Creedy Number 1 Limited

Creedy House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 1, 2, 3, 6 and 7 August 2016 and was unannounced.

Creedy House is registered to provide personal and nursing care for up to 44 people. There were 41 people using the service during our inspection with a further two people being treated in hospital. People were living with a range of complex nursing, mental health and care needs. These included: Schizophrenia, learning disability, diabetes, catheter and continence management, pressure wounds and mobility support; and many people were living with different types and stages of dementia.

Creedy House is a large, detached premises situated in a residential area in Littlestone-On-Sea. The service was divided into two areas: The House which accommodated people requiring nursing as their primary need and The Lodge where people living with dementia had their bedrooms.

The service was not well-led. Leadership and oversight of the service was poor meaning that people did not receive a good standard of care. People had experienced harm and neglect as a result of this. Audits designed to identify shortfalls in the quality and safety of the service had not been effective and records were not always accurate or complete. Feedback about people's experiences had not been sought and staff concerns had not been addressed.

There was not a registered manager in post at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. 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. There was however, a new manager who started work at the service on the first day of our inspection; and who intends to apply to the CQC for registration.

Creedy House was last inspected in October 2014, when it was rated as good.

At this inspection, people had not been kept safe from abuse or improper treatment. Some people showed violent or aggressive behaviour and this had not been properly managed. Staff had not received effective training which left people and staff exposed to risk of harm.

Other risks, including those associated with the environment and medicines had not been minimise to ensure people were kept safe. Recruitment checks had not been sufficiently robust so that only suitable applicants were employed.

There were not enough trained and competent staff on duty and as a result people's needs were sometimes overlooked. Staff training had been ineffective in equipping staff to carry out their roles.

People's healthcare including what they ate and drank had not been monitored or managed effectively; meaning people did not receive appropriate care and support to keep them well.

The principles of the Mental Capacity Act had not been followed, so people's rights were not always protected.

Most staff were kind and gentle but they were constantly rushed; which led to people's needs being disregarded at times. Care plans were presented in a person-centred way but people's preferences and choices were not consistently respected. Activities were available but there was limited meaningful stimulation for people living with dementia.

Complaints had been not been managed in line with the provider's policy and people and relatives were unclear about how to complain.

The service was not well-led and had been without a registered manager for about a year. Leadership and oversight had been lacking meaning that people did not receive a good standard of care. Audits designed to identify shortfalls in the quality and safety of the service had not been effective and records were not always accurate or complete. Feedback about people's experiences had not been sought and staff concern had not been addressed.

We identified a number of breaches of Regulation. 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.

People were not kept safe from abuse or improper treatment.

There were not enough skilled and competent staff on duty to support people and keep them safe.

Risks had not always been assessed or where they had been assessed; actions to minimise them were ineffective.

Medicines had not always been managed appropriately.

Is the service effective?

Inadequate

The service was not effective.

People's health care, nutrition and hydration needs had not been appropriately met.

People's rights had not been protected by proper use of the Mental Capacity Act (MCA) 2005.

Staff training and supervision was not effective in equipping staff for their roles.

Is the service caring?

Inadequate

The service was not always caring.

Staff did not act consistently to protect people's privacy and dignity.

Not all staff engaged well with people.

People were not always supported to be independent.

There were limited adaptations to the premises, to support people living with dementia.

Is the service responsive?

Inadequate

The service was not responsive.

Care planning was presented in a person-centred way but people's choices and preferences were not always observed.

There was a lack of meaningful activity for people living with dementia.

People and relatives were not given sufficient information about how to raise concerns or complaints. Accurate records of complaints had not been kept.

Is the service well-led?

Inadequate

The service was not well-led.

There was a lack of leadership and management which had a detrimental impact on the care and treatment people received. Auditing had been ineffective and oversight of the service was lacking.

Feedback had been not been sought from people or relatives and concerns raised by staff were not acted upon.

Records were not accurate or complete in many cases.

Creedy House

Detailed findings

Background to this inspection

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

This inspection took place on 1,2,3,6 and 7 August July 2016 and was unannounced. The inspection was carried out in response to information of concerns that had been received from a number of sources. Three inspectors, an Inspection Manager and a specialist nurse advisor took part in the inspection. Prior to our inspection, we reviewed all the information we had about this service including previous inspection reports. We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people, looked at any safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We met with twenty one of the people who lived at Creedy House. Not everyone was able to verbally share with us their experiences of life in the service. We therefore spent time observing their support. We spoke with three people's relatives. We inspected the environment, including the bathrooms and some people's bedrooms. We spoke with the provider, the manager, the operations manager, the clinical services manager, ten care staff and four nurses.

We 'pathway tracked' twenty one of the people living at the service. This is when we looked at people's care documentation in depth, obtained their views on how they found living at the service where possible and made observations of the support they were given. This allowed us to capture information about a sample of people receiving care.

During the inspection we reviewed other records. These included five staff training and supervision records, five staff recruitment records, medicines records, risk assessments, accidents and incident records, quality audits and policies and procedures.

Inadequate

Is the service safe?

Our findings

One person told us "I'm safe enough here. Someone comes round at night to check on me". A relative said "I think X is safe here. X gets very good care and the home is always clean with no smells".

However we found that the service was not safe. Some people showed violent or aggressive behaviour, and this was not properly managed. As a result, people and staff had been hurt during episodes of these behaviours. During the inspection we witnessed occasions when staff were unable to manage people's violent outbursts. Staff told us that they were scared of some people who were aggressive and said that they had not received training in how to safely and appropriately deal with behaviours that challenge. Although one-to-one staffing had been provided for one person who had assaulted people and staff, the agency staff providing this support had not had training to help them manage the behaviours. This meant people; staff and visitors were not kept safe and protected from actual or potential harm. The manager told us that they had recognised that they could not meet the needs of one person and had taken action to notify the local authority about this. However, all the time this person remained in the service, the provider had a duty to ensure that person and others were kept safe; but this had not happened. Following our inspection, one person who showed aggression was transferred to a service which could better meet their needs and a second person was being considered for transfer as a priority.

A fire alarm sounded during the second day of the inspection and all staff, including the staff who was providing one-to-one supervision, left people alone in The Lodge while they congregated in the front hallway. There was nothing to prevent aggressive or violent people coming into contact with other people during that time. Some people had stair gates across their bedroom doors and managers told us this was to prevent aggressive people entering the rooms of other people and potentially harming them. However, one person was observed telling staff that someone had been in their room and "Been standing over me". They were distressed and staff told them that nobody could enter, but another staff member overheard and said that they had seen another person going into the room and that this person had "Worked out how to open the gates". The gates were sometimes ineffective and people's behaviours had not been appropriately managed to prevent them harming or frightening others.

Not all staff had received up to date training about keeping people safe from harm; or could describe the different forms that abuse may take. Records showed that 15 out of 34 care staff had received training in safeguarding adults. Referrals had not always been made to local authority safeguarding about situations where people suffered harm. For example; one person had a serious and deteriorating skin wound which the local authority were not aware of and had therefore been unable to investigate. Processes for alerting the local authority when people suffered harm had not been sufficiently robust to prevent this omission.

Some other people's needs had been overlooked; which left them unclean and unkempt. People's clothes were stained and had food debris on them in the early morning and some people's hair was very greasy and lank. Three people we spoke with had long fingernails with dirt ingrained under them and two people had not received personal care by 3pm on one afternoon. People called out to Inspectors to ask for food, drinks or because they needed continence pads changed or were in pain. We made staff aware of these needs

immediately but one person told us" [Staff] just don't come. I call and call but I'm just left here". Another person said that they often waited for more than an hour for soiled pads to be changed. This was neglectful of people's needs for care and support.

The failure to protect people from abuse and improper treatment is a breach of Regulation 13 (1) (2) (3) (4) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessments had been made about a range of risks to people. However these were often not effective in keeping people safe. For example; one person who showed violence and aggression was left alone with other people and visitors when an assessment about their behaviour stated they posed a risk to others and should be supported in a separate area. Another person's assessment about being mobile recorded that staff should always ensure the person's feet were on the wheelchair footplates when being supported to move around. Our observations showed this did not always happen and the person injured their leg as a result of this instruction not being followed in practice. Although staff and the manager said there was a physical reason for the footplates not being used, no alternative equipment or method had been investigated to make sure the person was helped to move safely.

Environmental risks had not been adequately assessed or minimised to ensure people were safe. There were no measures in place to prevent people climbing the stairs and we intervened three times to stop one person from doing so; after staff said the person was at risk of falls and should not be using the stairs. Doors to the first floor corridor led out onto an open landing and a flight of stairs. There was a notice on the doors to remind staff to keep them closed to prevent the possibility of people falling down the stairs. However, these doors were open for long periods during our inspection and there was no barrier at the top of the stairs to reduce the chance that people could fall.

Accident and incident reports had been completed when people had falls or there had been events which resulted in other injuries. However, the information from these was not used to consistently update people's care plans and risk assessments. For example; one person had been hurt by another and an incident report documented this, but there was no update to risk assessments to ensure this person was kept safe following the altercation.

The failure to identify risks and take actions to minimise them is a breach of Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not enough trained and competent staff to keep people safe and meet their needs appropriately. There were three nurses and eight carers; including two senior care staff, during the days and one nurse and four carers, including a senior overnight ; working across The House and The Lodge. Many people had complex and/or nursing needs, or were nursed in bed; which meant they required regular and consistent input from staff. Although staffing levels had been determined by looking at people's dependencies; the impact of caring for so many people with diverse and involved needs had been under calculated.

Other people were living with dementia and constantly looked for staff reassurance; but we frequently saw these people alone and pushing chairs around instead of their Zimmer frame or climbing stairs; which was unsafe for them. People who had been assessed as aggressive towards others were left unattended and we witnessed an altercation between two people. This was broken up by the nurse who was in the middle of the medicines round, because there were no other staff in the vicinity to help. Staff who are administering medicines should not be interrupted or leave their post in case they lose concentration; which could lead to errors.

Staff were witnessed struggling to manage physically aggressive and violent episodes; in which staff were injured and upset. They told us that they had received no effective training about managing behaviours. This was unsafe and left people and staff at risk of harm. Another person who was at high risk of falling was seen in the conservatory sitting on the very edge of their chair and trying to transfer themselves into a wheelchair alongside them which did not have the brakes on. We had to seek out staff to come and attend this person to prevent them from falling.

During the inspection there were periods when there were no staff at all on the first and second floors; and people were calling out for help. One person waited almost 30 minutes for assistance to change a pad and told us that they were becoming cold as their clothes were wet through. Another person had knocked over a drink in their room and was calling out for another, saying they were thirsty. We visited this person in their room and they said they had been waiting "For ages" and that staff did not attend them promptly. We pushed the call bell again and staff came after approximately five minutes. Call bells were sounding for long periods throughout the first two days of our inspection. The manager and operations manager had not carried out a call bell audit so it was not possible to tell how long people had waited on average, but our observations showed that people did not always receive prompt support.

Every staff member we spoke with said that there were not enough staff to care for people properly. One staff member told us that they had to "Cut corners" with people's personal care because there simply were not enough staff to complete all the necessary tasks. Staff said that the impact of this was that people did not always have a wash until late in the day and that they had a "Quick wash" rather than showers or baths. One person's care plan recorded that they liked to have a bubble bath once a week, but daily notes showed this had not happened between 1 May 2016 and the date of our inspection. We asked staff about this and they told us that it was not possible to give people baths as often as they would like because of the lack of staffing. People were not encouraged to drink often enough and as a result a number of people had low fluid intake; which could be detrimental to their health and well-being. Staff and managers acknowledged that some people had not received enough to drink and that insufficient staff numbers and training had contributed to this situation. On the third day of our inspection, the provider increased staffing numbers in response to our concerns and was seeking to book suitable training for staff to ensure they were equipped with the knowledge to keep people safe.

Some people's needs could not be properly met because staff did not have the knowledge, understanding or experience to deliver their care and support appropriately. This had not always been recognised by senior staff or the provider; leaving people at risk of receiving inappropriate care and treatment. Following our inspection and assessments by social services, some people were transferred to services that could better meet their needs.

The failure to deploy enough trained and competent staff is a breach of Regulation18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment processes had not been robust enough to ensure that job applicants were suitable for the roles they were appointed to. One staff file contained no employment references because the applicant had no prior work experience. However, neither educational nor character references had been sought to compensate for this. Another applicant had a six year gap between the employments listed on their application form. No explanation for this had been sought or documented; which meant the provider could not be sure that recruited staff had suitable backgrounds.

The provider had accepted disclosure and barring (DBS) certificates from other employers and had not completed further DBS checks of their own. The DBS helps employers make safer recruitment decisions and

helps prevent unsuitable people from working with people who use care and support services. One DBS certificate was dated four months after the applicant had started work at the service. There were no records of any additional checks or risk assessments made by the provider while they waited for a satisfactory DBS outcome, meaning the provider could not be sure that the staff member was suitable for working in a care role.

The failure to operate a robust recruitment process is a breach of schedule 3 of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Identity documentation was seen on all staff files and staff registered with professional bodies, such as the Nursing and Midwifery Council (NMC), had records of this retained and updated.

Medicines were not consistently managed in a safe way. A number of staff signatures were missing from medicines administration records (MAR) and these had not been picked up until our inspection. It was not always possible to evidence, therefore that people had received their medicines as prescribed for them. We observed that one person was asleep with tablets in a pot on their table. The MAR had been signed off by a nurse to show that the tablets had been administered. However, it is unsafe practice to sign the MAR until people have been observed swallowing their medicines. We spoke with the nurse who had signed the MAR and they told us they knew it was "Dangerous" to have left the tablets with the person, but that they had been rushed.

Where people had been prescribed medicines to take as needed or 'PRN', there was no guidance to staff about why the medicines had been prescribed, the circumstances in which people may need to take them and the safe maximum doses to be given in a 24-hour period. There was no information either about blood thinning medicines and the important signs and symptoms of over or under dosing that staff should be aware of. Staff had not been provided with sufficient guidance to help them provide medicines safely and effectively.

Medicines had not been stored in line with the manufacturers' advice. The temperature of the medicines room had exceeded 25 degrees on seven days in July 2016; with the maximum recorded at 29 degrees. Many medicines should be stored below 25 degrees and can become less effective if they are not. No action had been taken in response to the excessive heat in the medicines room. A bottle of liquid pain relief had been opened in May 2015 but should have been disposed of three months after opening. Bottles for collecting blood samples were out of date and had not been replaced until we highlighted the issue. Blood samples collected in these pots would likely have been rejected by the testing laboratory; potentially causing unnecessary second tests and delays in treatment.

People's creams had not always been applied in line with the prescriber's instructions. One person had a cream prescribed for twice daily applications. A cream chart showed that it had only been applied once on some dates and not at all on some others. There were no instructions on cream charts to tell staff where to apply creams; which could lead to them being used inappropriately.

The failure to safely manage medicines is a continued breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines for which there are special legal requirements had been stored correctly and two staff signed administration records to confirm the correct doses had been given. MAR charts contained photos of people so that staff could recognise the right people to receive medicines. Refrigerated items had been dated on opening so that staff could identify when it was time to dispose of those medicines.

Safety checks on utilities such as water, gas and electricity had been regularly carried out and documented. Equipment for hoisting people had been routinely serviced; as had the passenger lift. Maintenance of the premises had been carried out in a timely way and the service had undergone a recent programme of redecoration and refurbishment; in which new flooring had been laid to enable thorough cleaning to take place.

Inadequate

Is the service effective?

Our findings

Monitoring of people's health and well-being was not effective and had left people exposed to the risk of deterioration. Some people had catheters in place and others were prone to infection or were generally frail or unwell. In these cases, fluid charts were in use to document people's input and output. Many people had not received adequate fluid to keep them well, despite written instructions to staff that they should receive between 1000 and 2000mls per day. For example; one person with a catheter had drunk only 200mls and 250mls on two separate days and a maximum of 650mls in the week leading up to our inspection. Sometimes catheters can block if there is not enough fluid intake; which is uncomfortable and can be serious. Some people had experienced repeated catheter blockages in the last year but the records of output from people's catheters had not always been recorded or at other times was not consistent with the amount of intake shown on charts. Managers said they had not been made aware by staff of the low intake and output for some people; which meant there was a risk that any deterioration in their health would go unchecked.

Another person's fluid charts recorded that they should drink 2000mls per day but in the week prior to our inspection they had received as little as 400mls on one day and between 600 and 680 mls on others. This person and a further person were noted by staff to be at risk of retaining urine; which can be a serious health issue. There were no records of either persons urine output and staff could not tell us how they would know if people had passed enough fluid. Staff were also unable to say how they would know if a person was dehydrated; which meant they might not recognise problems which needed to be escalated.

Some people had food charts to document how much they had eaten. These people had been assessed as at risk of losing weight or had lost weight. The charts were inconsistently completed by staff who sometimes measured intake in spoonfuls and at other times in percentages. For example; some charts noted '60% eaten' but this was unhelpful as the amount of food initially presented to people was not recorded. In addition, the composition of meals was frequently not shown. For example; 'Supper', 'Chicken', 'BBQ' or 'Main' was the only information provided. This lack of consistent detail would make it difficult to spot if people were not eating enough to keep them well.

One person had lost around 6kgs in July 2016. Their care plan about nutrition stated that they could eat independently but needed prompting. On 1 August 2016 we observed this person eating in their room alone, with no staff in the vicinity to prompt them. Their food chart had been completed on that date to state that they had eaten all of their lunchtime meal and pudding when we observed that they had not; and some of the meal had been removed uneaten by staff. On 2 August 2016 the same person told us they were hungry and we passed this message to staff who replied that the person had had their breakfast. They did not offer the person a snack, given that they had expressed hunger and had lost considerable weight in the previous month.

Another person had been prescribed food supplements by the dietician as they had lost weight. These supplements were signed off by staff on the MAR as given twice each day between 11 July and 2 August 2016. However, this did not match with the records on food and fluid charts; which sometimes documented

one supplement given and on some others none at all. This person had lost 1.3kgs between June and July 2016.

The failure to ensure people receive adequate hydration and nutrition is a breach of Regulation 14 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people appeared to enjoy the meals they were given; which looked appetising and had been well-presented on plates. One person told us "It's good enough for me and there's always enough" another person commented "Food is really good and I've got no complaints about it". Tea trollies made regular rounds in the service and jugs of squash and water were available for those people who could help themselves.

There were no care plans about the management of people's catheters and a lack of detail in records about their use. Some people had experienced frequent blocking of their catheters. One person's had to be changed due to blocking, 14 times in six months; when manufacturers' guidelines state that they should normally be changed once every 12 weeks or, at most every six weeks. Special catheter wash outs had started; but only the week before our inspection, when prompter action might have prevented repeated blockages. Other people also had catheters changed more often than recommended because they were blocked. Catheter care plans would have offered guidance to staff about fluid intake and output and ways of preventing blocking where possible.

Some people had pressure wounds and the management of these was not always effective in ensuring people received appropriate care and treatment. For example; one person had a severe and deteriorating wound and professional advice had been sought from a Tissue Viability Nurse (TVN); by email about treatment. In February 2016, the TVN advised that a full assessment should be made of the wound. There was no record of a full assessment in the person's wound care notes. The next contact with the TVN about this wound was not made until July 2016; when the wound had deteriorated significantly. The response from them asked whether the person and the wound had been seen by a GP. This had not happened at the time of our inspection; although the person had been visited by a podiatrist and a GP had prescribed antibiotics. On 2 August 2016 a GP visited after we raised our concerns about the extent of the wound. They told us that the wound must be seen by a specialist in skin wounds urgently and that it was very infected. The GP doubled the dose of antibiotics this person had been receiving and added in an extra one. They also prescribed very strong pain relief as they said the person must be in extreme pain when dressings were changed.

Pain assessments for this person showed they had been in considerable pain during the last six dressing changes. However, nursing staff had told us that this person was not in pain at those times because they were taking regular doses of two pain killers. This conflicted with the information recorded in pain records and the GP's assessment and meant the staff had not sought GP intervention or increased pain relief in a timely way for this person.

Repositioning charts for this person said they should be supported to turn every hour. However, there were times when this did not happen, for example one day when they were in their chair from 10am to 4pm without being repositioned and another from 12pm to 5pm. National Institute of Clinical Excellence (NICE) guidelines document the importance of frequent repositioning for people with pressure wounds to keep them comfortable and relieve the pressure on vulnerable areas. Specialist pressure relieving equipment had been provided, but on two occasions when we visited this person in their room, one of their legs had slipped off the pressure cushion and this had caused the other to move into an unnatural and uncomfortable position. We asked staff to reposition this person's legs, but the repositioning regime had not been adequate

to prevent further pressure and discomfort.

The repositioning charts for other people with pressure wounds or at risk of skin breakdowns also had gaps where people had not been supported to turn; and there was not a full wound assessment for one person so factors contributing to the wound had not been taken into account in the treatment planning. This person was also assessed as experiencing pain during dressing changes, but there was no clear guidance about how this should be managed to ensure that they received appropriate pain relief.

The failure to provide appropriate care and treatment which meets people's needs is a breach of Regulation 9 (1) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Catheter bags had been changed weekly and staff had initialled and dated the bag when doing so to prompt further changes to happen at the right time. Some nurses had been trained in changing some types of catheter for both males and females.

People with pressure wounds had charts which were completed at each dressing change to record the size and condition of the wound and the dressings used. Wounds had all been photographed and measured to provide a pictorial record of their progression.

We checked to see whether people's rights had been protected by assessments under the Mental Capacity Act 2005 (MCA). The Mental Capacity Act is to protect people who lack mental capacity, and maximise their ability to make decisions or participate in decision-making. Assessments made about people's capacity were not decision-specific but covered a range of day-to-day activities. Where decisions had been made about other matters; such as the use of bed rails or stair gates across people's bedroom doors, no capacity assessments had been made. Neither had there been any best interest decisions recorded about their use; to show that other, less restrictive options had been considered. This did not protect people's rights or adhere to the principles of the MCA.

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). 10 DoLS authorisations had been granted for people but one of these had expired two weeks before our inspection. There had been no system in place to alert managers when the authorisation was nearing expiry. This meant people could be deprived of their liberty without the proper authority to do so. The operations manager told us she would apply for an extension after we brought this to their immediate attention.

The failure to act in accordance with the MCA is a breach of Regulation 11(1) (2) (3) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff had not received effective training to help them carry out their roles. Those staff we witnessed struggling to manage aggressive and violent people told us they had either had no training at all in this field or had completed workbook-based training. Much of the training was in this format and staff told us that it was not in-depth or detailed enough to be useful to them. One staff member said "Training needs to be hands-on; everything we do here is about the theory and not what it's really like". Another staff told us "I feel totally unprepared for some situations and the training's just not enough". Agency staff who had been employed specifically to provide one to one care and supervision to people with violent tendencies told us that they had not had any training to manage challenging behaviour. They also said that they had not received a proper induction or full information about the person's needs. The provider had not taken steps to ensure that agency staff were appropriately trained and prepared for working in the service. Following our

inspection, the provider introduced an induction for agency staff.

We asked for records of staff training and were provided with a matrix dated May 2016. We were told that this was the most up-to-date available. This showed that many staff had not completed mandatory training in health and safety, fire, manual handling and safeguarding. 13 out of 34 staff had received training about nutrition and we found poor fluid intake and recording of food. Eight out of 34 staff had training about the MCA and DoLs and the principles of the MCA were not always being followed. Although staff offered people choices of what to wear and sought verbal consent from them in some cases, knowledge about restricting people's liberties and rights had not been properly understood.

Staff told us that they received regular supervision; but records about this were not provided to us when requested. However, supervision had not been effective in highlighting the shortfalls in staffs' training, understanding and practice; as identified during the inspection.

The failure to provide appropriate training and supervision is a breach of Regulation 18(2) (a) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Inadequate

Is the service caring?

Our findings

One person told us "I feel comfortable with staff and they respect me" and another person said "You can joke with staff and pull their legs. If I ask for chocolate or soap or a razor they'll get them for me". A relative told us "I'm happy X is here. They treat X alright. Sometimes X says staff are horrible to him but he might imagine it-I think they're lovely". Another relative commented "The staff are great and they do what they can".

The service was not consistently caring. Most staff spoke with people kindly and interacted gently with them. However, they were constantly busy and rushed which often meant that people's needs were not met properly or in ways that protected their dignity. For example; people who used continence pads frequently had these showing above their lower garments. Other people could be seen from corridors lying in bed with only pads on their bottom halves. This was not considerate of their dignity. Screens were used while people were assisted into small toilet cubicles with a hoist, because it was not possible for the door to be shut while equipment was in the room with the person and staff. However, the screens did not prevent others from hearing conversations about intimate matters coming from the toilet. Some people were not supported to be washed and dressed until 3pm on one day of our inspection and others wore stained clothing and had greasy and unkempt hair. Staff referred to some people as "Double-handers", meaning that they needed two staff to support them and one person was referred to as a "Right lump" when staff were speaking together privately. This was not likely to be how people would choose to present themselves and was not mindful of their self-esteem.

The failure to adequately protect people's privacy and dignity is a breach of Regulation 10(1) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff knocked on people's doors before entering and one staff member rushed to adjust a person's clothing after they had visited the toilet. They did so in a sensitive way which did not draw attention to the issue.

Some nursing and care staff had long fingernails that had sometimes been manicured to points. Many people had thin skin which was vulnerable to tearing and there was a risk that nails could scratch people's skin or pierce latex gloves. These staff were involved in wound and personal care when people's skin would be most vulnerable. This had not been addressed by managers to ensure people were protected. People sometimes waited for unacceptably long periods to receive support and care from staff. We went to people on a number of occasions because they were calling out or in distress because they needed assistance. Although staff were kind when they attended; the delays caused people unnecessary upset and affected the quality of their lives.

We observed some occasions when staff did not engage well with people. Some did not acknowledge people who were calling out from their rooms and one staff member told us "I will come back but I'm tied up with someone else and if I go in to them, they'll want me to stop and help them". Another staff member roughly pushed a person's hands away, when they were trying to hold their hand and others were seen leading people around by their wrist. One person was pushed in their wheelchair with their feet dragging;

which caused them to injure themself. One person's mattress was stained in a number of areas but linen had been placed over this. Cleaning staff told us that this should not happen as staff were supposed to clean the mattress over before making up the bed. Caring attitudes towards people were not consistently demonstrated by staff.

People's care plans noted the tasks with which people required support and those which they could undertake independently. However, this information was not always followed in practice. For example; one person who needed prompting to be able to eat independently, did not receive that encouragement from staff during the inspection. There was little evidence that people or their families had been involved in care planning. Although there were detailed records of people's life histories in some care files, which had been contributed to by relatives; others had not been completed or held scant information. There was no one receiving end of life care during our inspection, but information in people's care files about 'Last Wishes' was often incomplete. This meant staff could not be sure they would be acting in accordance with people's choices about their final days.

The service had not been adequately adapted to take account of people living with dementia. Although the provider told us that toilet and bathroom doors had been painted purple to help people recognise these, people's bedroom doors were all painted the same colour and their names were written in small lettering on them. There was no picture or other clear signage to help people to locate communal areas such as the lounge and conservatory. This did not help people with impaired memory to find their way around the premises.

The failure to assess and meet people's needs appropriately is a breach of Regulation 9 (1)(a)(b)(c) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Two staff were observed supporting people to eat. They made eye contact, described the meal and engaged the person in reassuring conversation while they helped them. Another staff member spoke quietly and calmly to a person who was becoming agitated. They distracted them from their distress by suggesting a cup of tea and the person quickly settled. Staff told us that they "Want to do the best they can for people" but consistently mentioned the lack of enough staff to make this happen.

Inadequate

Is the service responsive?

Our findings

One person told us "I don't join in with anything; I prefer my own company". Another person said; "I've been lucky today and they've got me up at a reasonable time. Other days it's much later". A relative said "I like to see X up and I do ask but they won't let him; I don't know why". Another relative commented; "I do worry that X is left in bed most of the time. If you don't encourage X they won't try anymore and that's it then, isn't it".

People's care plans were written in a person-centred way so that they included information about people's preferences. However, the choices people had expressed were not always provided to them. For example; one person's care plan recorded in detail the way in which they liked a hot drink to be made and served. When we visited this person in their room at different times during the inspection, they did not have the drink there. We asked two staff members what this person liked to drink and neither could describe it correctly. When we told staff what their care plan stated, they said they had never known this person to be given a drink made in that way. We noticed that there was only tea being offered from the drinks trolley. Staff said that they "Know what people like" but this did not take into account that people may have liked a change sometimes; or to be given the choice. Another person's care plan documented that they preferred bathing to showering and would like a bath at least once a week; with bubble bath in it. We checked daily notes made by staff about this person's personal care for the three months prior to our inspection but found they had not had a bath once in that time. They had been given a wash or shower but their preferences had not been acted upon.

Some people's care plans noted the times they liked to get up or go to bed, but again this did not always happen in practice. Staff said they could not always meet people's expectations because there were not enough of them on duty to complete tasks. Other care plans stated that staff should spend time chatting to people who could become isolated in their rooms but one staff member said "We don't have time to do that. We try to cover the basics but that's all". One person's relative had raised concerns about their loved one being in their room constantly and had asked for attempts to be made to take them to the communal lounge. This did not happen once during the first three days of our inspection. Managers told us that it might not be safe for this person to go to the lounge because another person who showed violent and aggressive behaviour sat there for much of the day. The relative had also asked staff to ensure that this person had their TV or radio on for company but this did not happen until we raised the matter with staff. We spoke with the person who told us that they enjoyed having the TV on and did not know why it was not.

There was an activities coordinator working in the service from Mondays to Fridays. There was a programme of activities but there was little for people living with dementia to enjoy. The coordinator said that they had not received training about special activities that would be suitable for those people but was booked onto a course in September 2016. People living with dementia were observed pacing the corridors for much of the day or sitting in the conservatory with no staff, the TV off and bare tables with nothing to offer stimulation there. Other people followed staff constantly and were very demanding of attention, but there were no meaningful activities to distract them. We heard that one person who showed aggression was very creative and liked to make things. However, they were not engaged in any such activity during the inspection. We

observed altercations between people living with dementia when they had been left alone without interaction or stimulation. People's needs had not been properly met and may have been a contributory factor to episodes of challenging behaviour.

The failure to meet people's needs is a breach of Regulation 9(1)(b)(c) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Entertainers such as singers or visiting pets came into the service on a weekly basis. Musical bingo and virtual greyhound racing were also on offer. There was a summer fete during our inspection; which people seemed to enjoy, and one person had a recent celebration party in the garden. There were no group outings planned; although one person told us they had been taken into the local town in the previous month. One person was observed laughing and chatting with the coordinator as they looked through a reminiscence book together. Care plans recorded people's religious or spiritual preferences and documented that staff should remind them when they could take Holy Communion.

People and relatives we spoke with said that they did not know the process for making a complaint; although they told us they would "Possibly speak to staff or the manager". We asked for a copy of the provider's complaints policy, but at the time we requested it, the policy document had not been adapted to make it specific to the service. We were sent a copy following our inspection. There was no information on display to guide people through the provider's complaint's procedure. The provider's complaints policy however, states that the process will be well-publicised. We pointed this out to the managers and they arranged for signs to be put up immediately. There was one complaint logged in 2016 but the information recorded about this was limited. For example; there was no detail about the cause for complaint or the investigation into it. The provider's complaint policy says that a documented audit trail of the steps taken and decisions made would be kept. There was no record of an acknowledgement being sent to the complainant within three days or of them being reminded that they could contact the CQC at any time: as per the policy. However a copy of the original complaint and the response was provided to us. The provider's own complaints policy had not been followed in the handling and recording of complaints.

This was a breach of Regulation 16 (2) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

A number of thank you cards and compliments had been received by the service. These recorded relatives' appreciation for care received. One read,' Thank you for the care you showed X; they were happy with everything' and another said 'Thanks to all the staff for your kindness to Mum'.

Inadequate

Is the service well-led?

Our findings

The service was not well-led. There had been no registered manager for around a year. It is a condition of the provider's registration that the service is run by a manager who is registered with the CQC. A manager had been in post and applying for registration, but had resigned their position about two weeks before our visit. The new manager started work on the first day of our inspection and told us that they would be applying to become registered. A clinical nurse manager position had been created to assist the manager; and the post had been filled by an existing nurse, because the new manager was not trained or registered as a nurse and many people were receiving nursing care.

There had been a lack of consistent leadership which translated into poor care being provided to people. Although all the staff we spoke with told us there were not enough of them to meet people's needs, this situation had been allowed to continue; placing people at risk of harm. Staff had provided feedback about this at a meeting in February 2016. The minutes of the meeting recorded that staff said; 'We feel that staff levels are not sufficient as we often only have time to walk in a residents room, give them their food and walk out again as we are having to double handle several which takes time. Some days it is 3.00pm before some get a wash due to work load before which means we cannot care for the residents as we would like to'. These comments reflected our findings during the inspection, so improvements had not been made in response to staff raising concerns.

We asked to see minutes of relative and resident meetings so that we could read what had been discussed and determine whether open feedback had been invited. However, the manager was unable to locate any such minutes or records of meetings to seek people's views about the service. Similarly, we requested sight of any surveys issued to gather people and their relatives' opinions about the quality of the care provision, but there were none available. Following the inspection, the manager told us that she would be issuing a survey in the very near future. People's views had not been sought in order to make improvements to the quality and safety of the service.

The lack of a system to seek and act on feedback is a breach of Regulation 17 (2) (e) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

There had been inadequate oversight by the provider; especially given that there was no registered manager in place. Audits and management checks had proved ineffective in identifying the shortfalls in quality and safety found during our inspection. Monthly audits had been carried out by the operations manager from March to May 2016 but there were no records of any in June or July. These highlighted some issues; such as gaps in staff training, but these had not been wholly remedied. There had been no proper or sufficiently detailed auditing of wound or pain management and food, fluid and repositioning charts; meaning that risks to people had not been mitigated promptly.

The provider told us that they had renovated and redecorated the premises but had "Forgotten about the basics". They said that this was partly because the service had been rated good previously and they had turned their attention to their other services. They also said that they had believed that appropriate

standards of care were being provided. This assumption had led to insufficient and ineffective quality assurance processes being carried out, which had, in turn, resulted in people receiving care which was sometimes unsafe.

The lack of a robust auditing process is a continued breach of Regulation 17 (1) (2) (a) (b) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Records about people's care were not always up-to-date or accurate. We found information about an injury filed in the wrong person's notes; which meant details about the incident leading to it were incomplete. Charts to record episodes of challenging behaviour were not updated promptly following the incidents we witnessed and risk assessments were not reviewed to take account of them. Food and fluid charts sometimes included information which was not a true reflection of people's intake. For example; we saw a beaker containing 200mls of tea on one person's table in their bedroom al 11:55am. The entries on their fluid chart showed they had drunk 200mls of tea at 8am and then been offered another 150mls at 11am. This was not possible as more than the150mls offered remained at 11:55am. On another occasion a person's food chart noted that they had eaten all of their meal when we observed staff removing some of it uneaten. A further fluid chart showed a drink given at 10pm when the fluid chart was checked by an Inspector just after 9pm. We were told that the staff member had made an error and that the drink should have been timed at 8pm; but the record was inaccurate and could have led to the person's fluid needs being overlooked at 10pm.

The failure to maintain accurate and complete records is a breach of Regulation 17(2) (c) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

There had been a lack of prompt recognition when the service was unable to properly meet people's needs. People had been admitted with complex conditions, including mental health needs; which staff were not adequately trained or experienced in managing. Although one person had been highlighted by managers as having care needs beyond those they could support, our inspection served to identify others whose care could not be safely or appropriately managed. This should have been identified sooner and suitable arrangements made to ensure that people received care in a different setting. The failure to do so had exposed people and staff to the risk of, and actual harm.

Staff told us they worked well as a team and felt supported by the clinical nurse manager. Some staff said they had tried to bring about positive change but they did not feel they had been listened to by managers. Staff had not understood their responsibility to whistle blow when the problems at the service had remained unresolved; to ensure that people's safety was treated as a priority. The provider told us that they were "Determined to put things right in whatever way is necessary".

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 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider's own complaints policy had not been followed in practice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed A robust recruitment process had not been operated by the provider.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's needs were not being appropriately met.

The enforcement action we took:
Warning Notice

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

The enforcement action we took:
Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The principles of the MCA were not put into practice.

The enforcement action we took:
Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people; including those relating to medicines, had not been minimised.

The enforcement action we took:

Warning Notice

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

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People's nutrition and hydration needs were not being met.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Oversight of the service had bee lacking and audits and management checks had been ineffective. Records were not always accurate or complete. Feedback had not been sought or had not been acted upon.

The enforcement action we took:

Warning Notice

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 There were not enough trained and experienced staff deployed to meet people's needs. Staff had not received effective training or supervision.

The enforcement action we took:

Warning Notice