Lifestyle (Abbey Care) Limited

Lifestyle (Abbey Care) Limited Archery - Bower

Inspection report

Abbey Care Village
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Date of inspection visit:
25 October 2016
02 November 2016
28 November 2016

Date of publication:
07 June 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out this inspection on the 25 October, 2 and 28 November 2016. The inspection was unannounced, which meant the staff and registered provider did not know we would be visiting.

Lifestyle (Abbey Care) Limited Archery – Bower had three inspections since the introduction of ratings in 2014. Initially in July 2014 the home was rated as inadequate. The home was in breach of seven regulations and we issued two warning notices. At a follow up inspection in February 2015 the home continued to be rated as inadequate. However, it was found that action had been completed to achieve compliance with breaches of regulation but continuing action was still needed in relation to staffing, governance and the need to obtain people's consent. A further inspection was conducted in September 2015 and we found although some improvements had been made the home still needed to take further action. We made recommendation to improve the administration of covert [hiding] medicines and quality assurance systems had not been in long enough to demonstrate an overall improvement and ensure it was sustained. We rated the home as requires improvement.

Lifestyle (Abbey Care) Limited Archery - Bower is a nursing home, providing care for people with nursing needs, some of whom were living with dementia. The home is part of the Abbey Care Village, located in the North Yorkshire village of Scorton. The home is a purpose built, two storey building, providing bedrooms with en-suite bathrooms. There is also parking and private grounds. Local pubs, a coffee shop and village shop are located within walking distance. The home can accommodate up to 60 people. On the first day of inspection we were told by staff that 27 people used the service.

The service has not had a registered manager since January 2014 and the nominated individual was acting as the manager. 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. It is condition of registration that a registered manager is in place at the home.

We have written to the registered provider about their failure to meet this condition of their registration. To date no application to register a manager has been submitted. We are taking action outside of the inspection to deal with this matter.

We identified significant concerns during the visit and discussed these at length with the nominated individual and on 28 October 2016 we wrote to the registered provider to outline our serious concerns about the health, safety and wellbeing of people who used the service. On 1 November 2016 the registered provider agreed at the request of the commission to accept no more admissions to the home, until improvements had been made.

On 2 November 2016 we returned to Lifestyle (Abbey Care) Limited Archery – Bower to continue the

inspection. We found that since our first visit five people had been admitted with one of these people being admitted on 1 November 2016. We found one person had passed away since our last visit and there were 31 people using the service. The acting manager who is also the nominated individual was unaware that a person had been admitted on 1 November 2016.

We found there were multiple breaches of regulations of The Health and Social Care Act (Regulated Activities) Regulations. The breaches were in relation to person-centred care, dignity and respect, need for consent, safe care and treatment, safeguarding service users from abuse and improper treatment, meeting nutritional and hydration needs, receiving and acting upon complaints, good governance, staffing and fit and proper persons employed. But more seriously, there was a significant risk being posed to service user's life, health and wellbeing. We found the impact of seriousness to people who used the service was risk rated as extreme or high

The nominated individual and registered provider were made aware of the risks posed to service users during our visit on 25 and 28 October 2016 followed up with a letter. No action had been taken between then and 2 November 2016 to mitigate these risks and people continued to be admitted into the home. In light of this we used our enforcement powers to prevent any more people being admitted to the home.

Following our visit on 2 November 2016, we continued to have serious concerns about the competency of the staff working at the home and their ability to ensure the safety of people who used the service. Therefore, we asked the registered provider to produce an action plan detailing how they would be reducing risks posed to people. They sent us an action plan we found was inadequate, with insufficient detail about how they intended to reduce the risks posed to people and who would be responsible to make sure risks would be reduced, so asked for this to be revised. On 14 November 2016 we received the revised action plan, again this failed to give sufficient detail about how the proposed measures that would reduce risks posed to the people who used the service.

In light of continued concerns we used our urgent powers and served a notice that required the registered provider to submit, on a weekly basis, information to confirm that sufficient staff were on duty at the home and that they obtained robust information from agencies about the staff they were supplying.

The notice required that the registered provider reviewed all of the people's care plans and risk assessment to ensure these followed best practice guidance. Also that they reviewed medication practices at the home to ensure all service users received medication appropriately.

The registered provider was required to supply us with all of the information confirming that these actions had been taken, which they did.

During our inspection we found that the registered provider had not displayed the rating for the home either on site or on their website. This is a legal requirement that the CQC rating is displayed. The information about the home was now shown on their website but was not on display in the home. This was being dealt with outside the inspection process.

The registered provider had not sent notifications about incidents and DoLS authorisations, which are required under the Care Quality Commission (Registration) regulations 2009. We wrote to the registered provider about this failure and are dealing with this matter outside the inspection process.

During this inspection we found risks to people's health or well-being had not always been assessed and plans were not always put in place to protect people.

Medicine practices were unsafe and medicines were not handled safely

Care plans and instructions from external healthcare professionals were not followed.

Action was not taken to reduce the risk of malnutrition. We found staff had not completed the MUST tool correctly and where people had lost weight a recording was made to say there was no weight loss. Where people required their weight to be recorded weekly or monthly, we could not find evidence that this was taking place consistently. This meant that people were at risk of becoming seriously ill.

Accidents and incidents were not monitored each month to see if any trends or patterns were identified. The form staff completed following an incident or accident was unclear and this meant it was very difficult to identify any patterns and therefore take action to reduce the risk.

We found people were cared for by insufficient numbers of suitably qualified and experienced staff. The nominated individual did not know which staff were on site at what time or which agency staff came to the home. This meant that if an emergency was to take place they could not account for who was in the home at that time. No names were recorded of which agency staff worked at the home, the rota just named them as agency.

Appropriate recruitment checks had not been undertaken before staff began work. The registered provider used agency staff to cover both nurse and care worker shifts. There was no information to confirm which agency staff member had been on duty at what time. No prior checks were done to ensure agency staff were suitable to work at the service. This meant that they could not be assured that staff had been working at the home or that unauthorised people were in the building.

People's privacy and dignity was not always respected. For example staff compromised people's dignity by telling them to soil in continence aids rather than taking them to the toilet and people were not bathed on a regular basis.

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A nurse was employed at the home had an interim order from the Nursing and Midwifery Council (NMC) which set out conditions they needed to meet in order to practice. An interim order is a restriction or suspension of a registrant's registration with the NMC. In this case the nurse had restrictions in place. We found the nominated individual had not ensured these conditions were met. On 16 November 2016 the NMC suspended this nurse from practice because they had failed to adhere to the conditions that had been imposed.

Staff were working excessively long hours and although the nurse signed out of the building at 8am they were still working at 11:30am. Working excessive hours can lead staff to be overtired and prone to making errors and having accidents.

One person lived alone in a wing of the home. There were no staff working in that part of the home. Staff visited the wing at meal times to give the person their food. This meant during other parts of the day there was no supervision and the person lived in isolation. We found staff had not considered the isolation people may experience when they were confined to bed and were the sole occupant of a wing.

We found that some of the staff struggled to understand what people who used the service were saying and could not outline people's needs. We were concerned that these staff members had not been supported to understand people's care needs or to be able to communicate with the people who used the service.

Four people had been admitted between the first and second day of inspection . All four care records contained exactly the same content of assessment and care plan information. All that had been changed was the name of the person. In some records the incorrect gender was used. Care plans also contained contradictory information. This meant staff may not have accurate information about the people's care needs so may deliver inappropriate care.

Staff did not adhere to pre-assessment information so failed to ensure the appropriate equipment such as air flow mattresses were in place.

People on end of life care were not supported to express their wishes and preferences, as either staff did not realise individuals were on end of life care pathways or care records failed to identify this was an issue. End of life care plans were completed incorrectly. One person's care file stated they wished to stay at Archery Bower for their final days, on speaking to their family we found this not to be the case.

Staff had not received support through supervision and had not received relevant training.

We did not see evidence in people's care files that they had agreed to the care plans. Where people were unable to consent decisions no best interests decisions had been made.

Deprivation of Liberty Safeguards (DoLS) authorisations had been obtained, however no system was in place to ensure these were renewed in a timely manner and that any conditions were met.

The chef cooked the meals for the 58 people who lived in the two homes on the site. The weekly budget for all of the food for all these people was £600. On 28 November 2016 the nominated individual informed us that following our visit on 2 November 2016 the registered provider had increased the catering budget.

People were offered a choice at meal times. However the dining experience was not dignified. Where people needed support to eat only one member of staff was available and during lunch was feeding four people at once.

Staff we spoke with understood the principles and processes of safeguarding, as well as how to raise a safeguarding alert with the local authority. Staff said they would be confident to whistle blow (raise concerns about the home, staff practices or registered provider) if the need ever arose. However we found they had not raised any concerns about the issues we identified during this inspection.

People were not always supported to access healthcare professionals and services.

We did not see any evidence of activities taking place.

Some certificates for safety checks and maintenance had not been completed in line with the legally

required timescales. The handyman had completed portable appliance testing [PAT] however there was no evidence they had the necessary training or skills to carry out this work.

Hand gel machines throughout the home were all empty.

On the second day of inspection we found the upstairs unit had an offensive smell. Staff told us this was because the domestic staff had not been able to clean the unit that day.

A complaints and compliments process was in place. However not all complaints were recorded or had an outcome to show the person making the complaint was satisfied.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. The service will be kept under review. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. Improvements were needed in many areas where the provider was not meeting the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

We found medicines management practices were unsafe.

Staff were not always reporting incidents or recognising when their practice constituted institutional abuse.

Assessments were not always undertaken to identify risks to people using the service and others.

There were insufficient numbers of suitably qualified staff to care for people's needs.

Health and safety checks had not always been completed in line with legal requirements.

Is the service effective?

Inadequate

The service was not effective.

Staff training needed to be updated and there was a lack of appropriate supervision. Also no checks were made to confirm that agency staff were trained and competent to work at the home.

People were not always supported to have their nutritional needs met.

The requirements of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards [DoLS] were not always adhered to.

People were not always supported to access healthcare professionals and services.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not respect people's privacy and dignity. Staff failed to attend to people's personal care needs.

Staff had not considered the isolation people may experience when they were confined to bed and were the sole occupant of a wing.

People on end of life care were not supported to express their wishes and preferences at this time.

Is the service responsive?

Inadequate

The service was not responsive.

People's needs were not always assessed and care plans were not person centred.

Staff were unaware that people had been admitted to the home and therefore not ensured the care records were in place to meet their needs.

Staff did not folow pre-assessment information so failed to ensure the appropriate equipment such as air flow mattresses were in place.

We did not see evidence of activities taking place.

Not all complaints were recorded with an outcome to show the person making the complaint was satisfied.

Is the service well-led?

Inadequate

The service was not well-led.

There was no registered manager in post.

Minimal audits to monitor the quality of the service were in place. The audits in place were not effective.

The nominated individual did not action to investigate a controlled drug discrepancy until November 2016, despite the commission pointing this issue out in October 2016.

The registered provider and nominated individual had not identified the serious failures at the home.

The nominated individual did not understand their responsibilities in making notifications to the Commission.

Lifestyle (Abbey Care) Limited Archery - Bower

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 the 25 October, 2 and 28 November 2016. The inspection was unannounced. The first inspection day started early in the morning in order to observe the night shift.

The inspection team consisted of two adult social care inspectors, a pharmacy inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before our inspection, we reviewed the information we held about the home. We looked at statutory notifications that had been submitted by the home. Statutory notifications include information about important events which the registered provider is required to send us by law. This information was reviewed and used to assist us with our inspection.

The provider was not asked to complete a provider information return [PIR]. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the visits we spoke with eight people who used the service, seven relatives, the manager who was also the nominated individual, the deputy manager, the administrator, the training manager, the cook, two nurses and four care staff members. We undertook general observations and reviewed relevant records. These included nine people's care records, 14 medicine records, seven staff files, all of the available information from the agencies who provided nurses and care staff and other relevant information such as

policies and procedures.

Inadequate

Is the service safe?

Our findings

During our inspection in September 2015 we made a recommendation that the registered provider updated their practice around administering covert medicine (adding medicine to food and not telling the person they are getting the medication)

At this inspection we found this had not been met. Some people had medicines administered covertly. We saw that the GP had authorised covert administration (adding medicines to food) for people who did not have capacity and were refusing essential medicines. However, the information on how this would be done was not clear and there was no information to confirm that staff had sought guidance from the pharmacist to make sure that these medicines were safe to administer in this way. This information would help to ensure people were given their medicines safely.

We looked at how medicines were handled and found that the arrangements were not always safe.

Records relating to medication were not completed correctly placing people at risk of medication errors.

Medicine stocks were not properly recorded when medicines were received into the home or when medicines were carried forward from the previous month. This is necessary so accurate records of medication are available and care workers can monitor when further medication would need to be ordered. For medicines with a choice of dose, the records did not always show how much medicine the person had been given at each dose. We also found gaps in the records we looked at where staff had not signed for the administration of medicines. It was therefore not always possible to confirm if care staff had given people their medicines as prescribed.

For three people whose records we looked at staff had produced handwritten MARs however, a second member of staff had not countersigned these to confirm that the record was accurate as detailed in the medication policy.

For two people staff had changed the dose of a medicine on the MAR; however, it was not clear when the dose had changed or who had authorised the dose change.

Care staff applied some creams. Although the medication policy stated that clear information on where to apply and the frequency of application should be available for care staff, we saw this was incomplete. We looked at the records for three people that had creams applied by care staff. There were no records kept for any of the three people to show when the topical preparations were applied and for one person the cream was not listed on the MAR.

When we checked a sample of medicines alongside the records for 14 people, we found that ten of the medicines including oral medicines and six people's nutritional supplements did not match up. This meant we could not be sure if people were having their prescribed medication administered correctly.

Four medicines for three people were out of stock. This means that appropriate arrangements for ordering and obtaining people's prescribed medicines was failing, which increased the risk of harm. Pain relief medicine for one person had not been given as prescribed for 19 days, because there was no stock.

For a medicine that staff administered as a patch, a system was in place for recording the site of application; however, staff had not fully completed this for one person whose records we looked at. This is necessary because the application site needs to be rotated to prevent side effects.

We looked at the guidance information kept about medicines to be administered 'when required'. Although there were arrangements for recording this information, we found this was not kept up to date and information was missing for some medicines. For example, several people were prescribed medicines for pain relief and there were no care plans or guidance in place to assist in their decision-making about when these would be used.

Appropriate checks had taken place on the storage, disposal and receipt of medication. This included daily checks carried out on the temperature of the rooms and refrigerators that stored items of medication. For all of September and October the maximum temperature recorded was over eight degrees centigrade. This is higher than recommended for cool storage and no action had been taken by staff to ensure medicines were safe to use.

Staff knew the required procedures for managing controlled drugs. However we saw that the controlled drugs records that staff had made on the MAR for one person did not match the records in the controlled drugs record book and that the stock balance records were incorrect. In addition, a nurse had incorrectly recorded the receipt of another medicine. This meant the registered provider was in breach of Misuse of Drugs Act record keeping requirements as well as the Health and Social Care Act 2008 regulations.

Relatives told us that staff had not followed assessment information for a new admission and had not adhered to guidance about how to provide their care. this included the need for an air flow mattress; positional changes every 30 minutes; and support to take fluids.

Risk assessments were not always in place. For example; care plans had a one page synopsis of people's care and dietary needs. One person's one page synopsis stated they needed normal fluids. Further on in their care plan it was recorded that the person needed their fluids thickened due to risk of choking and aspiration. There was no risk assessment in place for this.

Another person's Waterlow score (a tool for assessing pressure care needs) showed they were at very high risk of developing pressure sores. There was no pressure sore risk assessment in place.

Another person had a pressure sore on their heel. The family had raised concerns with the nominated individual that the pressure sore had been evident for at least a week and nothing had been done about it. We reviewed the person's care plan and this stated that staff needed permission from the doctor before they were able to dress the pressure sore. We found no evidence that the doctor had been consulted and therefore the pressure relieving equipment was not used, which placed the person at increased risk of developing further sores.

We found the registered provider had not ensured action was taken to reduce risks to people. This meant action was not being taken and this posed significant risks to the people who used the service's life, health and wellbeing.

This is a breach of Regulation 12 (Safe care and treatment) Heath and Social Care Act (Regulated Activities) Regulations 2014

We saw certificates for safety checks and maintenance which had taken place within the last twelve months such as fire equipment and water temperature checks. However the registered provider could not supply us with an electrical safety certificate and the passenger lift were due in August 2016, these had not taken place. On 14 November 2016 the registered provider supplied us with an electrical safety certificate dated 9 November 2016 and information to say the lifts had been serviced.

We looked at seven staff recruitment files and all of the available employment agency staff profiles. We found that the nominated individual had not obtained profiles for all of the agency staff who had worked in the home.

One permanent staff member had previously worked at the service as an agency nurse but was then employed directly by Lifestyle (Abbey Care) Limited in July 2016. The NMC had imposed conditions on their practice, which they had to meet in order to remain on register. Conditions in place, included the person could not administer medication until being assessed as competent. We found no evidence to show the nurse had been deemed competent to administer medication.

We also saw for some staff no Disclosure and Barring (DBS) checks had been carried out and for other staff the full information about any offences had not been obtained. The DBS carry out a criminal record and barring check on individuals who intend to work with children and/or vulnerable adults. This helps employers make safer recruiting decisions and also minimises the risk of unsuitable people from working with children and vulnerable adults.

Another staff member who commenced work as a senior care worker had declared on their application they had been a registered nurse. We found that this person was suspended from practicing nursing and part of this was for medication errors. The nominated individual had done no checks on why this staff member was suspended from practice. No medication competency checks had been completed since the person started work at the home and the last medication training certificate was dated prior to their suspension.

The service used agency staff for the majority of the shifts. We checked the information the nurse agencies had provided for nurses supplied for duty. The nominated individual had only obtained information for three agency nurses. The nominated individual was unable to tell us which other agency nurses had worked at the home or when.

The Nursing and Midwifery Council PIN number for one of the nurses recorded on the agency records did not match the name recorded on the agencies profiles. No checks had been done on this or to make sure nurses had valid PIN numbers.

We found the lack of safe, robust recruitment processes meant staff could be employed at the home or agency workers used who posed risks to service users life, health and wellbeing.

This was a breach of Regulation 19 (Fit and proper persons employed) Heath and Social Care Act (Regulated Activities) Regulations 2014

We found people were cared for by insufficient numbers of suitably qualified, skilled and experienced staff.

Some staff were working excessively long hours, which meant they were at increased risk of making

mistakes. One staff member had worked a 12 hour night shift, although the sign in record indicated they left the home at 8am we found they were still working at 11:30am. The lack of accurate recording meant the management team could not know who was in the building and this person was placing people at risk because they were working long hours.

Records showed that another agency staff member had worked both day and night shift on the same day on a number of occasions. We found they had worked at these times 24 and 72 hours at once. However they had never signed in or out of the building and the nominated individual told us they were not aware that this had happened.

During the inspection the call bells were ringing continuously. At one point because bells were unanswered we looked for a staff member upstairs and found none. We saw no member of staff on this unit for at least ten minutes. We had to use the alarm bell to obtain a staff member. We saw one person who worked in the kitchen and as a carer wearing their kitchen uniform even though they were working on care. This was unhygienic and compromises food safety guidance, such as harmful bacteria spreading to the kitchen.

We asked people and their relatives if they thought there was enough staff on duty. One person who used the service said, "It could be better here if there were more staff on duty." Relatives we spoke with said, "They can be understaffed on occasions and they use a lot of agency staff." Another relative said, "You come in on a weekend and there are no regular staff, it is all agency and they have no idea."

One nurse and five care staff worked during the day and one nurse and four care staff worked overnight. The home was large and spread over four units with three in operation. We found that people had high levels of need and all needed at least one-to-one support with personal care. Over a third of people needed two-to-one support with their personal care. We asked for but staff could not produce information about how staffing levels were calculated. We asked the nominated individual to explain how staffing levels were determined but received no answer. The staff we spoke with told us they had raised with management that there were insufficient staff but this was dismissed.

This was a breach of Regulation 18 (Staffing) Heath and Social Care Act (Regulated Activities) Regulations 2014

We looked at the arrangements that were in place for safeguarding vulnerable adults. The service had policies and procedures for safeguarding vulnerable adults, whistle blowing, accidents and incidents. Staff we spoke with understood the different types of abuse, how to report, escalation of concerns and whistle blowing procedures. However, it was of concern that they failed to recognise and report instances we found such as; people's personal care being neglected, staff instructing people to urinate in their pads rather than taking them to the toilet, the medication errors, that unknown staff entered the premises or that staff were working excessive hours. Following the inspection we raised a number of safeguarding alerts.

This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) Heath and Social Care Act (Regulated Activities) Regulations 2014

We saw that the service was clean and tidy and there was plenty of personal protection equipment [PPE] available. However the hand gel machines were all empty. This meant that people could not maintain appropriate hand hygiene and this compromised infection control guidelines.

On the first day of inspection we found the home smelt pleasant.

Inadequate

Is the service effective?

Our findings

We asked people who used the service and their relatives if they thought staff had the necessary training and skills to fulfil their role. One person we spoke with was concerned about staff cutting corners and said, "Members of staff are well trained although some choose not to use it." Another person said, "Agency staff are a problem but usually teamed with a knowledgeable member of staff." A relative we spoke with said, "The permanent staff are better trained to deal with residents than agency staff."

We were provided with a training matrix during inspection which highlighted some gaps in training. The dates on certificates we looked at did not match the dates on the training matrix. After the inspection we were provided with an up to date training matrix. Due to the confusion it was difficult to evidence if staff had received up to date training or not. One staff member's certificates showed they had received training at Archery Bower however the certificate was dated a good eight months prior to the person starting at the service.

The service had an induction policy that was reviewed in January 2016. The policy stated that all new care staff were required to complete 'The Common Induction Standards.' In April 2015 the Care Certificate replaced the Common Induction Standards. The Care Certificate is a set of standards that social care and health workers stick to in their daily working life. We saw 23 staff had joined Archery Bower since April 2015 but saw no evidence that any staff had completed the Care Certificate. We saw an induction record, which covered a wide range of topics such as reading policies, care plans, completing mandatory training and walking around the building. The records we reviewed showed staff completed this in one day, which was of concern because it would suggest this was either a tick-box exercise or a superficial induction. Agency staff told us they had no induction.

Staff had not received support through regular supervision and appraisals. Supervision is a process, usually a meeting, by which an organisation provide guidance and support to staff. The services supervision policy stated 'Staff should have the opportunity to attend a supervision session at least 6 times a year'. We did not see evidence of this in the records we looked at. Annual appraisals for staff who had worked over a year had not taken place. All of the staff we spoke with could not recall the last time they had supervision. Staff who had been at the home for over a year told us they had not had an appraisal. We concluded that staff were not supported in their role or with their development.

The nominated individual could not provide evidence of checks of the agency staff to ensure they had the necessary competencies or up to date training to provide care and treatment to people who used the service. No checks had been completed to ensure they had the skills and competencies to care for people who had conditions such as unstable diabetes, who required PEG feeds, or stomas or urinary catheters. We found the registered provider had given no consideration to their responsibilities to ensure staff were suitable to work at the home.

On 2 November 2016 the agency nurse on duty was different to the one the nominated individual believed to be on site. They had no information about this nurse's qualifications or details to verify their identity. This

meant staff were working with people and taking charge of the home without the necessary checks being made. No action was taken to ensure the agency staff had received the training they required or completed an induction.

This was a breach of Regulation 18 (Staffing) Heath and Social Care Act (Regulated Activities) Regulations 2014

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 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Discussion with the nominated individual indicated that 13 people were subject to 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. The care records we reviewed contained limited assessments of the person's capacity to make decisions.

We found staff had a limited understanding of the MCA and what actions they would need to take to ensure the home adhered to the code of practice. We found there were no capacity assessments even though evidence suggested some people might lack capacity. Care records did not describe the efforts that had been made to establish that the least restrictive option for people and the ways in which staff had sought to communicate choices to people. There were no records to confirm that 'best interest' discussions had taken place with the person's family, external health and social work professionals or senior members of staff.

Staff had failed to ascertain the legal status of family members when making decisions for people who used the service. No information was available to determine if relatives had lasting power of care and welfare or had been appointed as a deputy by the Court of Protection. Staff we spoke with were unaware that in order to make decisions for others and the person needs to have the legal authority to make care and welfare decisions.

During this inspection did not see evidence of consent to care and treatment records being signed by people where they were able, in all care files.

This was a breach of Regulation 11 (Need for consent), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed the lunch time dining both upstairs and downstairs. Whilst observing upstairs we found one member of staff sat at a table with four people who used the service. All four people required support with eating, therefore whilst the staff member supported one person the other three people's food got cold. The staff member serving the food was aware of people's likes and dislikes and once finished serving was able to support the other member of staff. Both staff members talked to people, encouraging them to eat their meals and tried their hardest to make the meal time a pleasant experience however with two staff it was difficult due to the amount of people who needed support.

Lunch on the downstairs unit was later than upstairs and there were three staff members. We were told that one staff member was supposed to support both upstairs and downstairs, mainly where needed. We did not

see the staff member attempt to go upstairs. We saw that the mealtime practice was very task based and people were objectified.

The mealtime did not support a dignified experience for all people using the service.

Three people needed support downstairs, whilst they were waiting for staff to be able to support them their food was kept warm in the heat locker. Two people were being supported with their lunch in their room by relatives. One relative we spoke with said, "I visit every day and collect food from the kitchen and feed my relative myself."

We asked people if they were happy with the food on offer. One person said, "I am happy with the food now a new chef has been employed at the home." Another person said, "Choice is limited but this is due to budget issues."

On the first day of inspection we spoke with the chef. The chef had only started at the home about a month before and said they were not happy with a budget of £600 a week for 57 people. They said, "An increase of an extra £200 would make things easier and give scope for choice." The chefs hours were 07:30 – 15:00 but they said this was not enough time and was working ten hour shifts. We discussed the hours and budget with the nominated individual but they denied it was a problem. On our second day of inspection the chef had left the service and a new cook was in post who had previously been a kitchen assistant. On 28 November 2016 the nominated individual informed us that the registered provider had agreed to increase the catering budget.

People's weights were not appropriately monitored, which meant referrals to GPs and dieticians were not made in a timely when people unintentionally lost weight.

These findings evidenced a breach of Regulation 10 (Dignity and respect) and Social Care Act (Regulated Activities) Regulations 2014

At the time of the inspection no notifications had been sent to us about people who had been subject to a Deprivation of Liberty Safeguards (DoLS) authorisation. At the inspection we found that no one had produced an overview of who was subject to DoLS authorisations, the expiry date and any conditions that had been imposed. Staff could not tell us who was subject to a DoLS authorisation or whether the authorisations were current. However, the DoLS documentation was available and we found they were in date.

Requires Improvement

Is the service caring?

Our findings

People and relatives we spoke with raised concerns about staff failing to treat people with dignity and respect.

One person who used the service said, "They don't have time to support me, if I want to go to the toilet, I have been told we don't have time, go in your pad, I don't like that." Another person said, "I asked for a shower one morning and was told I couldn't have one as they don't have time and the night staff will do it, the night staff didn't do it and I didn't even get a wash as they were so rushed, this is the norm. I don't feel my needs are being met, due to my illness I am doubly incontinent and often wear the same pad from 9am to 8pm."

People and relatives had mixed views about whether staff were caring.

People we spoke with said "The staff are caring and some go over and above their duties." Another person said, "Some are kind and considerate, some are abrupt." And another person said, "Night staff are very good." One person said, "The night staff are absolutely wonderful, especially [staff name] I can't believe the hours she does, she is supposed to finish at 8am but she is often here after nine supporting me, nothing is too much trouble."

A few people raised concerns about staff not understanding English. One person said, "We have so many foreign staff who are unable to communicate properly, I see them tapping people and saying repeat, repeat." Another person said, "There is definitely a language barrier." And another person said, "Foreign workers tend to pass the buck for example they are unwilling to give showers and tend to leave it for the night staff."

Relatives told us they found people appeared unkempt and unclean. We also found this to be the case.

A relative we spoke with said they felt staff did not treat their family member with dignity and respect. They said, "[person's name] was sat in a chair on Saturday and complaining they were cold, we checked under their blanket and found them to be naked from the waist down. We were so shocked; we had to raise a concern." They told us they discussed this with the nominated individual who had suggested they were making this up and could not understand why they were upset. We raised this concern with the nominated individual who felt the matter had been resolved.

We found that people were left unattended for long periods of time and if people soiled their clothing during the day were dressed in night attire. This both shows a lack of dignity and respect.

We saw that one person was nursed in bed and was accommodated in a room on wing of the downstairs with no other people despite there being empty rooms in the adjoining wing. Throughout the day we observed very few staff visited only coming onto the wing at mealtimes or to bring the person a drink at 11am and 3pm. None of the staff we spoke with saw this as an issue or recognised they were isolating the

person. We found no evidence documented that this was the person's choice.

We raised safeguarding alerts about the concerns we had regarding the respect and dignity of people.

This was a breach of Regulation 10 (Dignity and respect) Heath and Social Care Act (Regulated Activities) Regulations 2014.

We were told one person was receiving end of life care. This person had recently moved to the home. We asked to see the end of life care plan. The training manager was busy trying to put a plan together but said there was not one at that time. We asked what plans were in place for the end of life, the training manager said, "I know they [the person who place them at the service] said they are on end of life but I am not sure, they are very upbeat." We found that none of the staff were aware this person was receiving palliative care and the palliative care medication was not being used. Staff informed us that this person was fine and not nearing the end of their life. This person died before we came back for the second inspection day. We did not receive a notification about this until a fortnight later.

The training manager and administrator told us they had five days to write individual's care plans and this was why no information was available for this person and the person had not lived at the service for long.

This was a breach of Regulation 9 (Person-centred care) Heath and Social Care Act (Regulated Activities) Regulations 2014.

We asked people if staff promoted their independence. One person said, "I need to have assistance due to illness so not really independent." Another person said, "I am encouraged to do as much as possible such as washing and cleaning my teeth." And another person said, "Staff listen to me providing they understand what I am saying."

Staff we spoke with explained how they ensured people's privacy. One staff member said, "I always knock on the door before entering." Another staff member said, "If we are undertaking personal needs we put a sign on the door and keep it closed." We saw evidence of a sign being put up asking people not to enter. A relative we spoke with said, "The staff put a card on the door, they keep the door and the curtains closed when seeing to my relative's needs."

Information on advocates was available however nobody was using an advocate at the time of the inspection. Advocates help to ensure that people's views and preferences are heard.

The environment supported people's privacy and dignity. The majority of bedrooms we went into contained personal items that belonged to the person such as photographs and pictures and lamps.

Inadequate

Is the service responsive?

Our findings

We asked people who used the service and their relatives if they were involved in their plan of care. We received mixed reviews, one person we spoke with said, "I am involved in reviewing my care plan." Another person said, "No I am not involved with discussions." Relatives we spoke with said, "I am totally involved with the care." Another relative said, "I am involved in reviewing the care plan." And another relative said, "I have asked to see the care plan but I have been ignored."

During this inspection we looked at nine care plans. We found the care records were not stored securely. The care records were in an unlocked cupboard in the admin office where the door was left wide open throughout both inspection days. This meant that any visitors had easy access to confidential information.

On the first day of inspection we asked to see a care plan for a person who had been admitted into the service the week before. We found a staff member quickly printing off sheets from the computer to make up this care plan. We asked to see and found the care plan was empty other than the one sheet the training manager had printed off. However we saw that one member of staff had signed to say they had read and understood this person's whole care record.

We asked the staff member who was printing this care record what their job role was, we were told they were the registered manager, training manager, administrator and personal assistant to the nominated individual. We later found out this person was the training manager not a registered manager. The nominated individual could not detail what qualified this person to write the care plans and assessments for people who used the service.

Four care records we looked at contained exactly the same assessment and care plan information. The information in each care plan was identical all that had been changed was the person's name. Some of the documents had been assigned the wrong gender for people. This meant the documents were not person centred and did not contain peoples preferences

One person who had arrived at the service on the 21 October 2016 had extremely complex needs. We found there was no written assessment for this person prior to coming to Archery Bower, which stated they could meet this person's needs. On the 25 October 2016 we could find no care records or daily records for this person. Therefore for four days the registered provider could not evidence any care had taken place. We raised this issue with the nominated individual and later in the day a set of records were produced. They were very generic and replicated other people's records. The records produced did not highlight this person's complex needs and care requirements such as two hourly turns and needing 1500mls of stage 2 thickened fluids a day. The relatives of this person told us they spoke to staff and explained the importance of this person's needs. On our second inspection day on the 2 November we checked this person's care records and found they still did not include vital information such as nutritional needs, choke risks or the need for regular positional changes. This meant that the service was failing to ensure this person's care needs were being assessed and care plans produced to meet identified needs.

On 2 November 2016 we found that people had been admitted to the home from 27 October 2016 and their care plans were still being produced. All of the available ones were generic and replicated other people's records. Some contained references to other people or inferred the person was of a different gender, which meant they may not be accurate.

Staff and the nominated individual were unaware of how many people were living in the service and failed to identify that an individual had been admitted on 1 November 2016. This person had no care plans and no MARs despite them requiring medication. This meant they had missed doses of their prescribed medication.

One person arrived at the service on the 16 September 2016; they then had a brief stay in hospital and returned to the service on the 20 September 2016. This person's family were concerned that certain aspects of their care had changed dramatically from before and after hospital. We asked to see the care records for this person prior to their hospital visit and we were told they no longer had them. Guidance on the storage of records states care records should be kept for three years.

There was no evidence in the records seen of the involvement of the individual or family in review of the care plans we looked at. One person's relative said if the person was nearing the end of their life it was their wish to take them home. The care records for this person stated the family wishes them to stay at Abbey Care. The family stated they had not been involved with the care plan, which meant they were not being consulted and their views were being disattended.

Daily notes were kept separately for each person with records regarding their basic care, how they had been that day and any updates. We found these to be missing, lacking detail or completed in advance. For example one person's daily records had been completed for the upcoming night. This meant staff were not producing an accurate record and in some instances falsifying care records.

This is a breach of Regulation 9 (Person centred care) Heath and Social Care Act (Regulated Activities) Regulations 2014.

We looked at the registered provider's complaint's procedure. The nominated individual had documented five complaints they had received. Each complaint had no recorded outcome to show the complainant was satisfied with any investigation. The main complaint recorded was around carpets not being clean and one complaint was about lack of communication.

We asked people who used the service if they knew how to make a complaint. People we spoke with said, "I know how to complain and I have done in the past." Another person said, "I would ask to speak to [name of nominated individual] but on past experiences they have not been interested." And another person said, "I have not complained but if I had cause to I don't think [name of nominated individual] would take it kindly and could be a bit of a Jekyll and Hyde character." Another person we spoke with said "I wouldn't complain, it might have repercussions I just jog along and conform."

Another person said they spoke to the deputy manager about their concerns and was told it was their responsibility to ask to be changed, but when the person asked they were told it would not be until 4pm, the person asked to be changed at about 1pm. This person went on to say, "The carers must have been told about my complaint as they were rough with me the next day and banging and clashing things, I felt intimidated." We raised these concerns as a safeguarding alert with the local authority.

Relatives we spoke with said, "I always speak to staff and the manager [nominated individual] about any concerns." Another relative said, "If I have any complaints I speak to the manager [nominated individual]

who responds promptly." And another relative said, "The manager [nominated individual] only records certain complaints." Other people told us that when they had raised concerns the nominated individual had become very angry and suggested they leave the home.

We were aware of two complaints that relatives had put in around the time of our inspection and both these complaints were not recorded. We discussed this with the nominated individual who told us they had not been made aware of the concerns and thought people were happy with the service.

This is a breach of Regulation 16 (Receiving and acting on complaints) Heath and Social Care Act (Regulated Activities) Regulations 2014.

During both days of inspection we did not see any evidence of activities taking place. There was an outdated list of upcoming activities on the wall but nothing recent.
We asked people if there were activities taking place and if they enjoyed them. People we spoke with said, "I would love to do some knitting but I don't get the chance." Another person said, "I like to read the newspaper but they are not always available." And another person said "They give me word searches to do."

People said they had the choice whether they wanted to join in activities or not. We saw a lot of people chose to spend a lot of time in their room watching television. Staff we spoke with said, "We encourage people to sit in the lounge so they have company and are not socially isolated. " Another staff member said, "We have lots of activities going on such as nails and hair, or we go to the local pub. We had a 40's party in the garden and a singer comes in regularly."

Although an activities coordinator was recorded as working at this and a sister home we never observed them working. People and staff told us there were rarely any activities. We found no evidence in people's records to show they were supported to engage in meaningful activity or to assess local community facilities.

This is a breach of Regulation 10 (Dignity and respect) Heath and Social Care Act (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

Relatives gave mixed views about whether the home was well-run and met people's needs. Some reported that they were very satisfied with the care their relatives received whilst others were extremely unhappy about the care being provided. One relative said, "Staff are kind and considerate, they sit with my relative when doing paperwork so they [relative] have company." Another said, "We are desperately trying to find another care home as the home is badly run and provides an unacceptable level of care. This is the worst home my relative has been in."

No registered manager has been in post since January 2014. In October 2016 a manager had been appointed but they only worked at the service for a week and then left. The nominated individual had subsequently been working as the acting manager. Prior to 28 November 2016 we were informed that a new manager was being appointed.

We have written to the registered provider about their failure to meet this condition of their registration. To date no application to register a manager has been submitted.

This is a breach of the registered provider's conditions of registration and we are taking action outside of the inspection to deal with this matter.

The nominated individual and staff completed audits on, for example, medication, kitchen, cleaning, night care and philosophy of care. We looked at how medicines were monitored and checked by management to make sure they were being handled properly and that systems were safe. We found that the provider had completed a medication audits but these were not robust and had not identified the issues we found. Where issues were identified there was no action plan in place to address them. Despite us raising issues around the management of controlled drugs on 2 November 2016 when we returned we found that no action had been taken to investigate the discrepancies.

The kitchen audit was ticked to say everything was fine each month. In October 2016 we had been informed by the new manager (now left) there was a robust kitchen audit, which had highlighted many concerns and an action plan. They told us the registered provider would not let them action this plan so the concerns were not addressed. The kitchen staff we spoke with confirmed that there were a range of concerns and although some action had been taken to provide sufficient catering equipment items were still needed.

All the audits we reviewed contained a list of ticks, which indicated everything was fine. An undated night care audit completed by staff stated everything was fine. The nominated individual said they also came in during the night to do spot checks. However they could produce no records to confirm these visits occurred and could not provide a date of when this was done or the last time they visited.

We asked the nominated individual what system they had in place for receiving feedback from people and their relatives. These were not dated so we could not establish when these were sent or returned. The main issue raised on the survey was the need for carpet replacement and a need to provide a varied menu. We

asked the nominated individual what they had done about the feedback. The nominated individual told us they were looking at updating the menu and the carpets had been cleaned.

We asked people who used the service if they had completed a survey and were involved in the running of the service. One person said, "I am not involved in the running of the service and I have never been asked to complete a survey." Another person we spoke with said, "No, not involved no one has asked me what I think of the care here."

We found records relating to the care and treatment of each person using the service were not fit for purpose or held securely. Records were stored in an unlocked office in the reception area and unlocked trolleys on the units. Data storage guidance states that all paperwork relevant to a person must be archived for three years from the person leaving the service. We found that staff overwrote the computer generated care plans and did not keep previous documentation.

Records asked for were not easily at hand and it took persistent requests to gain the information we needed. We needed to wait several hours before we received the risk assessment for a staff member. This was dated 31 September 2016 with no evidence of review or update.

We found processes for assessing and monitoring the quality of the service was not effective. Information was not up to date, accurate or properly analysed. Systems in place did not identify and assess risks to the health, safety and welfare of people who used the service. For example they failed to identify the medication errors, lack of robust recruitment processes and poor care.

We found that the registered provider had not displayed the rating for the home either on site or on their website. We reminded them it was a legal requirement.

We have not been sent notifications about incidents and DoLS authorisations. We have written separately to the registered provider about this failure to meet the statutory notification requirements of the Care Quality Commission (Registration) regulations 2009.

We found that the nominated individual and deputy manager were unaware who was in the building. There was lack of governance regarding the use of unsuitable agency staff. We reviewed records submitted by the registered provider, which indicated that agency staff paid them to have accommodation in the home. Staff and agency employees informed us that staff were accommodated in empty rooms in the home and these staff had free access to people and the food. This meant that the nominated individual and registered provider allowed this practice to occur and had not looked at the associated risks this may pose.

This was a breach of Regulation 17 (Good governance) Health and Social Care Act (Regulated Activities) Regulations 2014.

We asked staff if they felt supported by the nominated individual. Staff we spoke with said, "Yes I feel supported most of the time." Another staff member said, "They are approachable, quite strict but has a heart."

We found that meetings for people who used the service and their relatives took place. Topics discussed were food, activities and signing into the building. A recent meeting had been held to discuss the menu and people had asked for more variation of sandwiches and toasties.

We asked staff what they thought the visions and values and the culture of the service was. One staff

member said, "The culture is everyone is an individual." Another staff member said, "The culture is to be open and honest." And another staff member said, "The services visions are to have more residents, more staff and keep a happy and healthy environment."

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 Care and treatment was not appropriate, did not meet individuals needs and did not reflect their preferences. Regulation 9 (1), (2) and (3)

The enforcement action we took:

We issued a notice of decision under section 31 preventing further admissions without the registered provider first obtaining permission from CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not treated with dignity and respect. Regulation 10 (1)

The enforcement action we took:

We imposed 10 conditions in relation to checking the fitness and competencies of the sole director, the nominated individual, training manager, employees, agency staff and inform us of the outcome of these. Also they needed to review each person's care records and supply us with updated risk assessments and care plans. Finally they needed to supply us with information each week to confirm sufficient suitably qualified and experienced people worked at the home.

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 Staff did not adhere to the principles of the MCA and also informed consent to care was not obtained. Regulation 11 (1) and (3)

The enforcement action we took:

We imposed 10 conditions in relation to checking the fitness and competencies of the sole director, the nominated individual, training manager, employees, agency staff and inform us of the outcome of these.

Also they needed to review each person's care records and supply us with updated risk assessments and care plans. Finally they needed to supply us with information each week to confirm sufficient suitably qualified and experienced people worked at the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not receiving safe care and treatement

The enforcement action we took:

We issued a notice of decision under section 31 preventing further admissions without the registered provider first obtaining permission from CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from abuse and improper treatment. Regulation 13 (1)

The enforcement action we took:

We issued a notice of decision under section 31 preventing further admissions without the registered provider first obtaining permission from CQC..

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The equipment was not properly maintained. Regulation 15 (1) (e)

The enforcement action we took:

We issued a notice of decision under section 31 preventing further admissions without the registered provider first obtaining permission from CQC..

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 Complaints were not investigated and acted upon. Regulation 16 (1)

The enforcement action we took:

We imposed 10 conditions in relation to checking the fitness and competencies of the sole director, the nominated individual, training manager, employees, agency staff and inform us of the outcome of these. Also they needed to review each person's care records and supply us with updated risk assessments and care plans. Finally they needed to supply us with information each week to confirm sufficient suitably qualified and experienced people worked at the home.

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 Systems and processes for overseeing the service were ineffective and led to people being place at serious risks to their health, life and well-being.

The enforcement action we took:

We imposed 10 conditions in relation to checking the fitness and competencies of the sole director, the nominated individual, training manager, employees, agency staff and inform us of the outcome of these. Also they needed to review each person's care records and supply us with updated risk assessments and care plans. Finally they needed to supply us with information each week to confirm sufficient suitably qualified and experienced people worked at the home.

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 Recruitment processes were not operated effectively. Regulation 19 (1), (2), (3) and (4)

The enforcement action we took:

We issued a notice of decision under section 31 preventing further admissions without the registered provider first obtaining permission from CQC.

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 Insufficient suitably qualified, competent, skilled and experienced staff were deployed at the home. Regulation 18 (1) and (2)

The enforcement action we took:

We issued a notice of decision under section 31 preventing further admissions without the registered provider first obtaining permission from CQC.