Meridian Healthcare Limited

Roby House Care Centre

Inspection report

Tarbock Road
Huyton
Liverpool
Merseyside
L36 5XW

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04 October 2016

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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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We visited the service on 29 September and 04 October 2016. Both days of this inspection were unannounced.

Roby House Centre is registered to provide nursing care for 55 people. The service is located in the Huyton area of Liverpool, close to local shops and road links. There were 47 people using the service at the time of this inspection.

A registered manager was in post at the time of this inspection visit. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We carried out an unannounced comprehensive inspection of this service on 21 March 2016 and found that the service was not meeting all the requirements of Health and Social Care Act 2008 and associated Regulations. We asked the registered provider to take action to make improvements, which included planning people's care, dignity and respect for people, infection control practices, management of medicines and quality monitoring systems. We received an action plan which showed all actions would be completed by 31 April 2016. However, at this inspection we found that the registered provider had not met the legal requirements and we found further breaches of the Health and Social Care Act 2008.

You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

Since the inspection in March 2016 we received concerns from members of the public, Healthwatch and Commissioners in relation to staffing, care and welfare and the leadership of the service. We looked into those concerns as part of this inspection.

The storage of equipment put people at risk of trips and falls. Mobility equipment such as hoists and wheelchairs were left in lounges near to where people were sat, on corridors and in communal bathrooms. Other equipment such as mobile weighing scales, dismantled beds and mattresses were also stored on corridors. The door to a store room on a corridor near to people's bedrooms was left open despite it being packed with dismantled beds and mattresses and other unused equipment and boxes.

Allegations of abuse were not acted upon to ensure people were safe from abuse or the risk of abuse. The procedures set out by the registered provider and the local authorities for responding to allegations of abuse were not followed. Allegations of abuse brought to the attention of the registered manager were not raised with the relevant agency for investigation. These concerns were raised immediately with a senior manager who took prompt action to ensure people's safety.

There were sufficient numbers of staff to keep people safe however how staff were deployed did not ensure people's safety. Staff left the building in groups of up to four at a time to have a cigarette break, leaving people unattended to. Staff also carried out tasks which were not relevant to their role and during this time people were left unsupervised in other parts of the service.

People did not always receive the care and support to meet their needs. One person did not receive personal care as set out in their care plan. There was a lack of information about people needs contained in supplementary care records such as fluid intake and positional change charts, which put people at risk of not receiving the right care and support. Pressure mattresses which people had in place to reduce the risk of developing pressure ulcers were incorrectly set. In addition the amount of fluid people were required to consume in a 24 hour period to maintain appropriate hydration levels was not recorded on their fluid intake charts.

People were not always treated with dignity and respect. Terms used by staff when talking about people were not respectful, for example staff used terms such as she, feeds and double ups. People were left sat for over an hour in damp and stained tabards after being assisted with their meal. Mealtimes were not a positive experience for people and they were disruptive. Staff plated up meals with their backs to people and they carried out tasks such as washing dishes whilst people were eating. Staff served meals to people without checking that the choice of meal was suitable.

Complaints and concerns were not dealt with in line with the registered provider policy and procedure. Prior to and during our inspection we were made aware of a number of complaints which were raised with the registered manager, however there were no records detailing the complaints and the complainants told us that they had not received acknowledgement or an outcome of their complaint. Family members told us they had given up complaining because of the lack of response and that they felt it was a waste of time complaining because nothing was done.

People were not provided with opportunities to take part in activities and there was a lack of stimulation for people. An activities coordinator was employed at the service, however they were given other responsibilities which included assisting people at meal times and cleaning and preparing dining rooms. They said they had little time to organise and facilitate activities for people due to the other tasks required of them.

Throughout both days of our inspection people occupying lounges were either asleep or watching TV. Staff presence in communal areas was minimal and we noted little meaningful contact between staff and people who used the service. Whilst attending to people staff made little or no conversation with them about what they were doing or to give reassurance. On the first day of our inspection a group of people were left sat unattended for a long period of time in a darkened lounge watching a blank television screen after a film which staff had put on had finished.

Family members told us they lacked confidence in the leadership of the service and they described the registered manager as unapproachable and unsupportive. There was a lack of action taken to mitigate risks to people and make improvements to the service people received. Despite us receiving an action plan which detailed improvements made following the last inspection in March 2016 we found ongoing and new concerns. Quality monitoring checks on aspects of the service had not been carried out as required or they had failed to identify risks to people's health, safety and welfare. This included a lack of robust checks on the safety of the environment, staff practice and the maintenance and security of records in relation to people's care.

The registered provider had a safe procedure for recruiting new staff. Staff had completed an application form detailing their qualifications, skills and experience and they underwent a series of pre-employment checks to assess their suitability for the job.

Prompt action was taken by the registered provider to safeguard people and mitigate risks to them in response to the concerns which we fedback following both days of our inspection. Since the inspection we have also received details of arrangements which had been put in place to strengthen the overall management and leadership of the service.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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

The use of wheelchairs without footplates put people at risk of injury.

Equipment was not safely stored, increasing the risk of trips and falls.

Allegations of abuse were not responded to putting people at risk of unsafe care.

The deployment of staff put people's safety at risk.

Is the service effective?

Inadequate

The service was not effective

People did not receive all of the care they needed to meet their needs.

Information about people's care needs was not available to ensure they received the right care and support.

Some people did not have access to call bells and people were left waiting for long periods of time for assistance.

Is the service caring?

Inadequate

The service was not caring

People did not always receive care and support in a dignified way. Terms used by staff when describing people were not respectful.

People did not have a positive dining experience because mealtimes were disruptive and lacked staff interaction.

People's privacy was not always maintained and care records were not kept securely.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Complaints and concerns were not acknowledged and investigated in line with the registered provider's complaints procedure.

People were not given appropriate opportunities to engage in meaningful activities.

Is the service well-led?

Inadequate

The service was not well led.

The registered manager was described as unapproachable and unsupportive.

The registered manager failed to take appropriate action to mitigate risks to people and others.

Quality monitoring processes failed to identify risks to people's health, safety and welfare and to make improvements to the service people received.

Roby House Care Centre

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We undertook an unannounced inspection of the service on 29 September and 04 October 2016. This inspection was done to follow up on requirement actions we gave at the last inspection in March 2016 and in response to concerns which we received about the service. The first day of the inspection was undertaken by two adult social care inspectors and the second day was undertaken by one adult social care inspector.

During this inspection we spoke with eight people who used the service. We spoke with six family members, the registered manager, an operations director, assistant operations director, and seven other staff who held various roles including, nurses, care staff, domestic staff and the chef.

We looked at care plans and supplementary records for five people, including medication administration records (MARs). In addition we looked at other records relating to the management of the service including quality monitoring records.

Prior to this inspection we obtained information from commissioners of the service, Healthwatch and members of the public. We used the information they shared with us to help plan our inspection.

Inadequate

Is the service safe?

Our findings

At our last inspection in March 2016 we asked the registered provider to make improvements to people's safety in relation to the environment, infection control and the management of people's medication. Prior to this inspection we received concerns from commissioners, Healthwatch and members of the public about people's safety in relation to; the environment, infection control practices and staffing levels. As part of this inspection we followed up on the requirements given at the previous inspection in March 2016 and looked at the concerns we received.

The premises were not always safe putting people's safety at risk. Equipment including wheelchairs, mobile weighing scales and dismantled beds were stored on corridors accessed by people who used the service and others. Communal bathrooms were used to store items of equipment such as wheelchairs, mattresses, stand aids and hoists and the bathrooms were generally cluttered. For example, baths were filled with packs of incontinent pads and disposable gloves. Bathroom doors were unlocked and, in some cases the doors were wide open. On both days of the inspection hoists, stand aids and wheelchairs had been left in communal lounges near to where people were sitting and near to exit points. A hoist which was on charge in a corridor blocked the doorway into a communal internet room. A family member lost their balance whilst attempting to avoid the hoist as they accessed the room. We pointed the obstructions out to staff; despite this no immediate action was taken. For example a hoist in a lounge remained there for over 20 minutes before being removed and it was several hours before the hoist which was on charge was relocated.
The door to a store room on the first floor was left open. The room was disorganised and cluttered with broken and unused items including bed frames, mattresses, wheelchairs and boxes. Unsafe storage of equipment and other items put people at risk of slips, trips and falls. On the second day of our inspection bathrooms had been cleared and an unused room had been identified for storing equipment when not in use. Arrangements had also been made to remove from the service broken and unused equipment.

The unsafe use and lack of equipment put people's safety at risk. Staff transported people around the service in wheelchairs which were not fitted with footplates. When we raised this with staff they commented that people came into the service without footplates on their wheelchairs, others get lost and they get taken off and never get put back on. The use of wheelchairs without footplates meant that people were at risk of serious injury. On the second day of our inspection all wheelchairs in use were fitted with footplates.

Areas of the service and equipment to help people with their mobility were unclean and unhygienic increasing the risk of the spread of Infection. Some wheelchairs were heavily stained with dried food debris and spillages and hoists and stand aids were dirty and dusty. Some items of furniture and floor coverings were heavily stained. This included a sofa on a corridor on the ground floor, easy chairs and carpets in the first floor lounge and in some bedrooms. There was a build-up of food debris behind a sideboard in the dining room on the ground floor which indicated that the area had not been cleaned for some time. Two catheter bags containing urine were left on the floor in one person's ensuite bathroom and we saw many examples of bins in bathrooms and bedrooms over flowing with litter. One person's bedroom floor was littered with used tissues and another person did not have a litter bin and they were disposing of their litter in a carrier bag.

We were told that there was two domestic staff dedicated to cleaning the service, one on each floor, between the hours of 9:00 am and 2:00 pm each day. This meant that there is no domestic cover at the service during the afternoons and evenings. This had a negative impact on the cleanliness and hygiene of the service. Family members commented that they cleaned their [relatives] room because they did not consider that the service was clean. Domestic staff told us that they were not aware of any cleaning schedules or processes for checking the cleanliness of the service. There were no cleaning schedules in place or systems for checking the cleanliness of the service and the registered manager confirmed that they had not maintained any. Equipment including hoists and wheelchairs had been cleaned by the second day of our inspection and a cleaning schedule to ensure the upkeep of this had been put in place.

There were sufficient numbers of suitably qualified staff to meet people's needs; however how they were deployed put people's safety at risk. Staffing levels were calculated by the registered provider using a tool which took account of the occupancy levels and the needs and safety of people who used the service. The staffing levels which had been calculated to meet people's needs and keep them safe were being maintained. However, there was little staff presence in communal areas which people occupied and people were left unattended for long periods. We saw examples of this during the first day of our inspection. Staff went outside for a cigarette in groups of up to four at a time; this was despite this being brought to the attention of the registered manager by family members prior to our inspection. Family members raised concerns that they had regularly seen between four and five staff outside smoking together and that during those times they were concerned that people were left without any staff supervision. We raised this with the assistant operations director who took immediate action at the time to address the deployment of staff.

Improvements had been made since our last inspection to the management of people's medication. Medication trolleys were locked when not in use and they were supervised during medication rounds. We looked at a sample of medication administration records and found that they were appropriately signed or coded to show medicines had been given or if not, the reason why.

However we found other concerns in relation to the management of people's medication which put people at risk of choking. On the first day of our inspection a tub of thickener which had a prescription label on for one person was left unsupervised in a dining room, we immediately raised this with the registered manager. Despite this we found the same tub of thickener in the dining room unsupervised on the second day of our inspection. This was not in line with national guidance which states that medicines should be safely stored.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, care was not provided to people using the service in a safe way because people were not protected against; the spread of infections, the proper and safe management of medicines, safe use of equipment and premises.

People were not safeguarded from harm and the risk of harm because appropriate action was not taken in response to allegations of abuse. The registered provider had a safeguarding policy and procedure and copies of those set out by the relevant local authorities. The procedures which were easily accessible to all staff clearly set out the actions which they were required to take in response to an allegation of abuse being made. The procedures made it clear that people should be made safe and that the allegation of abuse should be reported to the relevant agency without delay. Prior to our inspection we were made aware of a safeguarding incident which had recently been raised by a family member with the local safeguarding team for investigation. It became evident during the inspection that these concerns and other related safeguarding concerns had previously been reported to the registered manager. However, the registered manager failed to take appropriate action because they did not ensure people were kept safe and they did not raise the allegations of abuse with the appropriate agency for investigation. These concerns were raised

immediately with the assistant operations director and they took prompt action to ensure people's safety.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, care was not provided to people using the service in a safe way because people were not protected against the risk of abuse.

The recruitment of staff was safe and thorough. Appropriate checks had been undertaken on applicants before they commenced work at the service. Staff whose files we looked at showed they had completed an application form, attended interview and provided photographic evidence of their identity. A series of pre-employment checks were also carried out before an offer of employment. This included a check carried out by the Disclosure and Barring Service (DBS). A DBS check consists of a check on people's criminal record and a check to see if they have been placed on a list for people who are barred from working with vulnerable adults. A minimum of two references were also obtained in respect of staff including one where possible from their most recent employer. Regular checks had taken place to ensure nurses registrations were being maintained and kept updated; a record of the checks was kept.

Checks had been carried out by a suitably qualified person on systems and equipment used at the service to ensure it was safe to use and a record of the checks were kept. This included checks on the gas and electricity systems and appliances, the passenger lift and hoists.

Inadequate

Is the service effective?

Our findings

Before our inspection we received concerns about the care and welfare of people, including the lack of care planning and monitoring of people's care needs. We looked at those concerns as part of this inspection.

People told us that they had to wait for a long time for staff to attend to their requests for assistance. People's comments included, "I've waited for an hour", "I asked for a bin days ago and I still haven't got one". Prior to lunch were asked people what they were having for their meal and very few people were able to tell us. "One person said, "I'm not sure, we haven't been told today" and another said, "We don't usually know until it arrives". Family members told us they had seen people waiting for long periods of time after requesting assistance to use the toilet.

People did not receive effective care and support to meet their needs. We met one person who was being nursed in bed and found that their finger nails were long and dirty and their lips were dry and peeling. When we checked the persons care plan it stated that they were unable to maintain their own personal care needs including nail and oral care. The care plan stated that staff were to ensure that the person's nails are to be kept clean and filed and that the person required mouth care. The condition of the person's nails and mouth indicated that they had not received the care they needed and there were no records to demonstrate that the care was given. We raised this with the person in charge who took immediate action to ensure the person's needs were met. We also raised this with the local safeguarding team as a safeguarding concern.

We saw a number of examples when staff failed to engage with people when providing care and support and dismissed people's requests for assistance. A member of staff entered a lounge, approached a person sat in a chair, pulled off a pressure relieving cushion from around the person's bandaged foot and replaced it with another one. The member of staff made no attempt to speak with the person prior to, during or after the intervention. In addition the member of staff made no attempt to reassure the person despite facial gestures made by the person which indicated that they were in pain.

When on a corridor on the first floor we heard a person shouting for assistance from the lounge. A member of staff entered the lounge and shouted to the person "Wait your turn, you are not the only one in this place you know, and there are others so you'll just have to wait". We immediately raised this with the assistant operations director who took appropriate action. One person who was in their bedroom told us they were waiting to be taken for breakfast and had up to that point waited for over an hour. We activated the persons call bell and after five minutes we saw staff walk past, but it was another three minutes before a member of staff entered the person's room. The staff member walked into the room, turned off the call bell then left without saying anything to the person. Another person told us that on a number of occasions over several days prior to our inspection they had requested a litter bin for their bedroom. However the person had not been given a bin, they had a carrier bag on their bedroom floor which was full of litter.

We saw examples were people who were being nursed in bed did not have access to a call bell. This was because adaptations to extend call bells were not in place and those that were, were placed out of people's reach. Call bells in a number of people's ensuite bathrooms and in communal bathrooms and toilets were

tied around towel rails making it difficult for people to reach. We activated a call bell in one person's room and there was no response from staff for over five minutes. We asked two members of staff if they had received the call on their pager and both said they had not. Staff confirmed that the pagers had failed to work because one was faulty and the batteries on the other had expired. This meant that people were at risk of receiving unsafe and effective care and support. The pagers had been repaired and were in good working order on the second day of our inspection.

Some people who were at risk of dehydration required their fluid intake monitoring. Charts to record people's fluid intake were in place; however they did not include essential information about people's needs and the care given. For example, the charts did not indicate the amount of fluid the person needed to consume in a 24 hour period to remain hydrated. In addition the amount of fluid which people had consumed over a 24 hour period had not been calculated to determine if the person had achieved their target. Fluid charts should have been checked and signed at the end of the 24 hour monitoring period. This was to determine if people had achieved their fluid intake target and if not why, and any actions taken. None of the fluid intake charts had been checked, therefore people were at risk of not receiving the right care and support.

Some people who were at risk of developing pressure ulcers had an air flow mattress on their bed and a chart in place for recording and monitoring the mattress settings and positional changes. The charts included a number of sections to be completed with information about people's needs. For example, the required setting of the mattress, frequency of change of position and the actual setting of the mattress during each positional change. However, none of these sections were completed. Care plans for two people showed they required repositioning every two hours however records did not reflect two hourly positional changes. In addition care plans showed that two people's mattresses should be set at a pressure between 25 and 30 however both mattresses were showing a setting of 40. This meant people were at risk receiving ineffective and unsafe care.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as people using the service did not receive appropriate care to meet their needs.

Inadequate

Is the service caring?

Our findings

At our last inspection in March 2016 we asked the registered provider to make improvements in relation to dignity and respect. Prior to this inspection we received concerns from Healthwatch and members of the public about a lack of dignity and respect for people. As part of this inspection we followed up on the requirements given at the previous inspection in March 2016 and looked at the concerns we received.

People told us that some staff were kind and caring and that other staff were abrupt. When asked if staff were kind one person replied "Some ok, others not". One person told us that when they ring their bell staff say "Now what do you want" and another person said "They [staff] are rough when they put you to bed". Family members told us that some staff were good but others were not so good. One family member told us there were some really lovely staff, however they said that they had heard some staff speaking to people inappropriately and people being told off for asking for a cup of tea.

People were not treated with dignity and respect. One person was administered an injection whilst they were sat at the table eating their breakfast. The member of staff asked the person to pull up their clothing to expose their stomach area and proceeded to administer the injection in full view of others sat in the dining room. The member of staff said this was usual practice. This practice undermined the person's dignity and others around them. We raised this with the assistant operations director who confirmed they would address this practice immediately.

Staff did not refer to people in a respect and dignified way. For example; when we enquired about a person a member of staff referred to the person on more than one occasion, as "She". Another member of staff described one person as forgetful and delusional. We held a conversation with that person in the morning and, at lunch time we met with the person again and they remembered us. Terms such as "feeds" and "double ups" were used to describe people. For example, when describing the arrangements for serving meals a member of staff said "We see to the feeds first".

Meal times were not always a positive experience for people. Food was transported from the main kitchen onto the dining rooms in hot trollies. Staff had their backs to people whilst plating up meals and they did not check with people what their choice of meal was before serving it. In one instance a person was served a meal which they told us they did not like. We alerted staff to this and after five minutes of the meal being served staff replaced it with another. Staff made little attempt to interact with people at meal times, for example they did not check if people were happy with their meal. Some people left large amounts of their meal and staff removed their plates without offering prompting or encouragement to people. In addition people who left their food were not offered an alternative meal. Staff focused on tasks around people whilst they were eating, including scrapping leftover food from plates and washing dishes. This created a lot of noise and deterred staff from spending time with people to enhance their meal time experience.

Two people who were sat in a lounge were wearing stained and damp tabards after being assisted with their breakfast earlier. Staff removed the tabards after we alerted them of this. One person who was sat in a wheelchair in a lounge was served their lunch time meal on a side table; however the person struggled to

access their meal because it was out of reach.

People's personal belongings were not treated with respect. We saw many items of clothing in the laundry which were stored on racks and in boxes. We were told that those particular items were clothes which had not been returned to people because they were unmarked. After three months the clothing was disposed of, despite there being many items of good quality garments.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, people were not treated with dignity and respect.

People's confidentiality was put at risk. Care plans and other personal information in respect of people who used the service were stored in offices on the ground and upper floors which were unlocked. The door to the office which was situated on the ground floor near to people's bedrooms could not be locked because it was faulty. A cupboard and filing cabinet in the office which contained people's personal records including care plans were unlocked which meant the information was accessible to anyone in the area. The office on the upper floor was locked when we alerted staff to this and the cupboard and filing cabinet were secured. Arrangements were made immediately to repair the faulty door to the ground floor office.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, people personal records were not securely maintained.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in March 2016 we asked the registered provider to make improvements in relation to responding to people's needs. Prior to this inspection we received concerns from Healthwatch and members of the public about a lack of response to complaints and concerns, a lack of activities for people, people being left unattended whilst staff were smoking outside and a lack of response to people's requests for assistance. As part of this inspection we followed up on the requirements given at the previous inspection in March 2016 and looked at the concerns we received.

Concerns and complaints were not listened to or responded to. The registered provider had a complaints policy and procedure which clearly described their process for making a complaint and the management of complaints. A copy of the procedure was displayed in areas around the service including on the back of bedroom doors. The process assured people that their complaints would be acknowledged, listened to and dealt with within a set timescale. It also advised people that they would receive a written response. However, we were provided with examples from family members which demonstrated a failure to act upon concerns and complaints in accordance with the registered providers policy and procedure. A family member told us that they had raised a number of concerns about their relative's care however they said they felt they were ignored because nothing was done. A second family member told us that they had raised issues and concerns time and time again and did not receive a satisfactory explanation. Another family member commented "You ask them something and they just fob you off therefore you don't ask them again". A further family member told us they had raised a concern two weeks prior to our inspection but as yet they had not received a response and their concerns remained unresolved. They also said it's a waste of time complaining because nothing is done. When we checked the complaints log there was no record of the complaints which family members had told us about. The registered manager confirmed to us that they had not kept a record of the complaints in line with the registered provider's complaints procedure.

This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, complaints received were not investigated and acted upon.

During both days of our inspection visit we saw no organised activities taking place for people. This was despite there being an activities plan displayed at the service which showed a range of activities. We were told that there was an activities coordinator employed at the service and that they worked Monday to Friday from 9 am to 4 pm. When we met with the activities coordinator on both days of our inspection they were preparing people's meals in dining rooms and assisting people to eat. In addition the activities coordinator washed dishes and prepared the dining rooms for the next meal. The activities coordinator told us they had very little time to organise and facilitate any other activities for people due to the work they were required to carry out before, during and after mealtimes.

Throughout the inspection people who occupied the lounges on both floors were either asleep or watching TV. There was very little interaction between people who used the service and staff. We saw one instance when a member of staff entered a lounge with a drink and a biscuit, they sat in a chair away from people and made no attempt to engage in any conversation with them. The member of staff left the lounge after they

had finished their biscuit and drink.

After lunch on the first day of our inspection a group of people were sat in the lounge on the first floor watching a film which staff had put on for them. Curtains were closed to make viewing easier. However, when we entered the lounge on a number of occasions throughout the duration of the film, there were no staff present. After the film had finished people were left sitting in darkness looking at a blank screen and some people were agitated and shouting out. Staff attended the lounge after we alerted them this.

People's calls for assistance were not responded to in a timely way. Staff went outside into the courtyard for cigarette breaks at regular intervals throughout the inspection. During this time people were left unattended and there was a lack of response to their calls for assistance. For example, one person was asked for assistance but was told by a staff member they had to wait, assistance was only provided when staff who had been outside, entered the building. A second person was left midway through being assisted with care because the member of staff who was supporting them had to go outside in the courtyard to call upon assistance from other staff before they could proceed. A third person requested to use the toilet and was told by a member of staff that they would have to wait because staff were busy. At the time four staff were outside in the courtyard smoking. Three care staff unpacked and constructed new drink dispensers in the dining room whilst people were left unattended in the lounge. When we raised this with the assistant operations director they told us that the task was the responsibility of hospitality staff, not care staff.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, people did not receive care appropriate to their needs.

Inadequate

Is the service well-led?

Our findings

At our last inspection in March 2016 we asked the registered provider to make improvements in relation to the management of the service. Prior to our inspection we received information from members of the public, which included; a lack of leadership and unsupportive and unapproachable management. As part of this inspection we followed up on the requirements given at the previous inspection in March 2016 and looked at the concerns we received.

A registered manager was in post at the time of this inspection visit. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Family members told us that they did not have confidence in the management of the service. They told us they had found the registered manager to be unapproachable and unsupportive. Examples they gave included a lack of response to concerns and complaints and a lack of action taken to make improvements in response to issues and concerns raised.

Quality monitoring systems at the service were ineffective because they failed to identify and mitigate risks to people and others. The registered provider had put in place a comprehensive framework for assessing and monitoring the quality of the service and for making improvements. This required the completion of records following a range of checks carried out at various intervals on things such as the environment, care planning, medication, staff practice and training. However these checks were not carried out and recorded in line with the registered providers procedures, therefore areas for improvement had not been identified and acted upon. For example; the registered manager was required to carry out a minimum of two walk arounds each day or appoint a suitably qualified person in their absence. The aim of the walk arounds was to review and report on aspects of the service such as resident care, infection control and the safety of the environment.

The registered manager told us that they had carried out the walk arounds each day but had not completed the required documentation for at least a week. Records which we were provided with showed that a record of the walk arounds had not been completed since 18 August 2016 and prior to that the records had not been consistently completed. The registered manager confirmed to us that they had not always completed the records which they were required to do. This meant there was no guarantee that the checks had taken place. Checks carried out at the service by other senior managers on behalf of the registered provider had failed to identify the lack of quality monitoring at the service. This meant risks to people were not identified and mitigated.

Records in relation to the people's care and the management of the service were not maintained, accurate, complete and safely stored. Audits carried out on records including care plans and supplementary records failed to identify a lack of robust record keeping. For example records for monitoring aspects of people's care including fluid intake and repositioning failed to include important information in order to demonstrate

that people were receiving safe and effective care. In addition, some people did not receive the right care in line with their care plan. Witten records which contained personal information about people were stored in rooms and cupboards which were unlocked making them easily accessible to unauthorised people.

Risks to people's health and safety and a lack of effective quality monitoring of the service was identified at our last inspection in March 2016. Following the inspection we received an action plan from the registered provider which showed all the actions were completed by the end of April 2016. We were also given assurances that ongoing monitoring of the service would take place to ensure good standards were maintained. Despite this, during this inspection we found new and ongoing concerns including the unsafe storage of equipment, unclean and unhygienic areas of the service and a lack of dignity and respect for people. This further demonstrated ineffective quality monitoring of the service.

The registered manager failed to act upon information of concern which was brought to their attention. This included concerns raised by family members about the care and welfare of their relatives who used the service. The registered manager did not investigate the complaints in line with the registered provider's policies and procedures and they failed to raise safeguarding concerns with the relevant agencies, including the relevant local authority safeguarding teams and the Care Quality commission.

Staff practice was not appropriately managed. Whilst the right amount of suitable qualified staff were on duty, how they were deployed meant people did not always receive effective and safe care. Throughout the first day of our inspection staff in groups of up to four went outside into the courtyard to have a cigarette break. During this time people were left unattended and waiting for assistance.

On the second day of our inspection the assistant operation director provided us with an action plan which had been developed based on our feedback provided on the first day of our inspection. The action plan showed areas of concern had been addressed and the plans which had been put in place to further improve the service. In addition, the registered provider wrote to us confirming the measures they had put in place to address the concerns. This included the development and implementation of a project plan by senior managers, focusing on making the required improvements to the service to ensure people's safety.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as insufficient and ineffective systems were in place to assess, monitor and improve the service that people received and to protect them from the risk of harm and records in respect of people were not securely maintained and complete.

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 People using the service did not receive appropriate care to meet their needs.

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 People were not 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 People were not protected against; the spread of infections, the proper and safe management of medicines and the safe use of equipment and premises.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected against the risk of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints

Diagnostic and screening procedures Treatment of disease, disorder or injury	Complaints received were not investigated and acted upon.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Insufficient and ineffective systems were in place to assess, monitor and improve the service that people received and to protect them from the risk of harm and records in respect of people were not securely maintained and complete.