well-being. We saw areas on the first floor corridors walls, which were wet and had black mould on them. The provider told us these were new problems, because there was a leak in the roof. At our last inspection, we saw a room that had large holes in the wall where a bed rail had damaged the plaster. At this inspection we saw the room now had a new person living in it. The holes in the walls were larger and deeper and showed the wooden lathes in the wall. These holes had still not been addressed by the provider..
We asked the registered provider for their ongoing plan to upgrade the decoration and adaptation of the premises, which they could not provide us with.

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

The provider had recently employed a new chef. Relatives told us that the food had improved since they were employed. One relative told us that their family member's appetite had improved. They said, "They clearly give them things they like to eat." We spoke with three people about the meals they received. They all told us they enjoyed the meals. We saw that the staff ensured people were supported to eat well during mealtimes. Staff provided hot drinks mid-morning and mid-afternoon. They also gave people biscuits with the drink. One relative told us, "[Family member] needs encouragement to eat. They need snacks. I am not sure they get them." Another relative said, "I worry that [family member] is not getting enough liquid. They often take their drink away before it is finished." We looked at the care plan for this person. The plan stated that they needed to drink one and a half to two litres of fluid per day. There were no fluid intake recording charts in place to check the person's intake. Some people had been assessed by the Speech and Language Team (SaLT) where it had been identified that they had difficulties with swallowing. We saw that staff did thicken drinks for people as required to help reduce the risk of people choking.

The registered provider and manager told us that people were enabled to access the required healthcare services and receive ongoing healthcare support. GPs and community nurses were involved in the support of people within the home. The manager had also requested input from the memory team to assist them in

providing suitable care to some people living with dementia. In addition, support had been provided at the service by the community diabetic liaison nurse. These healthcare professionals had all expressed concerns about the support being provided by the staff to people with specific conditions. For example, we received concerns from the GP and community matron that a person living at the service who had diabetes was not receiving the correct care. They also were concerned that the advice given when they visited was not consistently followed.

Inadequate

Is the service caring?

Our findings

We found some examples of care, which did not meet people's needs, but also compromised their dignity. Some people who were living with dementia had difficulty communicating and expressing themselves verbally. We saw that some people were not supported to be involved in decisions about their care and support they needed. This was because some staff did not understand people's needs. For example, We found one person had recently suffered a serious injury and was in pain. This person was not moved from their chair or given pain relief for over 18 hours. The person had been incontinent and they were supported by staff in the communal lounge during this time in view of other people. Staff told us they did not want to move the person 'because they were in pain'. The person was later transferred to hospital for further care and treatment.

We saw another person was sat in a high backed chair which did not support them safely. The person was very stooped and had difficulty holding their head up. Staff told us this person slept in a chair in the lounge, but couldn't have a reclining chair to aid their comfort, because there was only one, which was being used by another person.. Staff told us this person was often found on the floor without their clothing. They [Person's name] spent nights sleeping on the floor because they did not know how to support them getting into bed. One staff member said, "We put [person] to bed and they fall and we have to bring them downstairs again."
We looked at the care plans and risk assessments for this person, who was living with dementia. They had not been supported to be involved in determining the care they needed. We saw that the documents did not provide information or instruction for staff as to how they could help support the person to be more comfortable. The plans did not help staff to understand why the person was behaving in the way they were.

We spoke with a healthcare professional who expressed concern about the staff's lack of understanding for one person they had been asked to review. They did not feel confident that the staff would be able to support them safely, because of their lack of understanding about people living with dementia. The healthcare professional gave advice on how to understand the person better, and prevent them being anxious or aggressive towards staff. However, we found their advice had not been followed and the person continued to be anxious and aggressive towards others. We saw that people's risk assessments all contained the same advice for staff. This included, "If [person's name] behaviour is affecting other residents, remove [person] from the communal areas." Another instruction was, "Never laugh at [person's name] behaviour as they may get more upset or view this as a good way to get attention." This showed a lack of consideration of the person's condition or needs and a lack of understanding for the person's individuality.

Some relatives told us of their concerns about their family member. One relative said, "I come in twice a week and don't see a lot of interaction between staff and [family member]." We spoke with a relative who told us that their family member did not always wear their own clothing. They said that they were not the type who cared, but it still shouldn't be happening. Another relative said, "A few weeks ago [person] didn't have a shave for three days. I had to get clippers to do it."

The registered provider failed to ensure confidential information was stored securely. We found that

individual people's care records were not consistently stored securely by the home. Confidential information was easily accessible to other people. In one person's room we found a file in another person's name on a wardrobe. In another room, which had a sign on the door stating 'Laundry Room,' we found a file containing personal confidential information and dressings in the name of a person who was living at the home. The registered provider told us that the person used to live in this room. They were unable to tell us why their information and dressings were not transferred to their new room with them.

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

We saw that staff showed a kind and caring attitude towards people. They provided care and support, which was considerate. Because the staff team was mostly new, they had not had the opportunity to get to know people they supported.

Inadequate

Is the service responsive?

Our findings

At our last inspection, the provider was in breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because they did not have systems in place to identify, record and respond to complaints. They sent us an action plan describing the action they were going to take to meet the regulation. The provider told us they had put a system in place to record all complaints and intended to respond to each complaint within five working days. There would be a monthly review of all complaints to look at the nature of complaints and any trends, including any staff-related concerns.

At this inspection we found the provider had not taken the action they told us they would. The complaints procedure had not been updated. It still contained the names of the previous owners as people to contact if people had a concern or complaint they wanted investigating. In addition, it still did not provide information about who people could contact if they remained unhappy at the provider's responses.

We saw the complaints book and noted that it had no further information added since the last inspection. The manager said that they had not received any complaints. The provider was unclear as to what constituted a complaint. They told us that a complaint was when someone came to the office to complain. The manager made us aware of a complaint, which had been received at the service on 21 September 2016. It was a concern, which had been made to the local authority safeguarding team. Both the provider and manager did not feel this was a complaint, and so had not acted on it.
Action had not been taken to investigate complaints that we had asked the provider to investigate. There were no records of the complaint being received, investigated or outcome for the person.

This was a continued Breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection the provider needed to make improvements in the way they planned and delivered people's care. We found people's care was not assessed, planned or delivered in a person-centred way. Person- centred care means ensuring the person is at the centre of everything which is done for or with them. This involved taking into account people's individual wishes and needs. Care plans did not reflect people's current needs, were difficult to follow and did not contain detailed information to enable care staff to know how the person should be supported. Reviews were not effective and when people's needs changed this was not reflected in their care plans or risk management plans. Care plans did not contain information about people's life histories. These are important tools to enable meaningful conversations and to support staff to reminisce with people who are living with dementia.. The provider agreed to look at all care plans and review their content.

At this inspection, we did see that some content of the care plans had changed. Life histories had been added to the care plans. However, other information provided was generic and not person-centred. Some phrases used were not relevant to the person whose plan it was. Information was confusing and did not inform staff how to support people. For example, one care plan for a person who was at risk of injury due to their condition stated, "Adopt safe practices as appropriate." Where people were considered to be at risk of

tissue damage due to reduced mobility, the instructions to staff stated, "Assess needs and allocate the appropriate pressure relieving equipment available." There was no information as to what safe practices to adopt, how or when. There was no guidance as to how to decide appropriate pressure relieving equipment was required.

We found that one person remained in their room throughout both days of our inspection. Throughout our visits, this person was seen seated in a chair within their room. We saw staff supporting this person with a meal on one occasion, however during the majority of our visit this person remained in their room, socially isolated. When we spoke to the manager about our concerns, they told us that the person preferred to remain in their room. We spent some time with this person. They appeared withdrawn and bored. There was no suggestion that staff had asked the person if they would like to come out of their room.

The service was recently visited by Healthwatch who undertook an 'Enter and View' visit. "They spent time in the home talking to people and observing care and support provided. They spoke with one person living at the service. The person told them that they never had the opportunity to walk around outside. This person also said that they would like something to do in the afternoons. One relative said, "[Family member] does not receive enough stimulation and that is one area where improvements need to be made. Often they are just sat in a chair, but staff do communicate well with them." Another relative said, "There is no entertainment or stimulation of any kind here." The registered provider told us that they planned to introduce an activities person once the current staffing problems had been resolved."

At the last two inspections the provider needed to make improvements to the way they supported people in maintaining their hobbies and interests. At that time there was limited opportunity for people to take part in activities. At this inspection we found that no further action had been taken by the provider to develop hobbies and pastimes, which would engage people and improve their well-being. We saw that one staff member was supporting three people to do 'colouring in'. Other people were sitting in lounges with the television switched on. We did not see anyone watching the television. They also stated that they expected care staff to assist people to enjoy hobbies and pastimes.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

We found that the current rating for the home was not displayed in line with the requirements of the regulations. Previous rating reports were present in a leaflet holder in the entrance to the main lounge. This is an offence as the provider is required to display their rating by law.
This was an offence under Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

It is a condition of the provider's registration that there is a registered manager in post. There was no registered manager in post at the home. Since our previous inspection in May 2016 the registered manager had left the service. The provider had employed a new acting manager in June 2016. The acting manager informed us at the inspection that they did not intend to apply for registration with CQC. They told us that this was because they were concerned about the legal implications of registering.

At our previous inspection we 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 the provider failed to take action where shortfalls in the service were known. Effective systems were not in place to assess and monitor the quality of the service provided. The provider's systems did not always identify when premises were unsafe. Where they had been identified, there were delays in making the premises safe. They sent us an action plan describing the action they were going to take to meet the regulation. The plan stated that the action the provider was taking to meet the regulation

At this inspection, we found there had been an increase in the number of concerns received by CQC. Our inspection findings identified a number of issues and concerns about care practice within the home. They also exposed areas where people were being cared for in an inappropriate or unsafe way. The registered provider had failed to identify or address these matters.

At this inspection we saw that some work had been completed within the home. The urgent repairs required by the Fire Service had been completed to their satisfaction. The provider had employed a maintenance man. They were undertaking regular checks and repairs in the home. The provider told us that they had an ongoing improvement plan. They agreed to let us have a copy of this but it has not been provided to us.

After the last inspection, the provider said that they would be spending more time at the service to provide support to the new manager. The registered provider had now reduced the time they spent at the service. When we met them they had not been at the service for a week. This meant that the provider had allocated overall responsibility for the day to day running of the service, including recruitment, training, staffing to the manager. The manager was working excessive hours in the home and told us they were very tired and stressed. They told us that the provider was aware of both of these issues. They said, "The provider knows I am behind with my work. This is because of all the hours I work on the floor. I do not have time to do my management work." They also told us, "I never thought I would have to spend so much time with care and the provider is aware of that." The manager was reluctant to confirm whether the provider was supporting them. We spoke with the registered provider about the unsustainable stress the manager was under. They

said that they were aware of this and supported them. However, they were not able to confirm to us how they were supporting the manager.

Because of the ongoing problems within the home, we were not able to see how people and staff were able to be involved in the development of the service. We reviewed the registered provider's statement of purpose which said, "We provide high quality, professional care service for elderly and for people with mental illness and dementia to help them live a full and normal life." The registered provider failed to ensure that the values they talked about had been promoted or upheld in the service. Staff were not aware of the provider's statement of purpose or vision.

People were supported by a new staff team who were still getting to know everyone they were supporting. They were working hard to develop as a team and support each other. Staff we spoke with understood what was expected of them, but felt it was still early days in their new role. All staff spoken with felt supported by the manager. One staff member told us, "I really do feel valued and supported by the manager. They always listen to any concerns I have." We spoke with the new assistant manager. They had been in post for two weeks. They told us that they were aware of the service being in special measures and wanted to help to improve things for people. They told us, "The manager has made vast improvements in the care provided. We have not been able to spend much time together as they are so busy." They also said that they had every confidence in the manager to pull the home through. Two other staff members told us that they had researched the service before applying for a job. They also echoed the assistant managers comment that they wanted to help improve things for people living at the service.

The manager had completed the Preparing to Teach for Life-long Learning programme (PTLLs). This is a recognised teaching qualification. They told us that they were working to ensure a new training programme was provided for all staff. However, this was not in place at the time of our inspection. The provider told us that, because of the staffing difficulties, they had to get the staff working as soon as possible. This was the reason they had made the decision to use the certificates from prior employment.

We saw that people's freedom and liberty was still being compromised and care was not being delivered in accordance with consent or the principles of the MCA. The provider was still uncertain who was being legally deprived of their liberty and who had been referred to the local authority for authorisation of any restrictions which were in place. There were still no systems in place to ensure that the provider was able to be sure people were not being unlawfully deprived of their liberty.

Plans and assessments pertaining to people's safe care and treatment still did not provide clear instructions about the care and support required. Plans were still generic and not person-centred. Reviewing and auditing of people's care and support plans was not being undertaken in an effective way. The manager told us that people's care plans were reviewed as soon as their situation and needs changed and every one to two months. Of the four care plans we looked at, we saw that they had not been reviewed regularly, were not signed and were up to three months out of date. The provider had not provided adequate training or support for new staff in post. Because of this they could not guarantee that the staff provided care which was up to date and reflected best practice.

Systems and processes were still not in place to effectively monitor and improve the quality and safety of support provided. There were inadequate in place systems to identify and mitigate any risks relating to the health, welfare and safety of people who lived at the home. In addition, we were unable to see any ongoing plan for the continued upgrading of the premises. We asked the provider to send to us copies of any reports they had made of their checks when they visited the service. These had not been received.

At the inspection in May 2016, we discussed the breakdown in collaborative relationships with the GP practice. This was also discussed at subsequent meetings with the registered provider. The registered provider recognised the need to work to improve the working relationship with the GPs and other healthcare professionals.

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