Coseley Systems Limited

Meadow Lodge Care Home

Inspection report

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23 March 2018

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 15, 16 and 23 March 2018. The inspection was unannounced. At the last inspection of the service in November 2017, the provider was rated as Inadequate in all five key questions and breaches in regulations 9, 12, 16 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found that while some regulations had now been met, there continued to be breaches in regulation in other areas.

Meadow Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Meadow Lodge is registered to provide care and accommodation to a maximum of 22 older people, younger adults and people with a diagnosis of Dementia. At the time of the inspection, there were 17 people living at the home.
There was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A manager had been recruited and was in the process of applying to register as a manager.

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

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

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

Risks were not managed to ensure people were safe. Where risks were known, action had not always been taken as required to ensure people were safe. Infection control practices were poor and the home was

visibly unclean with unpleasant smoke odours throughout the dining area and hallway. Staff were available to take care of people's immediate care needs but did not have time to spend with people. Medicines were not always managed or stored in a safe way.

Staff had not received the appropriate training to enable them to support people effectively. People did not have access to sufficient amounts of fresh food and meals provided did not meet people's preferences. Action was not always taken in a timely way to ensure that people had access to healthcare services when required. Staff knowledge of Deprivation of Liberty safeguards varied.

People were not always treated with dignity and were not consistently given choices in their daily lives. People's specific communication needs were met and people had access to advocacy services where required.

People were not consistently involved in the planning and review of their care. Care records were not always individual to the person. People felt that their complaints were not listened too and there was a lack of activities available for people.

The provider had failed to ensure that the concerns raised in previous inspections had been acted upon. Quality assurances systems in place were ineffective at identifying areas for improvement and this had led to people receiving poor care. Where people had given feedback on their quality of the service, this was not acted upon. People did not speak positively about the provider.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to people's health and wellbeing had not been managed by staff and people experienced deteriorating health as a result.

Medicines were not consistently administered or stored in a safe way.

Infection control practices were poor and the home appeared unclean with unpleasant odours.

Staff were recruited safely but staff were only available to support with people's immediate care needs.

Is the service effective?

Inadequate

The service was not effective.

Staff had not received training to enable them to support people effectively.

There was a lack of fresh food available for people and meals provided did not meet people's preferences.

People were not always supported to access healthcare services in a timely way.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always given choices or treated with dignity.

People had access to advocacy services where required.

People's communication needs were met.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People felt that complaints they had made were not listened too.

There was a lack of activities for people.

Records held in relation to people's care were not consistently personalised or robust.

Is the service well-led?

Inadequate

The service was not well led.

People did not speak positively about the leadership at the service.

Quality assurance systems were not robust and failed to identify the issues found at this inspection.

People's feedback about their experience of the service was not always acted upon.

The provider had not been proactive in making improvements to the service provided to ensure that people received safe care and treatment and that regulations were being met.

Meadow Lodge Care 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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.'

The inspection was prompted following a rating of Inadequate being given at an inspection of the service in November 2017.

This inspection took place on 15 and 16 March 2018 and was unannounced. The inspection team consisted of two inspectors, two specialist advisors and an expert by experience. An expert by experience is a person who has experience of using or caring for someone who uses this type of care service. The specialist advisors had specialist knowledge of infection control and Nutrition Following the first two days of inspection, we had significant concerns about the care being provided and returned to complete a third day of inspection on 23 March 2018.

We reviewed information we held about the service, this included information received from the provider about deaths, accidents/incidents and safeguarding alerts which they are required to send us by law. We also contacted the local authority who commission services to gather their feedback. Due to technical problems, the provider was not able to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We spoke with six people who lived at the home and four relatives. As some people were unable to tell us their views of the service, we completed a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with a visiting health professional, two members of staff, the cook, and the provider. We spoke on the telephone with a second health professional who has visited the service.

We looked at the care records for seven people as well as five people's medication records. We looked at the

weight records for 17 people. We checked records held in relation to staff recruitment and training, accidents, incidents, complaints and systems in place to monitor the quality of the service.

Inadequate

Is the service safe?

Our findings

At our last inspection in November 2017, we found significant shortfalls in the provider's systems to ensure risks to people were managed to keep them safe. This resulted in a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. We checked to see if improvements had been made and found that people remained at risk because staff did not recognise or act on risk.

We found that risks in relation to skin care were not always managed to keep people safe. We identified that one person had a pressure area that had recently been upgraded in its level of severity from a grade one to a grade two. We saw that there was a risk assessment in place for the person that identified that the person should be supported to re-position every two hours to protect their wound. However, when we looked at the daily records we found that this support had not been provided. We saw that there were gaps in recording that meant we were unable to see what support had been provided during that time period, and found other instances where the pressure area relief provided exceeded the two hour requirement. For example, we found instances where the person had not been repositioned for five hours. We raised this with the provider who was unable to explain why pressure relief support had not been given as required. This meant that the person was at risk of further poor health as the guidance in place to improve the person's pressure area had not been acted upon.

We found that staff did not respond in a timely way to keep people safe where risks were presented. We observed one person to be sitting on the stairs in a distressed state and was shouting for help. This person's records indicated they had poor mobility and a history of falls. A staff member saw this person but continued to go in the opposite direction and continue with the task they were doing. It was not clear if a fall had occurred or not and the staff member failed to act to keep the person safe. This meant that the person was left at risk of harm by staff who did not respond to risk in a timely way. The staff who responded to the person, did not appropriately risk assess the situation to keep the person safe. Staff who arrived to support the person did not ask them if they had fallen or if they were in any pain. The staff began to support the person to stand as they assumed the person was displaying behaviour that challenged. As the incident that led to the person being on the stairs was unwitnessed and it was not clear what had caused this, staff put the person at risk of further injury by not assessing whether a fall or injury had occurred before supporting the person to stand.

We saw that one person in the communal lounge required the use of oxygen. The tubes that would be inserted into the person's nose to provide them with their oxygen had been placed on the lounge floor. The floor was visibly unclean. When staff supported the person, they inserted the tubes that had been on the unclean floor directly into their nose. The staff had not identified the infection risk of using the tubes that had been exposed to unclean surfaces. This meant that there was a risk of potential of harm to the person as staff had failed to identify infection risks.

We saw staff support a person with their medication. The staff member gave the person all of their tablets to take at once, the person was visibly struggling with handling so many tablets at once and could not swallow them. Inspectors intervened and advised the staff member that it may be safer for the person to take their

tablets one at a time. The staff member responded and took the tablets from the person to give them individually. The person was then able to take their medication safely and without difficulty. This had meant that the staff member had not responded to the presenting risk to keep the person safe. Another person told us, "I have medication, they leave my tablets in my room if I am not there, they don't watch me take it. On a couple of occasions, they have forgotten to give me and ask me if I had it as it wasn't signed [On the medication administration record]". On our third day of inspection, we saw that medications had been left unattended and in easy reach of people. We saw that one cassette of medications had been left in a washing basket in a bedroom doorway. These medications remained there for approximately 20 minutes. This meant that medications were not being stored safely and could have been accessed and taken by other people.

This is a breach of Regulation 12 of Health and Social Care Act 2009 (Regulated Activities) Regulations 2014.

People told us they were unhappy with the cleanliness of the home. One person told us, "I don't have a bath; the bath is not clean". Another person said, "I think that there is a shortage of toilets, sometimes I have to wait until one is free and then it is dirty after the last resident". A third person said, "I have to clean the bath before I use it ". A relative also was not happy with the levels of cleanliness and told us, "My daughter won't visit as she said that she cannot take the smell of the home".

The home had a dedicated smoking room for people who wished to smoke. This room was joined to the dining area. However, the smoking room did not have adequate ventilation and as a result, smoke odours were being emitted through the dining area and into the hallway leaving an unpleasant smell in the home. We raised this with the provider who was aware of this issue but had not taken action to ensure that unpleasant odours from the smoking area did not disturb the rest of the home.

We saw that the home, and in particular the communal bathrooms and toilets were not well maintained. We found urine stains on a shower chair, faeces underneath toilet seats and broken plaster that had the potential to cause injury left exposed in a toilet. One bath had stains around the edges. In the garden area, we found a pile of cigarette ends that had not been disposed of safely. We spoke with the provider who advised us that they had one member of domestic staff who was responsible for the cleaning of the home. However, when we checked the cleaning schedules we found that these were either incomplete or missing so we were unable to determine that the cleaning tasks had been done. We could only find one cleaning schedule entry for March 2018 and four for February 2018. This indicated that the cleaning tasks were not being completed as required.

We saw that care staff were responsible for checking the cleanliness of communal toilets throughout the day. However, these records also indicated that this was not being done as required. We saw gaps in the recording of toilet checks and where these were complete, they were inaccurate. For example, we checked on the cleanliness of bathrooms during the early morning and again mid-morning. During this time staff had completed the cleaning schedule to say the toilet had been 'checked and cleaned'. However, on our second visit to the toilet, we identified the same stains that had been there on the first visit. This meant that staff could not have cleaned the toilet as documented.

This is a breach of Regulation 15 of Health and Social Care Act 2009 (Regulated Activities) Regulations 2014.

Staff told us that prior to starting work, they had been required to provide their work history, references from previous employers and complete a check with the Disclosure and Barring Service (DBS). The DBS check would show if a person had a criminal record or had been barred from working with vulnerable adults. Records we looked at showed that these checks had not been completed consistently. We saw that where one person required a permit to work within the UK, the evidence of this was not available. We raised this

with the provider who informed us they would address this. The provider submitted evidence of the person's right to work following the inspection. We saw that for other people, references had not always been sought from previous employers. One person only had one reference in place. The provider informed us that this was due to them having problems sourcing a second reference for the person. However the provider could not provide evidence of trying to obtain more than one reference.

We received mixed feedback from people when asked if there was enough staff available to support them. One person told us, "I think there is enough staff here". However other people did not feel there were enough staff. One person said, "I don't think that there is enough staff, some staff work long hours then go work somewhere else, they are not consistent enough". Another person added, "Sometimes they are short staffed, today I heard them calling staff asking them to come in". We spoke with staff who told us they felt there were enough staff available to support people. One member of staff told us, "Yes I do feel there is enough staff". We spoke with staff who told us that they would have to support with domestic tasks and preparing food when domestic and kitchen staff were unavailable. Staff felt that this did not have an impact on their ability to support people and one member of staff said, "Most days, I think we fit it all in well".

We saw that staff were available to support people. However, this support was limited to providing care support only and at other times, staff would be elsewhere in the home supporting other people. We saw that staff did not appear to have time to sit and spend time with people. For example, we saw that one person was walking around the home and was asking for help. A member of kitchen staff saw the person and reassured them that, "Hold on, [Staff members name] is here [to help]". The staff member then replied, "No I am busy". This meant that although the person's immediate care needs were met, staff were not available to provide reassurance and spend time with the person". We spoke with the provider who used a dependency tool to assess how many staff were required. This was reviewed monthly but we were unable to see where staffing levels had changed to accommodate people's changing needs, or the extra tasks staff needed to complete in the absence of the domestic and kitchen staff.

People were happy with the support they were given with their medication. One person told us, "I do have medication and they [staff] don't forget to give it to me".

We saw that where people required medications on an 'as and when required' basis, there were not always protocols in place informing staff of when these medications should be given. This meant there was a risk of medications not being given in a consistent way. Where protocols were in place, these were not robust and lacked detail. For example, where the protocol gave information about when medications should be given, consideration was not given to people's individual pain experience, how they express pain or any non-verbal cues that staff should be aware of.

We saw that one person had run out of their prescribed pain relief. The medication had run out eight days before the inspection visit. We spoke with staff who told us that the new prescription had just arrived. Staff told us that the shortfall in medication was due to the GP not prescribing enough to last the whole month. Staff were not able to demonstrate that they had identified they were going to run out of the person's required pain relief or taken steps to ensure this was available should the person need it. This meant that the process for ordering medications to ensure people have access to their prescribed pain relief when needed was ineffective.

People told us that they did feel safe at the home. One person said, "I feel safe and supported by staff". Staff that we spoke with told us they had received training in how to safeguard people from abuse and could tell us what action they would take if they thought a person was at risk of harm. One member of staff told us, "If I saw anything, I would write it in the notes and report it to the manager". We saw that where concerns had

been raised, these had been reported to the local authority safeguarding team and Care Quality Commission as required.

We found that action to make improvements where things had gone wrong was inconsistent. The provider and the staff spoken with were aware of their responsibilities to report incidents and we saw that a record and an analysis of any incidents took place. However, the provider had failed to learn and improve where concerns had been identified in service user meetings and questionnaires as well as take action on the areas for improvement identified in previous inspection visits. This meant that the provider could not consistently evidence their continuous learning from incidents and concerns raised.

Inadequate

Is the service effective?

Our findings

At our last inspection in November 2017, we found significant shortfalls in the provider's systems to ensure people received effective care. This resulted in the provider being rated as Inadequate in the key question of Effective. We checked to see if improvements had been made and found that people continued to receive ineffective care and support.

People told us they were unhappy with the meals provided. One person told us, "The food is rotten; I wouldn't feed it to a dog". Another person said, "I buy a lot of my own food as the food here isn't nice".

People were also unsatisfied with the amounts of food made available to them. One person told us, "Occasionally I am still hungry after lunch, but I go eat biscuits from my room" and another person added, "There are times when I think I want more to eat". We spent time in the dining areas where people were eating their meals and heard people making complaints about the availability of food. One person was only provided with six chips in their 'fish and chip' meal and was unhappy as this was not sufficient for their appetite. A member of staff spoken with also raised concerns about the amounts of food available and told us, "We have fruit bought and if it goes before the next shop then that's it, If someone wants one and it's all gone, they can't have it". The staff member explained that they have previously bought food in for people themselves and said, "I don't like to think of them [people] going without".

We looked at the availability and quality of the food being provided and found there were not sufficient amounts of fresh food for people. We found minimal amounts of fresh food that would not be sufficient for 17 people living at the home. The majority of food provided was in frozen or tinned format. Where protein sources such as fish was provided, this was low quality and had potential to have lower nutritional value due to its low cost.

We saw that the meals provided to people did not look appetizing. People's dietary needs were being met but we found that desserts made by staff used sweetener instead of sugar. This was done to ensure it met the needs of people with diabetes but meant people who did not require a diabetic diet, were being provided with desserts that did not have sugar in. There had not been consideration to people's preferences with regards to the use of sugar in their desserts and had potential to impact on health for people who require the calories provided by the use of sugar.

People's weights were being monitored and we saw that for some people, any identified weight loss was being acted upon. However, we saw that one person had lost a significant amount of weight between November 2017 and January 2018 and could not see any evidence that this had been investigated or referred to healthcare professionals. We spoke with the provider about this who took action and spoke with a GP; however, this action was only taken in response to inspectors raising the concern and had not been identified by staff or the provider. This meant that timely action to seek appropriate healthcare support where weight loss occurred had not been taken.

This is a breach of Regulation 12 of Health and Social Care Act 2009 (Regulated Activities) Regulations 2014.

People told us that they felt staff had the skills needed to support them effectively. One person told us, "I think that the staff know how to look after me, they are skilled". A relative added, "Staff do know what they are doing".

Staff told us that before they could start work, they had been required to complete an induction that involved shadowing and completing E-Learning. However one member of staff told us they had not received an induction. The staff member said, "I just came in and started. There was no induction". This meant that although an induction system was in place, this was not being used consistently with all new staff.

We found that training for staff that would ensure people were supported effectively was not consistently given. For example, some staff members training in relation to moving people safely was a year out of date. When we asked the provider to show us evidence of staff moving and handling training, he was unable to produce this. We also found that no staff had received training in catheter care despite providing support to people with their catheters. This meant that staff had been carrying out care tasks that they had not been trained in. We spoke to the provider about this who informed us that they would arrange for staff to receive training in these areas. The provider showed us on the third day of inspection, that training courses for staff had been booked.

People told us that had access to Healthcare input where required. One person told us, "You can see a GP and the Dentist, Optician comes in and the hairdresser". However, records we looked at showed that people had not always been supported to access services where required. We saw that one person had received letters in July and September 2017 asking them to attend an appointment to have their eyes checked. We could not see from records that the person had attended the appointment. We raised this with a senior member of staff who told us that the person had refused to attend the appointments but could not provide evidence of this or any other actions they had taken to address this. This meant that the person's eye health had not been checked as required to ensure their good health. We also found that where people's weight had fluctuated significantly, this was not always referred to GP's or dieticians to ensure the person's well-being.

Health care professionals we spoke with gave varied feedback on the support staff offer to people to access healthcare input. One health professional told us that staff presented as knowledgeable about people's healthcare needs and always followed their instructions. However, other professionals spoken with raised concerns about the staff skills in maintaining people's health and told us they were not confident that staff had followed the instructions they had given to keep people healthy. We raised these concerns with the local authority safeguarding team following the inspection.

The decoration of the service was not appropriate for the needs of the people living at the home. For people who had a diagnosis of dementia, there was a lack of clear signage or orientation aids to support people when moving around the home. The outside areas would not be safe to use due to the high number of cigarette ends littered on the windowsill and the floor. This meant that people also didn't have access to adequate outside space.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).We checked whether the

service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff displayed an understanding of how to seek consent prior to supporting people and we saw them put this into practice. One member of staff told us, "I never assume that someone doesn't have capacity. I will assess the person and if I think their capacity needs assessing, I will tell the manager". We saw staff seeking people's consent prior to supporting them. For example, we saw staff asking people before providing their medication support.

One person living at the home had a DoLS authorisation in place. This had been applied for appropriately. However, the staff teams understanding of DoLS and who had an authorisation in place varied. We found that some staff thought that people had authorisations in place where they did not. Other staff did not know who had a DoLS authorisation in place. Without this knowledge of who had a DoLS authorisation in place, we could not be sure that people would be supported in line with these authorisations and any additional conditions. However, we did not see people supported in a way that was not in accordance with their DoLS authorisation.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in November 2017, we found significant shortfalls in the provider's systems to ensure people were treated in a caring way. This resulted in the provider being rated as Inadequate in the key question of Caring. We checked to see if improvements had been made and found that people continued to receive care and support that was not always caring.

People gave varied feedback when asked if staff had a caring approach to them. One person told us, "The staff are very kind", and a relative said, "Staff have a good relationship with people". Whereas other people were not so positive and felt that staff did not spend enough time with them. One person told us, "The staff rarely sit and talk to you, but they would sit together and talk". We found that some staff made an effort to sit with people, discussing activities and asking how they were. However, we found that other staff did not always spend time with people unless supporting with care tasks as they were completing tasks elsewhere in the home. This meant that the systems in place did not support staff to develop caring relationships with people as they did not consistently make time to spend with people.

People told us they felt treated with dignity and had privacy as requested. One person told us, "The staff always treat me with respect." We saw that where people requested privacy, this was respected by staff who left people to spend time in their rooms if they did not want to be in communal areas. However, we also saw one person being given an injection in their bedroom by a visiting health professional. The door was left open while this support was given and staff supervising the visiting health professional had not monitored this to ensure the person's dignity was respected. This meant that the person was not given privacy while they received medical support. We raised this with the provider who told us they would address this with staff.

We saw instances where dignity had not been maintained. For example, we saw one person enter the bedroom of another person while they were receiving support from staff. Staff members in the person's room intervened and closed the door so that the person could not enter the room but this had compromised the person's privacy and dignity as another person had been able to walk into their room. We later saw this person try to enter the room of a second person but had been prevented from this by the door being locked. We saw another person use the communal toilet without fully closing the door. This toilet was directly opposite the communal lounge and so people sitting within the lounge would have been able to view the person on the toilet. As staff were in other areas of the building, they had not been able to respond to this and protect the person's dignity.

People gave mixed feedback when asked if they were given choices and were involved in their care. One person told us, "I choose what time I go to bed and what time I get up in the morning" and another person added, "I choose what I want to wear with the assistance of the carer". However other people did not feel they had choices. One person told us, "It's not like a care home, it's more like wormwood scrubs, I have to ask permission to go to the shops to get a newspaper or for a walk". People gave us examples of where they had not been provided with choice. One person told us they were not given choices of drinks at mealtimes and that they could not have a hot drink when they wanted this with their meal. Another person told us,

"Some staff just come into the lounge and change the television channel without asking our permission or if we were watching the programme". This meant that although people were provided with some choices, this was not consistent and further work was required to ensure people were able to be involved and have choices in their daily care.

Where people had specific communication needs, we saw that alternative methods of communicating were used. For example, we saw that a whiteboard was situated next to one person at all time as this was how they found it easiest to communicate. We saw staff use this with the person to support them in communicating their needs. We saw that there were pictorial aids available for people at mealtimes to support them in understanding their meal choices.

The provider told us that there were people currently living at the home who had the use of an advocate. An advocate can be used when people may have difficulty making decisions and require this support to voice their views and wishes. We spoke with the provider about this and they understood when an advocate may be required and how they could refer people to this service if required.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in November 2017, we found significant shortfalls in the provider's systems to ensure personalised care that met people's individual needs and inadequate systems to handle complaints. This resulted in breaches of Regulation 9 and 16 of the Health and Social Care Act (Regulated Activities) Regulations 2014. We checked to see if improvements had been made and found that not all regulations were being met. Where some regulations were now being met; further improvements were required to ensure people's concerns were acted upon.

People could not recall whether they had been involved in the planning or review of their care. One person told us, "I don't remember a care plan" and a relative added, "I don't remember a care plan or reassessments". One relative told us they had been involved in planning their loved ones care and said, "Before [person's name] moved in, we sat down and they [the provider] wanted all of the information. It was an in depth discussion". Records we looked at showed that assessments had taken place and that these looked at people's care needs and preferences with regards to their care.

We saw that while records held some personalised information about people such as preferred bedtime drink, hobbies and favourite music, there were other pieces of information about the person that was not available. For example, we saw that one person had a Do Not Resuscitate (DNR) authorisation in place. This was held in the person's room with their medicines. However, their care plan did not mention this DNR. This meant that there was a risk that staff who were not responsible for medicines, may not know that this is in place. Further to this, we saw that in some records people were referred to by incorrect names. One person was being referred to in their care plan by the name of another resident. This indicated that the information recorded had been taken from another person's care records and raises concerns that the records are not individual to that person. For another person, their care records held personal information about another resident. This meant there was a risk that people would not receive care that was individual to their needs as it was not clear what person the information related too.

We found that people's individual preferences in relation to the meals provided had not been met. We spoke with one person who informed us they would eat out at a local pub each day as they did not want to eat the meals provided. We spoke with the provider who was aware of this person's unhappiness with the meals, but felt that they were unable to afford the meals that this person wanted. We were unable to see that any further attempts had been made to ensure that the person's food preferences could be met within the home. Another person was able to show us the food that they bought themselves. The person explained that they did this as they felt the quality of food provided at the home was poor and so did not want to eat this. This meant that the provider has not met people's individual preferences or sought to offer alternatives to people to ensure their support was personalised to their wishes.

People told us that they felt staff knew them well. One person told us, "I think that the staff know me". We found that staff we spoke with displayed a good understanding of people's individual needs but did not always put this into practice. For example, One person's care records identified that they were likely to become distressed during a specific time of day when faced with another person. Staff we spoke with were

aware of this however we observed the person being confronted by this person throughout the afternoon as staff had escorted the person into the same area as the person who would prompt their distress. The person became visibly distressed by this and staff in the room failed to act to reduce the person's distress and continued to take the person into areas where their anxiety was likely to be heightened. The staff members did not take action to ensure the person's individual needs were met despite knowing what these were.

The provider was not currently providing care to anyone who was at the end of their life. We saw from records that end of life care plans were in place for every person but these did not provide sufficient information about people's preferences or choices for the end of their life. The records we viewed in relation to end of life care were minimal and consisted of one line only. This meant that there was insufficient information available for staff to enable them to support people In the way that they would wish at the end of their life.

People told us they were not happy with the activities available to them. One person told us, "We don't do activities; they used to do but no activity co-ordinator at present". Another person told us, "We have not been out in the garden, not even in the summer". A staff member we spoke with also felt there were not enough activities available and told us, "The activities could be better".

We observed a lack of activities available for people. People spent long periods of time in communal areas with little interaction with other people or staff. People's main source of stimulation came from the television. We did see some staff attempt to spend time playing dominoes with people, however this was the only activity we saw occur over three days. Some people spent time away from the home and where able we saw people leaving throughout the day to do things in the community. However, this was only for people who were able to go out independently and we did not see that similar opportunity was available for people who required staff support.

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

People knew how to make a complaint if required. One person felt able to do this and told us, "I would feel comfortable raising a concern or a complaint". However, we were told by other people they did not feel able to make a complaint. One person said, "It would do more harm than good". Some people told us that they had previously made complaints and they had not been listened too. One person said, "Of course I have told them [the provider] my complaint, but its 'if you don't like it, tough'". Another person said, "I have made complaints but nothing much happens".

We saw that a complaints procedure was in place and this was available in easy read format if required. We looked at the records of complaints made and saw that these had been responded too. However, we could not see evidence of the complaints people told us they had made that had not been resolved. We spoke with the provider about this who informed us they would only keep a record of official complaints and had no records relating to 'grumbles.' However, the people we spoke with felt that their issue was a complaint and so we were unable to evidence that there concerns were being addressed in line with the provider's procedure.

Inadequate

Is the service well-led?

Our findings

At our last inspection in November 2017, we found significant shortfalls in the provider's oversight of the service and their ability to monitor and improve the service. This resulted in a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. We checked to see if improvements had been made and found that there remained shortfalls in the governance systems in place. This meant that the breach of Regulation 17 had not been met.

There was not a manager registered with us. A manager had been recruited and had been working at the service for a number of months. This manager had made an application to register and was waiting to hear if this had been successful.

People we spoke with did not always know who the manager or the provider was and not all people spoke positively about the provider and the care they received. One person told us, "I have only seen the owner twice since I have been here". Another person told us, "They [the provider] is only after money" and "I would prefer to be dead, there is nothing to live for here". A third person was heard telling staff, "I want to die, got nothing here to do and no family, nothing".

We saw that people had been given opportunity to provide feedback on their experience of the service but that this was not always acted upon to improve the care provided. For example, we saw that in a Service User questionnaire dated 11 August 2017, four people responded 'no' when asked 'Is the food provided sufficient, tasty and suitable for your needs?' There was an action recorded that said as a result of this feedback, the menu would be changed. However, the provider told us that the menus had not been changed since July 2017. This meant the provider had not completed their recorded action to change the menu in response to service user feedback. We also saw that where people had made requests of items they would like to see added to the menu, the provider had not provided this and informed people that they could not provide their requested meals due to 'cost and shopping budgets.' Further, at the service user meeting dated 05 September 2017, people had raised concerns about the toilets being unclean. At this inspection, we found the cleanliness of the toilets remained a concern. This meant the provider had not acted on feedback in order to make improvements to the service.

There were systems in place to monitor the quality of the service but these had been ineffective in identifying the areas of concern found at this inspection. For example, infection control audits had been completed monthly but these had not identified the scale of the uncleanliness we found. The audits had not addressed the poor maintenance of the bathrooms and toilets, nor had it addressed the unpleasant odours coming from the smoking room. These audits also hadn't identified that cleaning schedules were not completed as required. The care file audits had failed to identify that records were not individual and held details relating to other people in them.

The audits that were in place and complete were not robust and did not provide opportunity for analysis. For example, the pressure area analysis completed had identified that one person's pressure area had deteriorated but there was no further analysis of this to look at any contributing factors or whether any

additional support was required. As a result of this lack of analysis, the provider was unable to identify that the person had not been receiving the pressure area care they needed. The activity audit that was completed provided statistics in relation to how many people had taken part in each activity. However, the audit did not expand on this to analyse whether these activities reflected people's interests and what people's feedback about the activity was. As this analysis did not form part of the provider's governance systems, they had been unable to identify that people were unhappy with the activities provided.

The provider lacked oversight of people's experience of the service and as a result had not acted upon their concerns, complaints and requests for improvements to the service. The governance systems employed were ineffective and had resulted in areas for improvement being missed. This had led to people receiving care that fell short of what should be reasonably expected.

This is the third inspection in which the provider had been rated as 'Inadequate' in the key question of Well Led. It is also the third inspection where breaches of regulation have been identified. This leads to concerns that the provider does not have the skills or knowledge required to make and sustain the required improvements to the care provided. The provider has been unable to evidence that they have taken proactive measures to improve the service so that they are no longer in special measures.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities0 Regulations 2014.

Staff we spoke with told us they felt supported by the manager and provider. One member of staff told us, "I do feel supported. I can always ask [provider name] and [managers name]". Staff told us they had regular team meetings and supervision with their manager in order to discuss the service. Staff had been informed on how they could whistle-blow if required and were confident in how they should do this. However, staff had not identified the poor levels of cleanliness, quality of food or the lack of activities for people.

It is a requirement that providers ensure that their most recent rating is displayed within the home and on any websites ran by the provider in relation to this home. We saw that the provider had displayed their rating in the reception area of the home and so had met this requirement. The provider had also met their responsibilities in notifying CQC of any incidents that occur at the service.