Willow Cottage Care Home Limited

Willow Cottage Residential and Nursing Home

Inspection report

127 Station Road
Yate
Bristol
Avon
BS37 5AL

Tel: 01454329133
Website: www.mulberrycare.org.uk

Date of inspection visit:
11 January 2018
16 January 2018
17 January 2018

Date of publication:
27 June 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Willow Cottage Residential and Nursing Home is registered to provide accommodation and personal or nursing care for up to 34 people. At the time of this inspection there were 20 people residing at Willow Cottage Residential and Nursing Home.

At the previous inspection carried out 1, 2 and 3 March 2017 we rated the home as Requires Improvement and identified concerns around the safety of equipment, compliance with the Mental Capacity Act 2005 (MCA), person centred care and the lack of audits undertaken. This inspection was undertaken on the 11, 16 and 17 January 2018. The inspection was prompted by continued concerns raised with the CQC about staffing levels, staff retention, the leadership of the home, recruitment of staff and the lack of action taken to address staff performance.

We liaised with other professionals and services such as the local authority safeguarding team, local authority Deprivation of Liberty Safeguards (DoLS) team, environmental health, the fire service and the local authority planning department.

At our inspection we found that the provider had failed to make the improvements needed and the overall rating for this home is now Inadequate.

During this inspection, we found that the registered provider was in breach of multiple regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

There was a registered manager in post, however they had handed in their notice. They left the organisation on the 15 January 2018 after our first day of inspection. There was a new manager in post and they planned become the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run.

The environment of the home was not safe. Environmental risks were not consistently identified or addressed, consequently people were exposed to the risk of serious harm. The provider had failed to develop a plan to support the refurbishment of the building to an appropriate standard. The quality monitoring of the home had failed to give an accurate view of all the improvements needed.

There was not enough staff employed at the home to meet people's needs and consequently there was a reliance on agency staff to fulfil both nursing and caring roles. The provider had not employed enough staff to fill the gaps in the rota. The provider had not used the needs of the people living at the home to inform the number of staff required per shift to provide safe care for people.

However on a positive note people said they were treated in a kind and caring manner and staff said they had access to, and obtained support and guidance from, external health care professionals.

Appropriate checks had been completed for new staff to ensure they were safe to work with vulnerable people. We identified gaps in the staffs training and regular supervisions to support staff had lapsed and had not been undertaken. The registered manager at the time of our inspection told us the quality manager was now undertaking staff supervision. We spoke to the quality manager who told us this was not the case.

People's privacy and dignity was not fully respected and we observed poor care practices. Some care practices in the home were institutional which included people being put to bed by staff early in the afternoon. Locks were not fitted to toilet, bathroom and bedroom doors.

People's care records were not person centred and did not contain information regarding people's likes, dislikes and life history. End of life care plans for people were clinical and did not contain information about people's wishes.

People's wellbeing was not supported by the activities offered to them and some people chose not to take part in the planned activities. Relatives had raised concerns about the lack of activities.

Where people had been unable to make the decision to live at the home the provider had not submitted appropriate applications for assessment under the Deprivation of Liberty Safeguards which meant people were being deprived of their liberty without the appropriate legal authorisation in place. Where people were not able to make decisions for themselves care records were not clear. They lacked essential detail regarding people's capacity to make decisions and best interest decisions.

Quality monitoring systems were not in place to identify, monitor, manage and mitigate risks to people's safety and welfare.

There was a lack of effective leadership in the home. The provider had little insight into what was going on in the service and this has led to there being multiple breaches of regulations. Lack of communication from the provider with people, staff and relatives had led to an increased level of anxiety.

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

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Staffing numbers were not adequate to keep people safe.

People were not always protected from risks associated with the environment or their care and support. People were placed at risk of serious harm.

Staff were aware of what constituted abuse. However the appropriate action had not always been taken to investigate allegations of abuse.

Medicines were not safely managed.

Is the service effective?

Inadequate

The service was not effective.

The principles of Mental Capacity Act (2005) had not been adhered to. The appropriate assessments of people's capacity had not been undertaken.

Staff did not receive sufficient training to enable them to effectively meet people's individual needs. Staff were not provided with regular supervision and support.

People were supported to have enough to eat and drink.

Is the service caring?

Requires Improvement

The service was not caring.

People's dignity was not always respected and we identified poor care practices.

People were subject to institutionalised practices.

Staff were observed to be kind and patient in their interactions with people.

Is the service responsive?

Requires Improvement

The service was not responsive.

Staff knew people well. However, people's likes, dislikes, choices and preferences were not always recorded. Care records for people lacked a person centred approach to their care needs.

People had access to the home's complaints procedure should they wish to make a complaint.

There were limited opportunities for meaningful activities for people.

Is the service well-led?

Inadequate

The service was not well led.

There was a clear lack of leadership and staff did not feel supported.

Multiple failings in the running of the home had not been identified prior to our inspection.

Systems in place to monitor and improve the quality and safety of the home were not effective.

Communication from the provider with staff, people and relatives was poor.

Willow Cottage Residential and Nursing Home

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 was 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 a focused inspection of Willow Cottage Residential and Nursing Home on 11 January 2018 due to concerns that had been raised to the CQC. Due to the concerns we found at the inspection on 11 January 2018 we carried out a full comprehensive inspection on 16 and 17 January 2018. This involved inspecting the service against all five of the questions we ask about services: is the service safe, effective, caring, responsive and well-led.

The inspection was unannounced. This meant the staff and the provider did not know we would be visiting. The inspection was carried out by two adult social care inspectors.

Prior to the inspection we looked at the information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. We had not requested the provider to complete the Provider Information Record (PIR) before the inspection. This is a form that asks the provider to give information about the service, tells us what the service does well and the improvements they plan to make.

We contacted three health and social care professionals as part of our planning process and invited them to provide feedback on their experiences of working with the home. We received a response back from two professionals. Some people were able to talk with us about the care they received. We spoke with five people who lived at the home. We also spoke with the relatives of three people and spoke with one professional. We sat and observed other people who were unable to communicate.

We spoke with 13 staff which included the registered manager, the new manager, operations manager, quality manager, handyman, admin staff, care staff and domestic staff.

We looked at the care records of four people living at the home, six staff personnel files, training records for all staff, staff duty rotas. We looked at other records in relation to safeguarding, complaints, mental capacity and deprivation of liberty, recruitment, audits, accidents and incidents and equality and diversity.

Inadequate

Is the service safe?

Our findings

At our last inspection on 1, 2 and 3 March 2017 we found people were not always kept safe as bed rails were incorrectly fitted and were not in line with the guidance from the Medicines and Healthcare products Regulatory Agency (MHRA). We also found that people's pressure mattresses were not always set at the correct pressure in line with people's body weight.

At this inspection we found improvements had been made. The operations manager told us they had met with a specialist company and ordered new nursing beds for all residents with integral bed rails and pressure mattress's for people. We were told that the old nursing beds and rails had been taken out of use. The operations manager told us they had ordered an extra 10 pressure mattress as spare in case any mattresses were faulty and in need of repair. Daily checks were undertaken to review the pressure of people's mattresses against their body weights. Bedrails were also checked to ensure they were in good working order. We checked the observation records of five people which were kept in their rooms. We found the pressure of people's beds compared to their body weight was set at the appropriate setting. We checked the care records of four people and found risk assessments were in place for the use of bedrails.

The environment was not well maintained to ensure it was safe. We saw the bathroom fan light window was broken and could not be closed shut and locked. One staff member told us this had been like this for many months which they had kept reporting. Another fan light window at the top of the second floor staircase was also broken and could not be shut and locked. Throughout the inspection we observed the downstairs and second floor sluice room doors were left open on many occasions. No locks were fitted to the doors. One toilet on the second floor had an internal cupboard which had no lock. We looked inside the cupboard which had a boiler inside with carrier bags and mop heads stored around the boiler. The pipes were hot to touch and posed a fire risk and risk of burns if accessed by people.

Whilst looking around the building we noticed the downstairs lounge ceiling had an area where the plaster was missing. This had been covered over with a piece of wood. We asked staff what had happened. We were told the shower room was above the lounge and that the shower had leaked into the lounge. We were told this had been like this for many months. We checked the shower room above and found the flooring was in need of replacing. Grey tape had been used to tape up an area of the flooring to prevent the shower from leaking. The shower room was in need of full decoration. Further investigation was needed to look into the cause of the leak and to check if this had effected appliances in the home. Two staff told us that the handyman had changed light bulbs on two consecutive days in the lounge where the leak had occurred. We asked to see the five year electrical safety certificate of the home. We were told this could not be found. We saw there was a sticker dated 2014 on the fuse box of the home however it was not clear if this was when the electrical check took place and confirmation of the certificate was needed.

Hot water temperatures were not managed in the home. Temperatures were taken weekly by staff and were recorded on a sheet called 'weekly water temperature record sheet'. It was recorded if temperatures were to go over 43 °C then this should be reported to the manager. There was no action taken where temperatures exceeded 43 °C to eliminate the risks of people being scalded. An example being on 24 November 2017 the

water temperatures were checked by staff and reached 50.1°C in room 37, 51.8 °C in room 36, 52.2 °C in room 24 and 52.7°C in room 27. There were no hazard warning signage displayed and people, their visitors and staff were at risk of being scalded. The Health and Safety Executive provides specific guidance about managing the risk from hot water in care homes. This guidance had not been followed. We spoke with the operations manager at the home to let them know about our concerns and findings and asked them to take action to reduce the risks of people being scalded. During the second day of the inspection we were told a plumber had commenced work in adjusting water temperatures with further actions planned.

Some areas of the home were not clean. For example, the downstairs lounge carpet was heavily stained in some areas. Staff told us they did not have access to a carpet washer. They told us a company had submitted a quote before Christmas but they had not heard if the quote was agreed. We checked the homes kitchen and found the cooker hob was dirty which staff told us was used to make porridge for people each day. One area of the kitchen work top surface was missing a section of protective laminate. There was a risk that bacteria could harbour within the wood which could not be cleaned effectively. We checked kitchen cupboards at random and found the bottom cupboards which contained crockery were dirty and stained. The flooring within the kitchen had areas where the flooring had ripped and was raised. There was an area of the ceiling above the cooker hob which was cracked. The paint was flaking away from the ceiling which was a risk as this could have fallen in to food being prepared. The staff room toilet was missing a pedal bin and was dirty at low and high level. One communal toilet upstairs contained a rusty bin and dirty cracked toilet seat. Another communal toilet had cracked tiles by the toilet cistern. On the second floor the bathroom had a bath with a bath hoist. We checked underneath the bath chair of the hoist and found this had area of rust. Areas of the bath were scratched with the enamel was missing. Both the bath chair and bath could not be effectively cleaned which posed an infection control risk. Infection control practices were not in line with up to date Department of Health guidance. The guidance was not available in the home. This meant people were at risk because there was poor prevention and control of infection in the home.

Some people were prescribed creams and ointments that were kept in their bedrooms. We checked five people's prescribed creams and ointments with the manager. We found concerns with each of the five people's prescribed creams and ointments as some did not have the date of opening or for disposal recorded. We also found one person's cream had the name of the person for who it had been prescribed scribbled out in pen. Another person had oral mouth treatment in there room dated November 2016 which was unopened with no MAR chart in place. We spoke to the manager who took the creams, ointment and mouth treatment out of use in order to replace the items with the newly arrived stock. This meant that people were not protected against the risks of being given medicines that were poorly managed.

The above all amounted to multiple breaches of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider used a safe-staffing assessment tool to calculate the number of staff needed for each shift. We checked the records of the assessment tool and found this had not been completed since 30 November 2017 therefore the provider was unable to demonstrate on what basis they had decided the current staffing numbers per shift against the needs of people. Staff we spoke with said there should be five care staff on duty during the day, one RGN and one manager. Nine staff had left before Christmas and during January 2018. This included the registered manager who was a registered nurse, two other registered nurses and six care staff. Staff told us they felt five care staff at the current occupancy of 20 people was not enough. One member of staff told us, "We may have just 20 residents but the ones we have require a high level of care and most of them need two staff". Another staff member told us, "We cater for each person's personal needs but we cannot do the extra things. We cannot take them out or sit and spend time with them". During the second day of our inspection the home were short of one care staff member as the shift had not been

covered which was an added pressure. On the 30 and 31 December 2017 staffing levels at the home fell short to four care staff in the morning and four in the evening. The home also did not have a permanent nurse on duty to lead the shift and an agency nurse was on duty both days.

Rotas confirmed that the home were short of housekeeping staff. On week two the rota showed that on the Sunday no housekeeping staff were rostered to work and the shifts had not been covered.

The home were using their own staff and agency to cover the shortfalls of registered nurses and care staff. One the second day of our inspection we were told the home had only one part time registered nurse working two days per week. The rest of the shifts were being covered by bank and agency staff. We were told by the quality manager that the home were looking to recruit care staff. This meant that staffing levels were not safe and people were not being care for by consistent staff.

The above amounted to breaches of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People looked relaxed in the company of staff. We asked people if they felt safe living at the home. Comments included, "Yes I do", "I feel safe and the staff are lovely". Health care professionals expressed no concerns about the care people received.

Staff had a good awareness about safeguarding vulnerable adults and how to report concerns. All staff we spoke with were able to explain how they would report any concerns they may have. A policy was in place to guide staff on actions to take in the event of any safeguarding concerns and details of the local safeguarding team were available. This enabled referrals to be made to the relevant organisations.

Prior to our inspection the home made us aware of two separate safeguarding referrals they had made to the local authority. These were both of a serious nature. We looked at the investigation notes available to us for one of the allegations. The quality manager had been asked to carry out their own investigation by the local authority safeguarding team. We found that the investigation notes were not comprehensive, lacked essential detail and were of poor quality. The quality manager and operations manager had held a meeting with the member of staff involved. Records showed the questions that had been asked but did not explore the allegations that had been made. Although the home had appropriately made a referral to the DBS and professional bodies they told us they did not have enough evidence to address the staff member's performance. The local authority also shared with us there concerns in the way the investigation had been carried out. This meant the appropriate action had not been taken to investigate staffs poor performance.

Maintenance records for the home were checked including water supply, moving and handling equipment and the gas system. Systems were in place to ensure the home kept up to date with annual safety checks in relation to fire safety, nurse call bell system and portable electrical equipment.

All medicines were stored safely in a locked room on the first floor and trolley on the second and third floor. There was a dedicated room for storing people's medicines. The downstairs medicines room was clean and organised. A fridge was available to store medicines which required lower storage temperatures. As part of the inspection we looked at the Medication Administration Records (MAR) of five people living at the home. We found that MAR charts had been appropriately signed by staff.

We looked at four current staff recruitment records and the past records of two staff. We spoke with staff about their recruitment. We found that recruitment practices were safe and the relevant checks were completed before staff worked at the home. The provider had recently recruited a number of staff from

overseas through a recruitment agency. A minimum of two references had been requested and checked. Disclosure and Barring Service checks (DBS) had been completed and evidence of people's identification, the right to work in the UK and medical fitness had also been obtained. A DBS check allows employers to check whether the staff had any convictions which may prevent them working with vulnerable people.

Inadequate

Is the service effective?

Our findings

At our last inspection on 1, 2 and 3 March 2017 we found care records contained limited assessments of people's capacity to make decisions. Assessments did not give guidance to staff regarding the best interest decision made, reasons for the decision and the people involved in making decisions for people.

At this inspection we checked whether the home was working within the principles of the Mental Capacity Act 2005 (MCA) and found improvements had not been made.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. These safeguards are there to make sure that people are looked after in a way that does not inappropriately restrict their freedom.

Care records did not describe the efforts that had been made to establish the least restrictive option for people and the ways in which staff sought to communicate choices to people. Care records we reviewed contained limited assessments of people's capacity to make decisions. Assessments were not person centred and did not follow the principles of the MCA. For example capacity assessments assessed people's capacity using one standard form to make decisions about personal care, nutrition, changing pads and covert medicines.

Assessments were not specific and lacked essential detail. We did not see any evidence of best interest decisions or information about who was involved in the decision making process. One person was administered their medicines covertly and had a mental capacity assessment carried out 28 March 2017. A covert administration form was also completed but this did not have the date the assessment was carried. The GP, family and pharmacist had signed this form. It deemed the person to have limited capacity. Both forms lacked essential detail and did not give guidance to staff regarding the best interest decision made, reasons for the decision and how the medicines should be administered covertly. The same person's care records stated they did not have capacity with decision making. This person was cared for in bed and unable to communicate with staff; they had bedrails, required 24 hour supervision of staff. We could not find any evidence of capacity assessments in place. This meant that staff were not following the guidance of the MCA and had not considered if people had the capacity to make decisions.

The above all amounted to multiple repeated breaches of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is a repeated breach.

People were supported by staff who did not receive supervision and guidance in their role. Supervisions are meetings with a line manager which offer support, assurance and learning to help staff to develop in their role. At our last inspection carried out on 1, 2 and 3 March 2017 the operations manager said plans were in place to change the format of staff supervision and appraisal meetings. However we could not find evidence

of supervisions taking place. We asked to see copies of staff supervision records twice during the inspection. However no records were given to us except for one senior staff member's supervision that was dated but had not been signed. We could see no evidence that the clinical supervision of registered nurses was being undertaken. We asked to see the supervision matrix with the dates of when supervisions were carried out and next due. We were told this could not be found as the registered manager had this and had since left. We spoke with staff to find out how often supervision meetings took place. One staff member told us they had not had supervision for 10 months, another staff member told us they had not had supervision for a year, whilst another said they had not ever had supervision.

The provider maintained a record of training courses completed by staff, which they considered were mandatory for staff to provide effective care. This allowed the provider to monitor when this training needed to be updated. These courses included health and safety, moving and handling, medicines, food safety, nutrition and hydration and safeguarding. However, there were a number of staff who had not completed training in some areas. An example being only seven staff out of 32 had up to date pressure ulcer prevention training, 12 staff out of 32 had completed MCA and DoLS training and 20 out of 32 staff had undertaken infection control training. This meant that people were being cared for by staff that were not appropriately trained and had not received the appropriate support.

The above amounted to breaches of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). Applications should be submitted if people could not freely leave the home on their own, also because people required 24 hour supervision, treatment and support from staff. The DoLS provide a legal framework and allows a person who lacks capacity to be deprived of their liberty if done in the least restrictive way and it is in their best interests to do so.

The provider was not aware of their responsibilities in making sure people were not deprived of their liberty. On the wall in the nurse's office were a list dated 5 December 2018 of six people who had a DoLS in place however we were unable to find evidence of application forms or reference made in peoples care records that they had a DoLs in place. We asked staff if they knew who had a DoLs in place and they were unable to answer. After our inspection we contacted the local authority who sent us some information. This showed that no DoLs assessments had been authorised for anyone but six applications had been submitted and were awaiting assessment. We compared the information sent to us from the local authority against the homes list. This showed us one person had not had an application submitted and another person had passed away and was still showing on the local authority list. We looked at peoples care records, spoke with people and their families. It was clear that some people were being deprived of their liberty without authorisation and without the appropriate safeguards in place. We asked the manager to carry out assessments of people to see if DoLS applications were needed. We spoke with the manager on 22 January 2018 and asked them to contact the local authority for a list of people who had DoLS applications submitted.

Where people needed their food and fluid intake monitoring this was not consistently taking place. Staff were not correctly recording how much people had to eat. An example being staff were recording on peoples food charts "Ate all lunch", "Ate all tea and "Ate all dinner and pudding". Information recorded was not specific enough regarding the quantity that people had consumed each meal time. Fluid charts had been totalled at the end of the day to review how much the person had drunk however it did not given any recommendation or guidance to staff about how much each person's guided intake should be each day. An

example being if a person should have 2000mls per day or 2500mls.

Care records showed people's nutritional needs were regularly reviewed. A three month overview of people's weight was kept up to date by nursing staff which showed people had maintained a stable weight. The home used a nationally recognised assessment called 'Malnutrition Universal Screening Tool' (MUST) to monitor people's weight. Records confirmed people's weight gain or loss was monitored and any concerns were appropriately referred to health professionals for advice.

Staff told us and records stated they had received induction training. The induction training was based on the Care Certificate for those staff who were new to the role within care. The Care Certificate is a nationally recognised qualification. This Certificate covers 15 standards of health and social care that all care staff should know as a minimum. It is achieved through assessment and training. Training records confirmed two staff had fully completed the care certificate. We were told by staff as well as training, new staff worked alongside permanent staff for one to two weeks. This was an opportunity to shadow competent staff and to learn within their role.

Requires Improvement

Is the service caring?

Our findings

There were mixed observations about people being cared for in a dignified way throughout our inspection.

People's dignity and privacy was not always respected. Whilst looking around the home we noticed that bathrooms, toilets and bedroom doors were not fitted with locks. People did not have a choice if they wished to lock their bedroom doors or if they wished to have their own room key.

During our inspection we found lounge areas were empty and quiet compared to our last inspection. We found people were left in their rooms or were in bed during the day. An example being on 17 January 2018 at 14.03hrs we observed six people were sat in the down stairs lounge and two people were sat in the lounge on the second floor. Other people were sat in their bedrooms or in bed. At a next of kin meeting held on 1 November 2018 concerns were raised that a relative's family member was being put to bed at 16.00hrs and having tea in bed. We looked around the home and found similar concerns. On 16 January 2018 at 14.56hrs six people were in bed and six people were sat in their rooms. Other people were sat in the communal lounges. We found evidence that people were being put to bed for the night as early as 15.00hrs by staff. We reviewed people's records which confirmed our findings as staff had recorded in people's daily notes when they had put people into bed. An example being in one person's daily notes it recorded on 2 January 2018 "Assisted into nightly at 15.00hrs, put in bed, drink, TV on". The same information was recorded on 3 January 2018 with similar recordings on 4, 5, 6, 7 and 8 January 2018. It recorded the night staff were the next staff on shift to get the person up at 06.30hrs. Another person's daily notes recorded on 4 January 2018 at 16.30hrs that the person had their nightie put on after a wash and was made comfortable in bed. One person told us they go to bed at 15.00hrs or 16.00hrs but would prefer 21.00hrs.

During the third day of our inspection, we observed people having lunch in the downstairs and second floor lounge dining. People who chose to stay in their rooms were served their meals in their bedrooms. Those who needed support were assisted by staff that encouraged people to do as much as they could by themselves. However whilst observing people in the downstairs lounge we saw two care staff inappropriately assisting people to eat their meals. We observed one member of care staff kneeling down to assist one person when a chair was available next to them. Another member of care staff was stood over a person assisting them to eat.

People living in the home were provided with a nursing bed and air mattress's that was purchased by the provider. Whilst it is not uncommon for people to have this type if bed in place we could not see any evidence why each person was required to have an air mattress on their bed. Records did not evidence that people were offered a choice in the type of bed and mattress they had. For example some people may find a pressure mattress uncomfortable and may not of had known health reason to have this in place. This meant that people were not being given a choice of when they wanted to go to bed. Care practices in the home were institutionalised and people's dignity and individual wishes were not respected by staff.

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

People told us the staff knew them well and they felt well cared for. We observed good interactions between staff and people. Staff were able to explain to us people's needs and how they liked to be cared for. The conversations we heard between people and staff were polite and friendly. Staff were attentive and engaged in conversation with people. An example being we observed two staff hoisting one person in the lounge. The staff continued to have a conversation with the person whilst offering them reassurance when using the hoist.

People looked well cared for and were well kempt. People were dressed appropriately wearing clean and tidy clothes. It was clear the staff invested their time in ensuring each person was dressed to their liking. One person was wearing pearls and had their hair styled by the staff. The person told us how much their appearance meant to them. We observed people being offered the opportunity to attend the visiting hairdresser. Those who attended told us they enjoyed this experience. One relative praised the laundry staff at how well cared for her family members garments were looked after. They told us the staff ensured their relatives drawers and wardrobe items were looked after.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection on 1, 2 and 3 March 2017 we found people's care records did not fully reflect their needs and preferences and lacked essential detail. They were not personalised and did not include enough information on people's likes, dislikes and personal preferences. Care records lacked essential detail relating to the management of wound care. Photographs did not always state the site of the body wound and lacked information around the healing process.

At this inspection we found improvements have been made to the management of wound care. Two people were being treated with pressure sores and records confirmed photographs were being taken regularly to enable the staff to monitor the healing the process. We found photographs were dated and signed by staff and contained information about where on the body the wound was and its size. Body maps were also in place with comprehensive information recorded about the grading of pressures sores. Information was recorded regarding the treatment plans the staff followed with evidence advice had been sought from professionals.

We looked at people's care records and found that since the last inspection care plans had been re -written. We found although people's care records had been changed the necessary improvements had not been made to personalise them. Care records were not centred around people's needs and did not include sufficient information about people's backgrounds, personal histories, hobbies or interests and personal goals which would help staff to engage with them. From speaking with people living in the home we were able to find information about people's life history and personal interests. An example being one person liked swimming which seemed to have had a positive impact on their life. We were not able to find information recorded in the person's care records about this. There was limited information about what brought wellbeing to people's lives, particularly for people living with dementia, or for people who may spend most of their time in bed due to frailty or illness. By documenting a person's past life events and developing an individual biography of that person, it would enable others to develop a better understanding of the person's past experiences.

End of life care plans for people were clinical, inconsistent and lacked person centred information regarding how people were to be cared for. People's end of life care plans contained an assessment of people's needs and illnesses and if people had a DNACPR in place. The goal/ expected outcomes section contained limited information regarding how people wished to be cared for and there last rites. An example being one person's goal was to "Ensure X is comfortable, peaceful and pain free" and to "Maintain privacy and dignity at all times". It did not contain information about how the person wished to be cared for. It did not include information on how the person's dignity and privacy should be maintained which was personal to them. Without this information staff would be unable to act responsively to people's personal preferences and this would not be respectful of people's wishes.

Staff completed daily notes for people that included the daily completion of individual 'toilet charts'. These were completed over a 24 hour period by staff and had been dated and signed. Within the comments box was written "PC" this code could have easily be misinterpreted by staff as we were unsure if this meant pad

clean or pad changed.

We spoke with people about activities in the home and how they liked to spend their time. One person told us, "Activities are a thing of the past. We don't do anything from one day to the next". Another person told us, "The Activities lady only works part time but hasn't been at work for a while. I spend my time watching TV". Another person told us they tried coming out of their room but the lounge was too quiet and nobody spoke to them. They told us this put them off coming out of their room again.

We looked at how people were spending their time and how the service was meeting people's social, cultural and recreational needs. We could not find evidence of structured outings, entertainment or activities for people taking place. The registered manager told us the home employed part time activities coordinator however they had recently been absent. The last recorded activity took place in December 2017. No further hours had been provided to people since. When activities, where offered they were group orientated with little variation or ability to look at individual's activities needs. We checked the weekly activity records and found that people had not been offered activities and had been left for long periods with no stimulation. Sometimes people did not leave the building for long periods of time. When we visited we met people who had either been in the lounge watching TV, sat in the lounge without the TV or left alone in their bedrooms for long periods of time because there was not enough staff to take people out or to engage in activities. Care records did not identify the support people required to engage in meaningful activity or continue their individual hobbies and interests. There was no proactive work with people to promote their wellbeing such as cooking, exercise, swimming, reminiscence or one to one time with staff. Two relatives were spoke with expressed their concern about the lack of activities in the home. The registered provider had not ensured that people had been offered meaningful activities that would prevent social isolation.

The above all amounted to repeated breaches of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is a repeated breach.

Care records evidenced referrals had been made promptly to a range of health professionals when people's needs had changed or they had become unwell. This included doctors, district nurse, the tissue viability nurse and nutritionists. The nurse on duty told us if people needed to see their doctor the staff could call the surgery to request a visit if this was urgent. If the matter could wait then people would be seen during the weekly GP surgery held at the home. In preparation for the GP visit the nurse devised a list of people who required to be seen by the GP. This was if people were unwell or to have a review of current treatment. During the inspection we met with two professionals who were visiting a person at the home. They confirmed the home were responsive toward the person's needs who they were visiting and gave praise to the home.

Some people were aware of how to make a complaint and felt able to raise concerns if something was not right. Other people were unable to tell us due to difficulties with communication. People were given information about how to complain. People told us, "I have no concerns but would talk to staff if I did" and "I would talk to the staff if I was unhappy". A complaints procedure was in place within the home and this was available to people. There had been two complaints raised within the last 12 months.

Inadequate

Is the service well-led?

Our findings

At our last inspection on 1, 2 and 3 March 2017 we found there had been two occasions when notifications had not been sent in to us. A notification is information about important events that have happened in the service and which the home is required by law to tell us about. At this inspection we found improvements had been made with the registered manager submitting notifications to us appropriately after events had occurred. An example being notifications of death or of serious injury.

At the inspection we checked if audits of the home had improved. Effective audits had not been untaken of the building in relation to repairs and decoration. We found areas of the home were in need of redecoration and repair. Other audits undertaken had not been effective as we had identified areas that required improvement which had not been picked up by the provider's audits. At this inspection, we found the provider had continued to fail in ensuring that there were systems and processes in place to continually review and improve the home.

During the inspection we looked around the home to follow up if improvements had been made to the environment of the home. Although an area of flooring had been replaced outside of the kitchen and some minor decoration completed we found that the required significant improvements had not been made. The premises were still in a poor state of repair and decoration. Flooring in many areas of the home were in need of replacement. An example being outside the staff room there was an area of flooring that had raised and was taped over. Other areas of flooring around the home looked discoloured. Some toilets and bathrooms were in need of redecoration and new equipment required. Radiator covers around the home were metal and were in need of painting or replacement. The main front entrance of the home did not look inviting or homely. This was used to store delivery items. An example being empty medicines delivery containers were stored in this area along with delivery boxes. The home was in need of redecoration throughout along with organisation and investment. Furniture was inappropriately stored around the home in shower rooms, corridors and empty bedrooms.

We spoke with the quality manager and operations manager on the first day of our inspection and asked to see audits that had been undertaken of the premises. We also asked for infection control audits of the home. We were told these had not been completed. The operations manager showed us a blank form which was a premises 'indoor checklist' which they planned to implement. After the first day of our inspection we asked the quality manager and operations manager to carry out an urgent infection control audit and full environment audit as we had identified concerns with the safety of the premises. On the second day of the inspection we were given a copy of both audits that had been completed. These lacked essential detail and did not specify a timescale of when the necessity actions would be completed. It did not give true account of the extent of the work needed. An example being the environment audit had picked up that bedroom furniture was in need of replacing. This did not specify which rooms and the quantity.

Multiple failures in regulations had not been recognised or addressed and failings included concerns across all areas of the home including safety of the premises, safeguarding, medicines, infection control, staffing levels, training and supporting staff, person centred care, MCA and DoLS, care delivery, nutritional records

and people's social and wellbeing needs. The service was being poorly managed and the widespread failings meant that people were placed at significant risk. The provider lacked the oversight required to ensure improvements were made and sustained. Our inspections have identified that this service has not been consistently been well led. This meant that the leadership from provider level was not driving forward improvements.

We found serious concerns with care and support delivery at the home along with infection control practices and the management of the premises that necessitated a referral to the local authority DoLS team, environment of health, the local authority planning team, the local authority safeguarding team and the fire service. These shortfalls had not been identified by the provider.

People, staff and relatives told us the home was not well-led. Three relatives shared their concerns with us that they felt the home was not well managed. One relative told us, "I have lost faith in the owner as we have raised issues and we haven't been listened to", "Another told us, "It does concern me that the owner is running the home into the ground". Staff told us, "Staff are leaving at a fast rate as the owner doesn't treat the staff very well". Another staff member told us, "It's his way or no way".

Openness and transparency were lacking at the home. We found that morale at the home was low with staff and relative's expressing their concerns to us. Staff were worried the home was closing and asked us if this was the case. They told us that prior to our inspection they had seen a person outside taking pictures of the grounds. Relative's also approached us during our inspection concerned that the home was closing because of this. We spoke to the quality manager on the first day of our inspection who told us they were not aware of the reasons behind the photographs being taken. On the second day of our inspection we were approached by relative who had searched the internet of land for sale in the area. They had found that some of the land to the back of the home was being sold at auction. Shortly after we were given a copy of a memo which was being sent out to staff, people and relative's to notify them that the land at the back of the home which included an area of the garden and carpark was being sold. Plans were in place for the front carpark to be extended. There had been no consultation and communication prior to the land going up for sale. This had caused distress to people living in the home, staff and relatives who were anxious and wanted reassurance.

Staff were not adequately supported and the staff turnover was high. Prior to our inspection we were contacted by five 'anonymous' whistle blowers and one person who shared their experience of the home. Their concerns were consistent with each other about the number of staff who were due to leave before and after Christmas, concerns about the registered manager and staff retention. We asked at the inspection for a list of staff that had left employment within the last 12 months at the home. We were told 22 staff had left their role due for various reasons. Staff were being recruited to replace them on a zero hours contract. A zero hours contract allows employers to hire staff with no guarantee of work. They mean employees work only when they are needed by employers, often at short notice. Their pay depends on how many hours they work. Staff said this had affected morale at the home with some staff looking for other jobs because of this. One staff member told us, "I don't feel very secure and personally I need fixed hours". We asked if exit interviews were conducted when staff had handed in their notice. This would be a way in discussing the reasons behind the staff member leaving to see if an employer could do anything to retain the staff member. The quality manager told us they should be being done but the previous registered manager didn't do them.

The quality manager said the provider (owner) visited the home monthly and attended staff meetings. We looked at the previous staff meeting minutes dated 20 December 2017, 8 November 2017, 11 August 2017, 24 March 2017 and 25 May 2017. This showed the provider had only attended two out of the five meetings. It was clear from reading the meeting notes that staff meetings did not always go smoothly and that morale

was low. During a staff meeting on 8 November 2017 three staff walked out of the meeting. Staff had tried to tell the provider about the pressure they were under and raised concerns over the number of staff leaving and staffing levels. Staff had also raised concerns about working zero hour contracts and were told that, "This is a business and a 3rd party could put an embargo on it". In the same meeting notes staff raised concerns regarding the registered manager. The provider had responded telling staff "He (provider) is trying to resolve the issues but it might need compulsory redundancy". Staff told us they did not feel supported by the provider and felt that they were not listened too during staff meetings. Staff told us staff meetings had sometimes got "heated" with raised voices.

The above all amounted to repeated breaches of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is a repeated breach.

At the time of the inspection there was a manager registered with the CQC however they had handed in their notice. They left the service on the 15 January 2018 after our first day of inspection. There was a new manager in post and they planned to apply to become the registered manager. During our inspection we met with the new manager who was being inducted into their role. The quality manager told us they had been supporting the registered manager in their role for the last 12 months and had been visiting twice weekly.

Staff achievements were recognised through holding an employee of the month system. Staff were nominated by each other or by the people living in the home and their relatives. This was to recognise the hard work of staff. A poster was displayed in the entrance hall with information on saying how to nominate staff.

Next of kin meetings were held at the home on 1 November 2017 and 16 August 2017. We read the meeting notes - the quality manager attended both meetings. The meeting on 16 August 2017 focused on the CQC inspection findings and staffing issues. At the last meeting held 1 November 2017 concerns were again raised by relatives about staffing levels. It was noted that morale was low in the home and the impact that this had. The minutes of the next of kin meetings were sent out to relatives.

Quality assurance surveys had been sent out to obtain feedback from people and relatives about the care they received. The quality manager told us the surveys were being analysed by the operations manager at the time of our inspection. Whilst we were assured the necessary action would be taken to address any shortfalls, the provider had not demonstrated they acted upon feedback so far.

The ratings from the previous inspection had been displayed in the entrance hall of the home and on the provider's website. The display of ratings is required by us to ensure the provider is open and transparent with people who use the service and their relatives and visitors to the home.

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 10 HSCA RA Regulations 2014 Dignity and respect The registered provider failed to ensure people were treated with dignity and respect. 10 (1), (2) (a) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing People were at risk due to shortfall identified in the rotas. Staffing levels were not safe and people were not being care for by consistent staff that were familiar to them. Staff were not appropriately trained and supported by the provider. 18 (1), (2) (a) (c).

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The environment was not safe and infection control standards within the home were not satisfactory. Medicines in the home were not appropriately managed. This meant the risks to the health and safety of people of receiving care or treatment had not always been considered.

The enforcement action we took:

We imposed additional conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People were not being assessed in relation to their mental capacity to make decisions.

The enforcement action we took:

We imposed additional conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The environment was not safe and infection control standards within the home were not satisfactory. Medicines in the home were not appropriately managed. This meant the risks to the health and safety of people of receiving care or treatment had not always been considered.

The enforcement action we took:

We imposed additional conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered manager had failed to assess,

monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity.

The enforcement action we took:

We imposed additional conditions on the provider's registration.