Sussex Clinic Limited

Sussex Clinic

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on the 4 and 6 December 2018 and was unannounced. The inspection was brought forward because of concerns raised to CQC from health and social care professionals. We had been told that a large number of staff had recently left the service, there were poor clinical skills, inconsistent management and lack of clinical oversight.

Sussex Clinic is a nursing home in Worthing for up to 40 people. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both premises and the care provided, and both were looked at during this inspection. There were 27 people living at the service at the time of the inspection. This included older people, younger adults and those with a physical disability. Some people were living with dementia. By the nature of their complex health and social care support needs, people who live at Sussex Clinic are considered extremely vulnerable.

We previously inspected Sussex Clinic on 28 November 2017 and the service was rated Requires Improvement. Breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified as the provider had failed to ensure that staff were sufficiently trained and that there were effective governance systems in place. After the inspection the registered provider wrote to us to say what they would do to improve and meet legal requirements.

The service has been without a registered manager since June 2017. 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.

At this inspection we identified serious failings and shortfalls in the care, and safety of people living at the service which either placed people at or exposed them to significant risk of harm. We raised multiple safeguarding alerts to the local authority for investigation. We also shared these concerns with the provider, manager and other statutory agencies. We took urgent enforcement action to address these concerns to improve people's safety. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

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.

People were not always protected from abuse and improper treatment. Systems and processes to protect people from abuse were not operating effectively. There were 13 incidents that the provider had failed to report to the local authority under safeguarding guidance. These included eight people with unexplained injury's and four allegations of physical assault by people who lived at the service. 12 of these had occurred in the 10 weeks prior to the inspection. Incident and accident records were not always accurate and some injuries had not been recorded. Staff did not know how to report an incident to safeguarding. This placed people at significant risk of harm as allegations and injuries were not being responded to appropriately. We asked the provider to take immediate actions to safeguard people.

People were not always provided with safe care and treatment. Risks were not always assessed and mitigated. We observed a situation where a person was at risk of harm from accidental ingestion or choking as the provider had failed to follow safety requirements. This is because thickening powder had been left easily accessible along with access to harmful cleaning chemicals to people who were assessed as living with dementia.

Some bedroom doors were closed and we saw people who were unable to get out of bed did not have access to call bells to summon help when needed. Some staff were staying in vacant bedrooms within close proximity to those occupied by people living at the service. The provider had not considered if an assessment of risk was required to assure themselves of people's safety. We asked the provider to take immediate action to ensure the safety of people and mitigate risks from staff living in the service.

The provider did not have an effective oversight of staff recruitment and had not ensured robust processes for ensuring people were suitable for the job they were applying for. For some staff the provider had failed to undertake suitable pre- employment checks including those with a professional body and criminal records check. This meant that they had failed to identify and mitigate risks within the recruitment process and could not be assured that people were safe and being supported by suitable persons.

Care records were not always up to date, accurate or complete. For example, staff could not confirm that pressure mattresses were set to the correct setting for some people who were at risk from developing pressure ulcers. Fluid balance records for people who required their hydration needs to be monitored were inaccurate and recordings were inconsistent. Some staff were recording the fluid offered to the person whilst others were recording what had been consumed. Staff did not always provide adequate assistance where people required support to drink sufficient amounts, and some people who could drink independently had their drinks placed out of their reach. Staff did not always follow people's communication needs and we observed people becoming frustrated with this.

People who were cared for, including people living with dementia and those who remained in bed did not have any meaningful stimulation and occupation. People were at risk of becoming isolated and some people told us that they were lonely. A person told us 'I just wait until a person happens to come by, they don't come by very often". Another said, "it's not easy living here", "I don't get out of bed much and there is very little to do and the conversation is not great'. The lack of engagement and stimulation meant that some people's moods were low and they expressed boredom.

Relatives described the staff as caring, our observations showed that people were not always treated with dignity and respect. On two occasions staff moved a person's bed whilst they were in it without any explanation. On both occasions the person was startled as they were unaware that this was going to happen. Some people who required support to dress had clothing that was inside out, soiled or had their name label visible. People were not always treated in a compassionate way. A person told us about how they had been sitting in the lounge since 6am, and that staff 'never wave or look in when they go past'. They said, "I could be in here all day and no one speaks, sometimes they shut the door".

People did not always receive consistency of support. We saw staff leaving people part way through assisting them to eat to assist someone else in another room and then returning to give the person another mouthful of food. People told us that they did not always have a choice of food and the food prepared was not always served of kept hot. A person told us 'The meals are good, you don't get a choice, sometimes they come around the day before and ask you but not often, they tell you what it is and I suppose you can say if you don't like it, but I have never done that".

Records showed that staff had been provided with training since the last inspection, however records were not always accurate. Although records noted that a staff member had undertaken safeguarding training they said they had not. Staff did not always demonstrate the skills and knowledge in areas in which records said they had received training in. There was no system for monitoring the competency of staff following this training. Staff told us that they did not have regular supervision including clinical supervision.

The service was not well-led and had been without a registered manager since June 2017. The provider had made steps to recruit a new manager and four had been employed since April 2018. The most recent manager commenced two weeks before this inspection. The provider had not ensured good governance and management oversight whilst the service has been without a registered manager. The findings throughout this inspection showed that there was a failure to assess, monitor and mitigate risks relating to the health, safety and welfare of people.

The provider could not evidence that there was an accessible complaints process and whether complaints were investigated.

People lived in a clean environment which supported their privacy. We have made a recommendation for the provider to consider guidance around suitable environments that support people living with dementia.

Information about the service was not always in an accessible format for people to understand. There was limited information for staff on people's communication needs in accordance with the Accessible Information Standard (AIS). We had recommended that the provider obtains information, sources training and implements policies and procedures in relation to compliance with AIS.

We identified multiple breaches of the Health and Social Care Regulations 2014. You can see what action we told the provider to take at the back of the full version of this 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.

People were not always safeguarded from abuse

Risks to people were not managed to make sure they received the correct care and treatment they needed.

Some staff were not recruited safely and did not have the skills to be able to meet people's needs.

Is the service effective?

Inadequate

The service was not effective

Peoples needs were not effectively met because staff did not have the right skills and knowledge, training and support to meet people's needs.

People had poor dining experiences and their dietary requirements and support did not always meet their needs

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always treat people with respect or maintain their dignity.

Relatives and visitors felt that staff were caring and they were happy with the service people received.

Is the service responsive?

Inadequate

The service was not always person centred and responsive to people and their needs.

People did not have things to stimulate them and keep them occupied.

Care plans id not always provide the right information for staff to provide personalised care.

Is the service well-led?

Inadequate

The service was not well led.

There was no registered manager and there had been many management changes

There was no systems in place to check that the service was being managed well.

Important records about what care people needed were not always accurate and update.

Sussex Clinic

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.

The inspection took place on the 4 and 6 December 2018 and was unannounced on both days. The inspection was conducted by three inspectors on the first day and two on the second day. The inspection was brought forward due to concerns we had received from health and social care professionals.

During the inspection we met and spoke with all 27-people living at the service and four relatives who were visiting the service. We spent time in communal areas and observed how staff supported and spoke to people. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand experiences of people who could not talk with us. We also spoke to the nominated individual, manager and six staff.

We looked at specific elements of six peoples care, health and support records and care monitoring records. In addition, we looked at elements of 27 people's daily monitoring records, people's medicine records and documents about how the service was managed. These included staff recruitment files, staff training records, audits, meeting minutes, maintenance records and quality assurance records.

Before the inspection we looked at the notifications we had received about the service. A notification is the action a provider is legally bound to take to tell us about any changes to their regulated services or incidents that have taken place within them. We spoke with Health and Social care professionals who have experience of the service.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We last inspected the service on 28 November 2017 where the service was rated as requires improvement

and two breaches of the Health and Social Care Regulations 2014 were identified.

Inadequate

Is the service safe?

Our findings

Systems and processes to protect people from abuse were not operating effectively. In the last 12 months there were 13 incidents that the provider had failed to report to the local authority for consideration under their safeguarding guidance. 12 of these had occurred in the 10 weeks prior to the inspection. These included unexplained injury's and four allegations of physical assault made by people who lived at the service. This placed people at significant risk of harm as allegations were not being responded to appropriately.

There were wide spread concerns of unexplained bruising and injuries which had not been identified or documented by staff. Whilst it is acknowledged that some people cared for may bruise more easily due to health conditions and medicines, no consideration had been made by the provider to identify other possible causes. One person said, "I tell the girls, not to handle me roughly as I bruise easily". Another person had a significant vertical scab on their leg. The persons relative told us that they had been informed that the persons leg had become caught in a bed rail. We checked the persons incident records, there was no record of this injury. There was a record supported by three photographs of a deep tissue skin tear to the other leg sustained eight weeks prior to our inspection. This injury was horizontal across the leg and stated that it was caused by the persons leg getting caught in the bed rail. We could not see evidence that the risks of this occurring again had been assessed or that preventative action had been taken to prevent a further occurrence. The lack of oversight and monitoring of people's injuries meant that risks that had the potential to cause harm could not be mitigated.

People had unexplained bruises which were not investigated. We observed that a person had a deep purple bruise on their right hand. We asked the person how they had got this and they made a specific allegation that the actions of staff had caused it. We viewed the incident record for this person and noted that it had been completed after the inspector had told staff about the bruising. The incident report states that there were no witnesses and the person says it was sustained whilst being assisted with personal care that morning. Later we observed the person had a new bruise on their other hand, when asked how it happened they said, "staff wrestling". Another person had bruising to their hands, they told us "staff hold too tight, they need to be more careful". There were four other people who were noted to have bruising that was not recorded or identified as to whether the bruising was unaccounted for. The provider was unable to demonstrate that this bruising had been noted by staff and recorded or that the allegation had been considered, recorded or reported to the relevant authority for investigation.

Incident records and wound charts had inconsistencies in the way that things were being recorded. For example, injuries had not been recorded as an incident. One person's wound chart records an unexplained injury to their leg. There was no record of how this occurred or evidence that it had been considered in line with safeguarding guidance. There were conflicting accounts of how injuries had occurred. For example, an incident report for one person stated they had sustained an injury to a limb whilst being hoisted. Two staff witness statement for this injury state that it was sustained on a door frame whilst using a wheelchair. Peoples injuries were not being accurately recorded to ensure effective oversight and monitoring. This meant that people were at risk of repeated injuries because inaccurate records did not identify the root

cause and enable preventative measures to be taken.

Where people had made direct allegations to staff these had not been responded to. Another incident report recorded that one person accused staff of removing their call bell as they said that they had used it too many times during the night. The person also reported that staff responded by shouting and being physically aggressive to them. The incident records show that there was no consideration given to safeguarding this person, and action was not taken to refer to the local authority for consideration under their safeguarding guidance. This placed the person at further potential risk of abuse.

In response to the serious concerns about unexplained injuries and direct allegations that the provider had failed to act upon we raised urgent safeguarding alerts for 13 people. We also asked the provider to take immediate action to notify the police of the allegations of abuse. The provider subsequently confirmed that this had been undertaken and the police visited the service.

Staff were failing to identify injuries and allegations as safeguarding concerns. The providers records showed that staff had undertaken safeguarding training. We spoke to staff about their knowledge of safeguarding. Staff were unsure of the process to report a safeguarding concern and none thought it was their responsibility. Each staff member told us that identifying and reporting safeguarding concerns was the responsibility of the manager. Incidents of harm or potential harm were not consistently reported which meant action required to reduce these incidents from reoccurring was not taken.

During our inspection we asked the provider to raise safeguarding concerns to the local authority for the seven incidents identified on 4 December 2018. On the 5 December 2018 we were given assurances by the provider that this had been undertaken. On 6 December 2018 we were informed that this information was incorrect and the safeguarding concerns had not been raised. When asked by the Local Authority the provider had notified us of an historic event, this had failed to include the safeguarding allegations. This meant that we could not be always be assured of the accuracy of information we were being told regarding the actions taken to safeguard people. To ensure peoples safety we also raised the concerns with the Local Authority.

We took urgent enforcement action to address these concerns to improve people's safety.

People were not always protected from abuse and improper treatment. The provider has failed to respond to allegations and record, report and investigate safeguarding incidents. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding services users from abuse and improper treatment. Subsequent to the inspection the provider implemented improvements to the way that staff record future accidents and incidents. In addition some staff had also undergone safeguarding training.

People were exposed to the potential risk of harm as reasonable steps had not always been taken to assess and mitigate risks. For example, two people who were assessed as being at risk from choking had thickening powder added to their drinks. We saw that for one person who was assessed as having dementia that the thickening powder had been left in their rooms and within reach of the person. A person who lived in a nearby room records stated that they had a history of self-injuries behaviour and mental health. This had not been considered when storing the powder in people's bedrooms which made it accessible. The provider had not ensured the safe storage of thickening powder which meant people were at risk of asphyxiation by accidental ingestion of fluid thickening powder, as outlined in the NHS England patient safety alert 2015.

An unlocked cupboard located in a main corridor thoroughfare and next to a main lounge contained substances that had the potential to cause harm to people if ingested, including various cleaning products and 12 bottles of bleach. We showed the provider who established that the lock was broken and arranged immediate repair. On the second day of our inspection the same cupboard remained unlocked with the key left in it. The contents of the cupboard remained the same. We informed the provider who immediately locked the cupboard and removed the key. The provider had placed people at risk of harm by failing to ensure the safe Control of Substances Hazardous to Health (COSHH) as set out in the COSH Regulations 2002.

The provider did not assure themselves of people's safety when allowing staff to live in empty bedrooms. The provider confirmed that two staff were living in bedrooms within the service. They told us that one person had been staying there for a few months and that the other would be staying for three weeks. The bedrooms were within close proximity to those used by people who lived at the service, and they were accessed through the communal areas of the service. The provider had not considered the risks posed by staff accessing areas of the service and the impact their lifestyles may have on the people living there. We asked the provider to take immediate action to ensure the safety of people and mitigate risks from staff living within these bedrooms. The provider subsequently confirmed that alternative accommodation was found for both staff members.

People who were dependant on staff for their hydration needs were at risk from dehydration and urinary tract infections (UTI) as the information to record their fluid intake was incorrect and misleading. People did not have accurate information to reflect their fluid intake because staff were not consistent with how they recorded this. Fluid balance records for people who required their hydration needs to be monitored showed discrepancies in what was recorded and what we had observed. For example, we observed that whilst a person was given a black coffee, this is what the staff member said they liked, full beakers of cold milky tea and orange juice were removed from their lap table in front of them. Their fluid balance chart had noted that they had drunk most of these drinks when this was not the case. The staff member moved the black coffee out of reach as it was described as 'very hot'. Over an hour later we observed that this drink was still in the same position and remained out of reach and had not been drunk. Their fluid balance sheet noted that they had drunk some of this coffee which was not the case. We observed that two people who could drink independently were unable to reach their drinks as they had been positioned away from them. The manager acknowledged that some staff were recording the fluids that were presented to the person and not what they had consumed.

Throughout the course of the inspection seven people were observed not to have access to their call bells. These people were assessed as unable to get out of bed and some people had their doors closed. One person had a sign above their bed stating that they must have access to the "orange call bell", the call bell was at the other side of their room out of reach. We asked one person how they would call for assistance, they said "I don't, I just wait until a person happens to come by, they don't come by very often" Another person told us that due to their physical disability they were unable to use a call bell and could shout for help. There was a system in place to check on people who did not have access to a call bell hourly. The risks to people of not being able to seek assistance had not been assessed which placed people at risk from not receiving the help they wanted.

People were placed at potential risk of skin breakdown as pressure care management was not always well managed. Before the inspection, a visiting health care professional told us a pressure mattress was not at the correct setting. They had also raised this with the local authority. Records of pressure mattress daily checks for five people, stated that each person's pressure mattress should be set at number 'two'. We observed that the mattresses for these five people did not actually have a setting of number 'two', but

instead was to be set by a person's weight in kilogrammes. We asked staff and the manager and they were unable to tell us why the records stated setting number two or what the equivalent setting would be in kilogrammes. Mattresses pressures were checked twice a day, all entries stated, "setting correct". We asked staff how they knew the correct setting for each person and were told that the pressure of the mattresses should be set at the persons weight in kg. Therefore, they could not confirm that mattresses were set at the appropriate setting to support good pressure care.

During our inspection West Sussex Fire and Rescue carried out a routine evaluation of the fire safety provided at the service. They found that some people were at risk from fire. This is because, equipment checks were not being properly tested, signage did not comply with the relevant safety standards and was confusing, fire doors were not properly tested and maintained and in full working order. Fire doors with signage stating, "keep locked" were either left unlocked, open or had broken locks. Work was required to reduce the spread of fire in the electrical cupboard and basement. Fire escapes did not always lead to safe and accessible places of safety that had appropriate lighting. West Sussex Fire and Rescue services have issued a scheduled of works for the provider to undertake. Subsequent to the inspection the provider unformed us that the required works had been completed. This information was shared with West Sussex Fire and Rescue in order to inform any future review,

Fire safety requirements were not being undertaken in line with the providers instructions. We observed a fire alarm practice and although staff responding quickly some staff presented as confused as to what was happening. One staff member ran down the corridor at speed "stating is it a test? they are meant to tell us if it's a test". Another said, "I don't know". This did not provide assurance that tests were being carried out weekly as per the providers instructions or staff knew what to do in the event of regular fire alarm testing. We observed staff going to the fire panel to ascertain what was happening, this was in line with the services requirement. We viewed the services fire safety recordings and saw that fire safety tests, checks and equipment were not regularly undertaken, checked or maintained.

The provider has failed to assess, record and do all that is reasonable practicable to mitigate risks to people's health and safety. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Staff employed were not always recruited safely. This is because the provider had not ensured they had sought all the documentation and evidence to make sure that staff were safe to work with people. For example, two staff had been appointed without a relevant Disclosure and Baring service (DBS) checks. The provided confirmed that they had not applied for a DBS for a person who had left their employment and returned at least two years later. The provider was unable to explain why another person's DBS was dated four years after their employment had started.

The employment record for a staff member showed a disclosure of a criminal conviction. There was no evidence that risks associated with this disclosure had been considered. We asked the provider about this and were informed that they did not have any processes in place to consider the risks of employing people with criminal convictions. We notified the provider that we had information about another person they had employed. The provider informed us that they were not aware of any concerns relating to this person's suitability for their role. The provider had failed to undertake suitable pre- employment checks including those with any professional bodies. This meant that people may be receiving care and support from people who are not suitable for the position they have been employed into.

Safe recruitment practices were not always followed. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Fit and proper persons employed.

Staff confirmed that there was enough staff on duty to support the personal care needs of people, The staff rota confirmed that there was always a consistent number of staff on duty. New staff were allocated to work alongside existing staff to ensure that they were supported and gain an awareness of people's needs before supporting the person on their own. Records confirmed that new staff when shadowing existing staff were also supernumerary.

Medicines were managed in a safe way. Registered nurses administered medicines and had clear and appropriate guidance to inform their practice. People told us that they had access to medicines when they needed them. Observations showed that people's consent was gained before staff offered support. They were asked if they required certain types of 'as and when required' medicines. Their right to refuse medicines was respected. People had access to regular GP visits where their medicines were reviewed and discussed. Information about people's health and the medicines that were prescribed, was readily available should people transfer to other settings, such as when they were admitted to hospital.

Infection control was maintained and the service was observed to be clean. Staff used personal protective equipment when supporting people with their personal care needs. They disposed of waste appropriately to minimise the risk of cross-contamination.

Inadequate

Is the service effective?

Our findings

At the last inspection on 28 November 2017 the service was rated as Requires Improvement in this key question. This was because the provider could not demonstrate that relevant training, including updates had been given to staff in a timely manner. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Following the inspection, the provider wrote to us and told us what action they were going to take to address the concerns. Although the provider had taken action to ensure staff received relevant training, the effectiveness of this training was not monitored and there continued to be a breach of Regulation 18.

The effectiveness of staff training and the competency of staff was not monitored. Training records showed that staff had undertaken training since the last inspection. Training records showed that staff had undertaken 11 refresher training topics in one day. These included moving and positioning, risk assessment, infection control, basic life support and first aid awareness, fire safety awareness, food hygiene, safeguarding, COSSH, MCA and DoL's, and equality and diversity. When we asked to see the training contents to help establish if staff had received the appropriate training and professional development we were told by the provider that this was not available. There was no process to establish the effectiveness of the training through for example the use of competency checks following this training. Our observations showed that staff were not always able to demonstrate the required level of competence and skills in areas records said that they had undertaken training in. This included recognising safeguarding concerns.

Concern was raised with us by a health care professional about the clinical skills of staff regarding safe catheter care. We observed that staff did not always display the skills needed to meet people's catheter care needs. When we asked the provider to confirm what training staff, including nurses have undertaken in relation to catheter care, they felt that staff were competent but they were not able to provide evidence of any training having been undertaken. The urine retention care plan for one person showed they required a new catheter to be inserted every 12 weeks. Daily records showed that that this person had instead received five catheter insertions in five weeks, this was far more than that they were assessed as needing. A staff member told us that the reason for this was due to the catheter becoming blocked which resulted in the need for the catheter to be changed more often. Therefore, it was essential the catheter be free draining to prevent blockages. Staff confirmed that sometimes they had difficulties changing the catheter and needed to seek additional medical assistance from community nursing and paramedics. Their care plan gave some very specific guidance which included ensuring the urine bag was on a catheter stand and not on the floor or bed this was to aid flow. We observed the catheter bag lying flat on the persons bed and was therefore not free flowing. It also stated that the catheter should be emptied every two hours. Records did not confirm that this was happening. Their care plan had not been updated to reflect the changes in the persons health and the potential need to increase the catheter changes. Therefore it could not be established that this was the reason for the rise in frequency.

Training records were not always accurate to establish if staff had received suitable training. We asked a staff member about the safeguarding training they had received. They told us that they had never received this training. The training records showed that this person was recorded as having undertaken this training

during 2018. They told us that this information was incorrect. Staff told us that they did not receive supervision on a regular basis. When asked, a nurse was unsure what clinical supervision was. Staff said that they had not had supervision because there had been a lot of different managers. They told us it had been difficult as managers did not stay very long and each one had a different way of working so things kept changing.

Failure to ensure that staff were supported to undertake training, learning and development to enable them to full the requirements of their role is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people's assessed needs were not always fully considered before a decision was made that their needs could be met by moving to the service. This had resulted in staff not being able to meet one person's complex mental health needs. There had been a marked deterioration in how well the person was and this was impacting on the persons wellbeing. Records and staff confirmed that they had not undertaken any mental health training. A health care professional feedback that the provider has 'accepted people who are not suitable for the service".

Not everyone had a positive meal times experience as it was not person centred. We saw staff leaving people part way through assisting a person to eat, to go and assist someone else in another room and then returning to give the person another mouthful of food. This did not provide the person with a dignified and person-centred approach to meal times. One person was sitting on their own in the dining room to eat their meal. There was no documented evidence to suggest that the person preferred to eat alone. They were observed to be staring at a blank wall whilst having their meal and did not have access to interaction or stimulation to enable them to have a sociable experience. When an inspector communicated with the person, the person responded well and engaged in a conversation. This demonstrated that the person responded well to interaction from others. The person had not eaten their meal and when an inspector asked if they had enjoyed it they said that they had not. Staff took the person's meal away and did not ask them if they had enjoyed their meal or if there was anything else that the person would like to eat instead. There was no interaction or explanation from staff and the person was supported in a wheelchair, to go back into the lounge area, where they sat on their own.

A visitor told us " often they just come in and cut up her meal and leave it in front of her, she falls asleep then they come back and take it away. I encourage her to eat when I am here, she can eat on her own but needs encouragement". There was very little interaction between staff and people they were supporting to encourage them to eat and to aid their orientation that it was meal time. The food trolley was left in the corridor whilst staff went into people rooms to support them to eat their meal. We observed that at least six meals remained on an unheated trolley for up to 45 minutes. This meant that the food prepared was not always kept hot which may have impaired their enjoyment of the meal.

People told us that they did not get a choice of food and often did not know what the meal was going to be. "I don't know what's for dinner, unless its Friday, it's always fish and chips". "The meals are good, you don't get a choice, sometimes they come around the day before and ask you but not often, they tell you what it is and I suppose you can say if you don't like it, but I have never done that"." The menu offered an alternative light snack in place of a meal. We asked staff if people could choose an alternative to the main meal and received mixed responses. We were told that there was no choice available to people, whilst another person said that they could ask for an omelette or sandwich. We were told that people were not involved in menu planning. People's preferences were not being taken into consideration. Some people were not being offered a choice and did not feel that they were able to ask for an alternative to what was being offered.

The care and treatment provided was not designed with a view to achieving people's preferences and ensuring their needs were met. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred Care

Care plans included information about people's dietary needs. One person who was assessed as being at risk from choking had their meals cut up very small in line with their assessed needs and were supported by staff to eat. Another person's Speech and Language Therapy (SALT) guidelines stated that they required a pureed diet. We observed that the person's meal was pureed and each food item was pureed separately to preserve the integrity of the food and aid presentation. Peoples weights were regularly monitored and recorded. Where there had been an unaccounted for weight loss suitable actions had been taken to seek additional support and guidance.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We checked whether the provider was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. The provider was following these principles and staff understood MCA and making best interest decisions. We spoke to the provider about their responsibilities regarding the Deprivation of Liberty Safeguards. Staff were aware of the 12 people who had DoL's authorised with conditions and could tell us what they had done in relation to meeting these conditions.

People had access to health care services. People who had complex health conditions had access to community nursing and a health professional from the local surgery visited on a weekly basis. A physiotherapist visited the service during the inspection and records showed people also had access to chiropody. Staff felt that they were very well supported by the health care professionals that visited. Staff sought immediate medical assistance when they were concerned about people and there was evidence of hospital admissions and visits by the emergency services.

The upstairs lounge had been decorated to replicate the 1940's. There were memorabilia from that era in the room. One person in the lounge said that the lounge was a nice place to be. One person told us that the service had a lovely garden but it was not accessible to them in their wheelchair. The provider advised that portable ramps were available to help promote garden access, these were not apparent during the inspection. The provider did not reflect national good practice guidance for supporting people with dementia. For example, the majority of décor was in neutral colours and for some people living with dementia they may not have been able to distinguish the differences between doors, furniture and walls. Some people who were unable to get out of bed had their bedroom curtains closed during the day, this made it difficult to distinguish night from day. There was a lack of signage around the service to help people orientate themselves.

We recommend that the provider reviews guidance issued from reputable sources about creating suitable environments that support people living with dementia.

Requires Improvement

Is the service caring?

Our findings

Relatives told us staff were kind and caring and they were happy with the care their family members received. We observed some positive and warm interactions between some people and some staff but this was not always consistent.

Staff told us that although there was enough staff to support peoples care needs they did not always feel they had the time to provide care in a supportive and compassionate way, as they were 'task focused' on providing personal care. They told us they did not have enough time to spend quality time with people. Staff told us they were afraid of not meeting the tasks that had been allocated to them. They said that they could not spend quality time listening and talking to people. A person told us during the late morning that they had been sitting in the lounge since 6am, that staff 'never wave or look in when they go past'. They said, "I could be in here all day and no one speaks, sometimes they shut the door". They told us they were unable to walk without their frame. This was in the corner of the lounge and they had a lap table in front of them which meant that they could not easily stand without support. We observed this person for 20 minutes and there were eight occasions when staff walked past and did not engage or acknowledge the person.

People were not always treated with dignity and respect. One person was sat in the communal lounge, they were wearing dirty shoes which were heavily soiled with a light brown liquid. Their socks were on inside out with the label showing their name clearly visible. Some people had nail varnish that had grown out half way up their nail and the remainder was worn and very chipped. A person told us "I like having my nails done, there is a girl that comes in and does them, she is really good but she hasn't been for a while". Another's person wrist watch was an hour fast.

Two people were observed to be in their bedrooms with their doors closed. There was no documented evidence to demonstrate that people had chosen to have their doors closed. Neither were there assessments of risk to determine if this was the most appropriate way of meeting the person's needs. Both people did not have access to a call bell to enable them to call for assistance from staff. They were observed mid-afternoon to be awake and in dark rooms, with no lights on and with the doors closed. This did not support people to orientate to place and time and did not meet people's social and emotional needs. When this was raised with staff they immediately turned on people's lights.

On two occasions we saw staff move a person's bed whilst they were in it. On both occasions the person was startled and surprised by this as they had not been asked if the bed could be moved or informed that it was going to happen. This appeared to cause the person unnecessary anguish. There was a sign on a person's wardrobe which said the name of their named nurse. Staff told us that this staff member had left in 2017. This meant that the person and their relatives were not provided with up to date information regarding their care.

People were not always treated with dignity and respect. This is a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Dignity and respect. .

Some people were being supported to uphold their faith and that provision was being made for their religious needs to be met. One person had access to their bible which they said was very important to them, another had regular visits for holy communion. People told us that the staff ensured that they had access to church or religious services held within the care home.

There were suitable facilities to promote people's privacy and to meet their preferences, which included assistive bathrooms. We observed staff knocking on people's bedroom doors before entering. A staff member was observed discreetly asking the person if they needed support with some personal care.

Inadequate

Is the service responsive?

Our findings

People did not always have person centred care that met their needs and preferences. Care plans did not adequately identify personal histories, the range of peoples personal and social needs and their individual preferences. Therefore, staff did not always have accurate information about people as individuals to be able to support them in a personalised way. This lack of personalisation impacted on people's emotional wellbeing.

People did not always receive personalised care. The care plan for a person stated that they were deaf and that their care plan stated that they required communication to be written in a book as they would read the text and respond verbally. For this purpose, there was a note pad and pen by the persons bed. The entries showed that this was not used on a regular basis. The last entry had been approximately two weeks earlier when the new manager introduced themselves and was advising that due to the fire risk this person's door had to remain closed. We observed on several occasions staff either ignoring the person when they entered their room or talking to them in a very loud voice. We observed the person telling staff that they could not hear them "I'm deaf". On day two of the inspection the last entry in the persons communication book was from the CQC inspector two days previously. The person was not being communicated with in a way that met their personal preferences and needs.

Speech and language therapy (SALT) guidelines were in place for people assessed as at risk of choking. We observed that these were not always followed. For example, a (SALT) assessment stated that the person should be given thin fluids from open cups with small sips with the support from staff. We observed drinks being given in beakers with spouts and placed where the person was unable to reach them. Staff said that the person could drink independently however the cup had been placed on the bed table tray out of reach.

A lack of engagement and stimulation meant that some people's moods appeared low and they expressed boredom. People who were cared for, including people living with dementia and those who remain in bed did not have any meaningful stimulation and occupation. We observed that a person who was cared for in bed had their bed facing a blank wall. Their care plan did not provide any guidance as to what this person's wellbeing needs were whilst being cared for in bed. Five people told us that they were lonely. One person told us "it's not easy living here", "I don't get out of bed much and there is very little to do and the conversation is not great. Another person said that they spent a long time on their own but had got used to it now.

Three people told us that their bedroom doors were kept closed which made them feel isolated. A relative told us that their relatives preference was to have their bedroom door kept open but that every time they visited the door was closed. This resulted in them propping the door open. It was not recorded in peoples records as to whether they had made the decision to have their bedroom doors closed. The manager and care staff told us that some bedroom doors were closed because there were no automatic fire closures to support the doors to remain open if preferred. One person said, 'I am very lonely and would like to go out more, maybe to a day centre or somewhere with a nice garden'.

All people that we spoke to told us that activities did not happen very often. Peoples activity diaries lacked detail as to their preferences and of any opportunities for engagement. Staff told us that peoples diaries are recorded in each day as to what activities they have been involved with. A sample of recordings said, "watching TV", "Foot massage" "declined activity" "chat to staff" "person was sleeping". The provider told us that there was a programme of activities and people came into the service to undertake these. They informed us that there were no activities at present as the activity person was off and no alternative provision had been made. Relatives told us: "there are no activities", "there is a lack of activities and anything to do". The comments book recorded "it would be good if there were more activities", "bring some pets in, have more singing". The lack of meaningful occupation meant that some people presented as withdrawn and isolated.

People did not receive the care and treatment to meet their assessed needs or which reflected their preferences. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred Care

We were told by the manager that there was a complaints procedure. On both days of the inspection we asked to view this as well as any complaints records, the provider and manager were unable to locate them. Therefore, it could not be established whether complaints were raised or investigated and if actions taken to improve practices. We received mixed feedback from people regarding raising concerns. One person told us that they would tell the nurses if they had any concerns. Others shared with us their concerns including allegations of mistreatment by staff which the manager and provider said had not previously been raised. This gave cause for concern that not all people felt able to raise concerns directly. One person told us that although they felt the food was nice, there was no choice and that they wouldn't want to ask for anything different but instead they would just manage without.

The provider has failed to operate an effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity. This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Receiving and acting on Complaints.

From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard (AIS) in full, in line with section 250 of the Health and Social Care Act 2012. Services must identify, record, flag, share and meet peoples' information and communication needs. Information about the service was not in accessible formats for people to be able to understand. People's care plans did not include information about people's communication needs.
We recommend that the provider obtains information, sources training and implements policies and procedures in relation to compliance with AIS.

We were told by the provider and manager that there was no one currently in receipt of end of life care. Most people's needs had been considered as part of any end of life care planning and people were supported to make decisions about their preferences for end of life care.

Inadequate

Is the service well-led?

Our findings

At our last inspection on 28 November 2017, we rated the well led key question as Requires Improvement. The provider had not assured they had effective governance this included auditing systems and processes. We found a breach of Regulation 17 (Good Governance) of the Health and Social Care act 2008 (Regulated activities) Regulations 2014. Following the inspection, the provider wrote to us and told us what action they were going to take to address these concerns. Not all of the actions taken to improve the governance of the service had been implemented and there continued to be a breach of Regulation 17.

The service was not well led. The service had been without a registered manager since June 2017. The provider told us that they had appointed four managers during this time but had found that all were unsuitable and were not therefore put forward for registration with CQC. A new manager had been employed during November 2018. After this inspection the manager left the service and a registered manager from another of the providers services was providing 24 hours per week managerial cover.

Not having a registered manager is a breach of the providers condition of registration. This is a breach of Regulation 33 of the Health and Social Care Act 2008 (Registration Activities) Regulations 2014. Failure to comply with a condition.

We received mixed feedback about the management of the service. Relatives said that people were well cared for and the staff were very caring, but the service lacked management continuity. Visiting professionals raised concerns about the lack of management oversight and said that the service was lacking management stability. We were told that "untrained nursing staff have lacked guidance and support and have lost confidence in their abilities" another said, "record keeping is very poor and this is a cause for concern". Some of the staff asked not to be named or identified for fear of repercussions by the provider. They did not feel that they could approach the provider for support. They said that staff had left because they were unhappy and that there was a culture of blame from the provider once people left.

There were concerns that the provider had not taken ownership or fulfilled their obligations and responsibilities. They had not monitored or supervised staff to ensure that people were receiving a safe and effective service and that system and processes were being adhered to. For example, there was a lack of supervision and oversight by the provider of people left in charge in the absence of a registered manager. Professional restrictions placed upon a staff member from a professional body were not considered to ensure that they had the right skills for their role and that any necessary support was identified and provided.

The systems for assessing, monitoring and improving safety and quality of the service were not always effective and had not identified the serious shortfalls found during the inspection. When asked we were told by the provider and manager that there was not currently an audits process in place to monitor standards of care at the service. The provider acknowledged at the start of the inspection that they had not followed their own processes, this included the auditing and monitoring of peoples care plans. They said that this was because previous managers had been inconsistent in their approach and oversight.

There was no robust governance process to monitor accidents and incidents. The provider told us that they were unaware of some of the safeguarding allegations that had been identified during our inspection, including allegations noted within the services own records. There were no systems in place to enable them to oversee accidents, incidents and allegations to identify safeguarding concerns, themes or trends and to try and prevent re-occurrence. In addition, how accidents and incidents were being recorded made it difficult for the provider to retrieve essential information for them to be able to do this. For example, accidents and incidents were logged together which included staff accidents as well as people who lived at the service. In addition, not all accidents or incidents we were made aware throughout the inspection were recorded and some were being recorded on separate individual incident forms.

There was no governance system for monitoring care planning to ensure that they provided clear accurate guidance for staff. There were multiple examples of care records not being completed accurately in relation to the care provided, so the provider was unable to monitor whether people were receiving the care they needed. This included hydration, pressure wound care and social needs. Up to date guidance was not always clearly available. For example, a person had a nutritional assessment in place which showed that they were at risk from malnutrition. The person had lost 5kilos in weight over a 10-week period and a referral had been made to external health care professionals. New guidance was issued by them on the 2 November 2018 which stated the person now required a pureed diet. The persons care plan still stated that they needed a soft diet and had not been updated to reflect the new guidance for staff to follow. This placed the person at potential risk of not receiving consistent safe support.

There was not an adequate process for assessing and monitoring the quality of the services provided and that records were accurate and complete. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

Throughout both days of inspection, the provider was not always transparent in information they provided to CQC. Differing explanations about events or situations that had occurred were given by the provider. This meant that it was not always possible to determine what had occurred. For example, when the inspection first began the provider introduced a staff member as a registered nurse. Information received after the inspection showed that there had been concerns about the member of staff's, abilities to practise as a registered nurse. Restrictions had been placed on them by the NMC and they were required to be supervised when undertaking any nursing practises and associated managerial duties. When this was raised with the provider they provided differing accounts. They informed us that they were aware of the staff members restrictions to practice, however, they had not been employed as a registered nurse and the restrictions therefore did not apply. Subsequently, the provider's explanation stated that they had been unaware of the restrictions on the persons practice and would take appropriate action.

The provider was asked for information about another member of staff who was working at the home on a temporary basis. The provider gave us different explanations about the reasons the member of staff was working at the home which raised concerns about the accuracy information that had been provided.

At inspection the provider told us and staff recruitment records showed that another member of staff left employment and returned to work in a different role some years later. A new Disclosure and Baring Service (DBS) was not undertaken. This was not in accordance with the provider's policy which states that a new DBS should be completed when staff leave employment. Documents within the member of staff's records confirmed this. After the inspection the provider informed us that the member of staff had never left employment. The variable explanations and accounts provided by the provider did not give assurances of the accuracy or credibility of the information that was being provided.

There was no established structured approach to act on feedback from people and stakeholders about the service, for the purposes of continually evaluating and improving the service. Staff told us they had attended a few staff meetings last year. During the inspection the provider had initiated feedback surveys to people and their relatives to gain feedback about the service. Any feedback was in the process of being analysed.

Services are required to display the most recent inspection ratings, this was not initially displayed at the service. Once highlighted to the provider this was immediately addressed. The providers website displayed the correct previous rating. The providers website stated that the service was managed by a registered nurse. The registration certificate for the registered manager who left in 2017 continued to be displayed by the front door. This meant that people were being given misleading information as to who the manager was and their professional status. The provider removed the certificate as soon as it was brought to their attention.

Services that provide health and social care to people are required to inform CQC, of important events that happen in the service. The provider had not always informed CQC of significant events in a timely way. This included 12 incidents that should have been identified as safeguarding allegations. This meant we could not check that appropriate action had been taken.

The provider has failed to notify CQC of relevant incidents that affect the health safety and welfare of people using the service. This was a continued breach of Regulation 18 of Care Quality Commission (Registration) Regulations 2009.