The Elms Residential Home Limited

Butterhill House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 15 and 16 August 2016 and was unannounced. At our last inspection in April 2016 we found that the service was not meeting the required standards. Regulatory breaches were identified and the service was judged to be requiring improvement. The breaches were in relation to the safe care and treatment of people, and safeguarding people from abuse and improper treatment. At this inspection we found no improvements had been made. There were continuing breaches in relation to the safe care and treatment of people, and safeguarding people from abuse and improper treatment. Four further breaches were identified regarding staffing, employing people, treating people with dignity and respect and governance arrangements.

The overall rating for this service is Inadequate which means it will be placed into 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.

Butterhill House provides support and care for up to 28 people, some of whom may be living with dementia. At the time of this inspection 21 people used the service.

The service did not have a registered 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.

Risks to people were not always minimised through the effective use of risk assessments. There were insufficient suitably trained staff to keep people safe and meet people's care needs in a timely manner.

Staff did not always have the knowledge and skills required to meet people's individual care and support

needs. The provider did not have robust recruitment and vetting procedures. Staff did not always have the induction, training and supervision they needed.

People did not receive care that was personalised and reflected their individual needs and preferences.

The principles of the Mental Capacity Act 2005 were not followed to ensure that people were consenting or being supported to consent to their care and support.

Care was not always personalised and did not meet people's individual needs. Advice from health professionals was not followed; therefore the action needed to relieve people from discomfort and distress was not taken.

People's medicines were not managed or administered safely.

Leisure and social activities were provided occasionally and arranged by the care staff in addition to their care duties. People's right to privacy and dignity was compromised.

Complaints were not always managed appropriately.

Systems in place to monitor the quality of the service were ineffective. The management systems were insufficient to provide leadership and guidance to the care staff. People were at risk of receiving poor, inconsistent and unsafe care. No improvements had been made since the last inspection.

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 were identified and reviewed but not always managed in a safe or consistent way. There were not always enough staff to keep people safe and meet people's care needs. Recruitment procedures were ineffective. Medicines management was not safe and not administered correctly.

Is the service effective?

Inadequate

The service was not effective. People did not always consent to their care, treatment and support. People's nutritional needs and preferences were not always met. People did not always receive the health care support they needed. Staff did not always receive adequate induction, training and supervision to ensure they provided support in a safe effective way.

Is the service caring?

Inadequate

The service was not caring. People's privacy and dignity continued to be compromised. Institutional routines did not afford people the person centred care they required.

Is the service responsive?

Inadequate

The service was not responsive. People did not receive personalised care that reflected their needs and preferences. Institutional routines did not afford people the person centred care they required. Complaints were not always addressed and action was not always taken to improve people's experiences, comfort and lifestyles.

Is the service well-led?

Inadequate

The service was not well led. There was no registered manager in post. Systems the provider had in place to monitor the quality of service were ineffective and improvements had not been made since our previous inspection.

Butterhill House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The inspection took place on 15 and 16 August 2016 and was unannounced.

The inspection team consisted of two inspectors 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 care service.

We looked at the information we held about the service. We looked at the notifications that we had received from the provider about events that had happened at the service. A notification is information about important events which the provider is required to send us by law. We reviewed the information we received from other agencies that had an interest in the service, such as the local authority and commissioners.

We spoke with 10 people who used the service, three people who visited the service, three members of care staff, the manager and the nominated individual. We spoke with other people but due to their communication needs they were unable to provide us with detailed information about their care. We looked at care records relating to the care of eight people who used the service. We also examined medicines administration records, training records, staff recruitment records and staff rotas.

Inadequate

Is the service safe?

Our findings

At the inspections in March 2015 and April 2016 we had concerns with the way medicines were being managed and administered. The provider was in breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) 2014. We took action and told the provider that improvements had to be made in relation to medicines management. We issued a compliance action in March 2015 and received an action plan from the provider informing us that action had been taken and the improvements made. We looked at medicines management again at the inspection in April 2016 and found that night staff still had not received the necessary training to administer medication to people during the night. We issued a warning notice telling the provider that improvements must be made. At this inspection we found staff training was still outstanding and there continued to be a breach of this Regulation.

Some people had been prescribed medicines that could be given on an 'as required basis', these are sometimes referred to as PRN medicines. We saw that some people had been prescribed PRN pain relief which could be given on request. We looked at the staffing rota and saw staff were allocated for night duty. Both the provider and the manager confirmed the staff on night duty the week beginning 15 August 2016 had not received medication training. This meant people who requested pain relief during the night experienced delays whilst the night staff woke a member staff who slept on the premises if one was available. The provider told us the sleeping staff were trained to administer medication, however they were not paid or identified to be on call. There were no records that the sleeping in staff had agreed to this or risk assessments had been completed to ensure safe procedures were in place. People who used the service were at risk of medication errors that may occur when sleeping staff were woken as they were not officially on the rota to complete this task.

People did not get their medicines as they had been prescribed. For example, one person was prescribed a seven day course of treatment which had specific administration instructions. The Topical medicines and Trans-dermal patches administration record (TMAR) recorded the instructions of 'apply three times daily and arrange review if not resolved in one week'. The TMAR was not completed to evidence the treatment was provided three times per day, there were gaps so the dates were not consecutive and the record showed a period of 18 days. No review had been completed. This meant the person did not receive their treatment in line with the instructions for the correct length of time or in a consistent way. We saw throughout the inspection the person continued to experience discomfort and distress from their medical condition for which the cream had been prescribed.

We saw that one person had been prescribed a sedative with the instructions one or two at night. The senior care staff told us: "I always give two as [the person] seems to sleep better". There were no clear instructions for when the person may require either one or two tablets. This meant the person may have been receiving the higher dose of this sedative when they didn't always require it.

Risk assessments were completed but those that we examined did not correspond with staff working practices. We saw one person was unsteady on their feet; they had poor mobility and were at risk of falling. We saw the person was unstable when they walked with a frame. The person's risk assessment and care

plan indicated the use of a wheelchair for when their mobility was poor. We spoke with staff and asked how they supported the person with walking, they said: "No we don't use a wheelchair". This meant this person's safety and wellbeing were at risk of harm as staff were not following the person's risk assessment for when they were having difficulty with their mobility.

We observed poor moving and handling techniques and saw people were at risk of slipping out of wheelchairs because as staff told us: 'They[the person] had not repositioned the person correctly'. We observed two members of staff, the senior carer and the provider tried over a 30 minute period to transfer the person, and using the hoist, from a wheelchair into arm chair. The person was eventually transferred into an arm chair but the length of time in the wheelchair, the hoist and sling impacted on their wellbeing and comfort. This person was at risk of harm and injury due to the unsafe moving and handling techniques.

We had concerns regarding the provision of safe care. We observed a person who used the service, who was dependent on staff for all activities of daily living, had slept in a high profiling bed that had been condemned and labelled clearly, do not use. We saw a red sticker had been placed on the plug following a portable appliance test in July 2015 which said 'rejected do not use'. No precautions had been put in place to minimise the risk of harm whilst using the bed. The electric profiling bed was removed immediately when we notified the provider and a divan type bed was provided. The divan bed was not fitted with bedrails; the person had been assessed as needing bedrails for safety when in bed. This meant this person was at high risk of harm to their safety and wellbeing.

We had concerns about infection control and the immediate risk to the health of people as we became aware of the extremely unhygienic physical conditions of the environment. A relative told us: "With a few more staff it could be cleaner". A person who used the service told us: "If someone makes a mess the staff clean it up quickly". However we saw chairs in the lounge areas were soiled with some fabric on the cushions ripped so that the foam was uncovered. The occasional tables from which people ate their meals were dirty and with food debris and stains. Carpets were old and worn; a piece of tape had been placed over the carpet and on the threshold of a door way where it had been damaged and frayed. This presented people with a tripping hazard and a risk to their safety.

In people's bedrooms we saw commode pots were not emptied after use. We saw care staff had served breakfast to one person, the commode had been used but care staff had not attended to it or replaced the lid. The person had to eat their breakfast next to an open commode full of human waste. We saw commode pots in other people's bedrooms that had not been washed or disinfected to reduce the risks of cross infection. We saw one pot that was extremely dirty with brown and black stains around the rim and inside the pot. We saw other equipment being used that was in need of a thorough clean, for example the mechanical hoist, the foot plate of the stair lift, and wheel chairs. People were at risk of infections due to the unhygienic equipment being used.

We saw a sling used with the mechanical hoist to transfer people when they wanted to use the facilities. We saw the same sling being used to transfer numerous people. Staff told us that people did not have individually named slings for use with the mechanical hoist. This presented a risk of cross-infection.

Areas around the service were unable to be cleaned sufficiently because the silicone around the floor, in bathrooms and toilets had disintegrated, presenting a high risk of cross infection and meaning it could not be cleaned properly. Soiled and overnight laundry was placed directly on the floor and not into laundry bags. We saw dead flies on window sills in the communal areas and people's bedrooms and in the lamp shades. There were dead insects on the floor in the corridor. Ineffective cleaning schedules and the lack of infection control procedures meant people who used the service were at risk of cross infection and

accommodated in an unhygienic, unpleasant environment.

This was a continuing breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) 2014. Care and treatment was not provided in a safe way.

Staff, people who used the service and visitors all commented on the shortage of staff. We asked a visitor about the staffing arrangements and if they felt there were sufficient staff to meet their relative's needs, they told us: "No, they are very overworked. Mum is worried about getting to the loo at night time". People who used the service told us staffing levels were low. One person said: "No there are not enough especially if two staff are needed to help someone. There are not enough staff on nights". Another person who used the service became tearful and told us: "There are only two staff on at night. I have to wait sometimes they [the staff] don't seem too happy that I have had to call them when I need to go to the toilet. It can be very embarrassing at times". This meant that some people who used the service were at risk and their safety and wellbeing compromised because the staffing levels were inadequate to provide the care and support people required.

On 15 August 2016 (the first day of the inspection) there was one senior carer and two care staff to provide care and support to 22 people who used the service. One person had planned to go home during the morning and was waiting for staff to support them with their preparations. Care staff told us that all people needed some level of support, and some people required two staff to support them. We heard the call bells rang constantly from 9am to 10.45am as people wanted help to prepare for the day. We observed one person was in bed in the same position for two and three quarter hours before they received support from staff. Staff told us the person was frail and regularly stayed in bed. We saw two other people were in bed for the duration of the day, they received limited contact and support from staff. This meant people experienced delays in receiving support from staff because of the insufficient numbers to support people in a timely way.

People did not receive or were not offered any refreshments for a period of two and half hours due to lack of staff to provide drinks. We saw that jugs of squash were available in the dining room for people to help themselves. However there were many people who had poor mobility and were unable to walk independently so would not be able to access these refreshments. People relied on the staff to provide them with refreshments. This meant that people were at risk of dehydration because staff were unavailable in sufficient numbers to provide help and support.

We saw that a risk assessment for one person identified the person as being at 'high risk of falls'. The action needed to reduce the risk for this person was recorded as, 'lounge not to be left unattended'. We observed this person and other people who were frail and dependent on staff sat in the lounge areas, staff were not in the vicinity. This meant staff were unavailable to provide this level of observation and people were at risk of falling.

Ancillary staff were not in sufficient numbers to attend to the laundry or the cleaning of the premises. Dirty washing was left in the laundry as there were no staff to attend to this. The duty rota indicated that cleaning staff had not been on the premises for a period of five days. The lack of ancillary staff was not conducive to ensuring people lived in a clean and hygienic environment. Care staff told us when time allowed they sorted out the laundry and did any surface cleaning that was needed. In addition we saw the care staff helped with providing people with food and drink and facilitating recreational activities.

The provider did not ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced staff to provide safe and effective care to people who used the service.

These issues constitute a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the way in which staff had been recruited to check that robust systems were in place for the recruitment of staff. In one personnel file we inspected we saw that references had been gained but these had not been translated in English. We were unable to ascertain the suitability of the references. The provider was sure the references had been translated but was unable, at the time of the inspection, to show us the translated copies. This meant that people were at risk of receiving care and support from people who may be unsuitable.

Agency carers were used to supplement the vacancies for the permanent staff on both days of the inspection. The agency carers both confirmed they had not worked at the service before and they had been given a tour around the building and told where the fire exits were. We asked the manager and provider how they ensured the agency staff were safe and suitable to work at the service. They told us if they had concerns they would ring the agency and request this information although this was something they did not do routinely. No information had been gained prior to these two carers working at the service and providing care and support to people. This meant the provider compromised the safety of people who used the service by not ensuring staff were of good character, had the skills, competence and experience to provide the necessary care and support.

These issues constitute a breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

At the inspections in March 2015 and April 2016 we had concerns that the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were not consistently followed to ensure that people's rights were respected. The provider was in breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) 2014. We issued a compliance action in March 2015 and received an action plan from the provider informing us that action had been taken to ensure people were not deprived of their liberty unlawfully and staff were to receive training. We looked at the MCA and DoLS at the April 2016 inspection and found the referrals for authorising restrictions for some people had been made. However some people continued to have their rights to freedom and liberty compromised and restricted. We issued a warning notice telling the provider that improvements must be made. At this inspection we found that some improvements had been made but we continued to have concerns regarding people's rights.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The DoLS is part of the MCA 2005. The legislation sets out requirements to make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom.

The manager told us that DoLS referrals had been made for people who lacked capacity, where they had their liberty and freedom restricted. We were unable to establish how many referrals had been made as the file used for audits and checks had gone missing so was unavailable for inspection.

The manager told us and we saw that a DoLS referral had been completed and sent to the local authority for the legal authorisation to restrict the person's freedom of movement. The application had not been authorised because the person had capacity to make decisions. The person in question was constantly monitored for their whereabouts every two hours during day and hourly at night. We saw monitoring records were completed each day. The care plan and risk assessment for this person had been completed with details about monitoring their safety but the documents had not signed by the person as being discussed or agreed. This meant the person's freedom and liberty was being compromised and care was not being delivered in accordance with consent or the principles of the MCA.

We saw a pressure mat had been placed in a person's bedroom at the point of their admission to the service. A risk assessment had been completed which identified the person was at high risk of falls. We saw no DoLS referral had been completed. A mental capacity assessment had not been completed to ascertain the decision making abilities of the person or that the use of the equipment was the least restrictive way to ensure the person's safety. This meant this action may not be in person's best interest or the least restrictive way to support the person with their safety.

We saw a care plan for another person for 'non-compliance to personal care and getting out of bed' it was recorded: "Be assertive and persistent if necessary". There was no reason given for this, and we could find no

record of any best interests meeting or discussions having been held in relation to this. This meant this course of action may not be in the person's best interests.

We saw restrictions were in place that affected all of the people living in the home for example, locked doors, bed rails, set meal and drinks times, constant supervisions and monitoring. There was very little evidence to ascertain the least restrictive way of delivering care, and no process for taking into account the best interests of those who may lack capacity. People's freedom and liberty was generally being compromised meaning that their care was being provided in a way that was unnecessarily restrictive, degrading, or disregarding of their needs.

These issues are a continued breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) 2014.

We saw a recently appointed carer was providing care and support to people. They told us they had received no induction, no training, competency assessments or supervision since they started working at the service. We looked at their personnel file; the required information regarding induction, training and supervision was not available. The provider told us this person had recently completed training in their previous place of work but they were unable to show us their certificates of training. This meant that people were at risk of receiving care and support from people who did not have the necessary skills or experience.

We saw two carers used the mechanical hoist to transfer a person from wheelchair to arm chair. The care staff had difficulty with positioning the sling around the person and the person was at risk of slipping out of the wheelchair. The sling used with the hoist had been positioned incorrectly across the person's chest, causing them discomfort. The two care staff told us they had not received any training in moving and handling or for the safe use of the hoist. The manager and provider were unable to evidence that these two staff had received training and had been assessed as competent to use the hoist. There was no clear leadership and direction offered to staff whilst completing their duties which led to poor practice being observed and people were at risk of harm and injury.

A care staff told us they had worked at the service for six months but had not received training in dementia awareness, catheter care or moving and handling. We saw this care staff supported people who were living with dementia, had indwelling catheters for continence issues and needed transferring with the use of the hoist. This care staff had a kind attitude when in contact with people but had limited knowledge of catheter care and we saw they were not skilled with the use of the hoist. This meant that this staff member would not be able to recognise the need for medical attention or extra support if there were problems with the catheter or other areas of this person's care. The manager told us of the plan to roll out training in first aid to staff over the coming week.

The manager had previously told us the provider had agreed to obtain training packs from an outside source to ensure staff had the latest and up to date training they needed. The manager had identified that an up to date training planner was needed to ensure they were aware of what training staff required, what had been completed and when updates and refreshers were needed. Staff told us they were unaware of these training packs and that most of the training they did complete was on the Social Care TV site. The manager was unable to show us the training planner but stated that training certificates were in a file waiting to be filed into staff's individual files. We were unable to ascertain the training staff had completed. People were at risk of having their care and support provided to them by untrained and unskilled staff.

These issues are a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) 2014.

People s health care needs were not always met and instructions from health professionals were not always followed. There was a failure to observe the express instructions of health professionals. We saw that one person had a health condition that caused them great distress and discomfort. Monitoring of this person's prescribed treatment had been overlooked completely by the provider, and we sought medical support for the person from a visiting district nurse. That nurse supplied advice for the person's overnight care until the doctor visited. When visiting the next day we observed that the nurse's advice had been ignored, meaning the person continued to be in extreme pain and discomfort.

We saw another person who had been assessed by the speech and language therapist as needing a fork mashed or pureed diet because of problems with swallowing. It was recorded on their food monitoring record they had been offered and consumed sandwiches. The person was at risk of harm because staff were not adhering to professional advice.

This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) 2014.

People who used the service offered mixed views on the food provided. Some people told us they get asked whilst they are at the dining table what they would like to eat. However people's specific dietary needs were not always catered for. One person who used the service told us: "I am a vegetarian but the cook keeps making me fish pie or can only offer me chicken. I don't like potatoes but the cook keeps serving them up to me. My son brings in three packets of couscous at a time and the cook cooks two of them at once and serves them to me on a plate. I have repeatedly asked for only one packet to be cooked at a time but the cook ignores that". Another person who used the service commented: "It's [the food] alright I suppose. We don't get much choice or say in what we would like though. We have faggots once a week, fish pie (mainly potato) once a week and chicken once a week. There is a revolving one week menu. All the food is bland".

We observed the lunch time meal; people were encouraged to use the dining facilities and some people needed support from staff. The tables were not prepared in advance of the meal. Cutlery was placed in front of people as they arrived at the table. People were not offered napkins but were routinely provided with blue plastic aprons. We saw very little action was taken when people did not eat their meal the plate was taken away from them with very little comment. We saw that where needed pureed diets were provided. However a district nurse told us they had asked the manager to ensure the diets were fortified to ensure people received adequate calories and nourishment each day but this had not happened. Some people had fluid and diet charts to monitor their daily intake. We saw not all of the charts had been sufficiently completed so we could not be assured that people received sufficient daily nutrition and fluids to fully meet their needs.

Inadequate

Is the service caring?

Our findings

At the inspection in April 2016 we had some concerns that the service was not consistently caring as we saw some staff working practices were not as caring as they should have been.

At this inspection we continued to have concerns that people's dignity was compromised. We witnessed one person being transferred with the use of hoist. Staff did not ensure the person's dignity was upheld with this manoeuvre, they were in a communal area with other people in the room. We saw that person's underwear and continence aids clearly on show when they were transferred from wheelchair to arm chair. We spoke with staff about this lack of attention to the person's dignity. Staff told us this was because their skirt had been put on incorrectly when they were supporting them with personal care and it hadn't been repositioned correctly. This person was not treated with the dignity and respect that was expected.

We saw several other incidences where the right to peoples' dignity and respect had not been endorsed. For example one person was served breakfast in their bedroom, the commode had been used and contained human excrement, the commode lid was not used, this did not promote a dignified dining experience. Another person had a strong odour of urine, the manager and provider said in addition to incontinence the person had bad halitosis, however they offered no explanation as to what was being done about this. This did not promote this person's self esteem and dignity. We saw one person had an indwelling catheter to support them with continence, we saw the catheter bag was hanging below their skirt. We advised staff three times about this but no action was taken, this showed that staff were not always treating people with dignity and respecting their right to privacy. People were not being treated with dignity and respect and attention to detail was not evident in the care being provided.

We saw no communication between a member of staff and one person when they needed support to go to the toilet. The person's care plan stated: "[Person's name] finds it difficult accepting intimate tasks and reassurance needs to be given and prefers female carers". Despite this clear instruction, we saw one male carer took the person to the toilet without asking or speaking with the person. This person was not being supported in a caring or compassionate way and their requests were not being respected.

This was a continuing breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) 2014. People were not treated with dignity and respect.

Inadequate

Is the service responsive?

Our findings

At the inspection in April 2016 we had some concerns that the service was not consistently responsive for the needs of people who used the service. Limited recreational and leisure activities were sometimes available and further improvements were needed to ensure these met everyone's individual needs.

We observed no recreational activities were arranged, the care staff were busy attending to the care and support needs of people. As with the findings of the inspection in April 2016 the activity board in dining room listed various activities for the seven day period. This programme of events bore no relation to the activities that were provided and was out of date. Staff told us they arranged activities when they had time to do, and this was not very often. We saw people sat in one of the three lounge areas either watching morning television, sleeping or observing their surroundings. People were unable to access the community unless they were able to do so alone or with their relatives.

Each person had a plan of care that recorded the way people wished to be supported. We saw that care plans generally were reviewed but not always up dated to reflect the current or changing needs of people. For example we saw it recorded that a person's mobility had reduced and they now needed pressure relief. The care plan had not been updated with this information so that staff had the guidance on how to reduce the risk to the person. We saw that the person sat for long periods of time with no pressure relief. The lack of information did not ensure the person's needs were met and this meant the person was a risk of developing sore skin and pressure ulcers.

We observed a person who was living with dementia looked unkempt and untidy. We saw and the person told us they were uncomfortable but they were waiting for their partner to visit. We saw the person was ill prepared for this long awaited visit; they had dirty fingernails, unbrushed hair, and wore pop socks with slippers. We looked at their care plan for personal care, it stated, 'proud lady … likes to feel clean and fresh…..to offer bath/shower once, twice weekly or when required'. Personal care records recorded they had been offered one shower from 1 August 2016 until the date of our inspection. The provider told us the person was offered a shower but care staff had not completed the monitoring on the personal care record. This person was not supported with personalised care that supported their individuality.

We saw some institutional practices with set routines being the norm, and very little consideration given to individuals' support needs and wishes. We saw that some people were lined up in one of the corridors to have their hair washed and dried. People were taken to a communal bathroom to have their hair washed. No one was offered the choice of their own hair products, we saw one bottle of shampoo and conditioner was used. People seemed very pleased with having their hair washed, no one made any negative comments about this. However people were not supported with person centred care, this institutional practice did not uphold people's personal and individual preferences.

A visitor told us: "Mum does not complain. The furniture in her room, including the bed is not in very good condition". The manager and provider told us no complaints had been received since the last inspection. The manager informed us they had received a compliment about the service and they had recorded this. We

were unable to verify this as the file containing the complaints procedures and associated documents could not be provided to us during our inspection.

Inadequate

Is the service well-led?

Our findings

At the inspection in April 2016 we had some concerns that the service was not consistently well led, there was a lack of consistency with the management arrangements which impacted on the quality of the service provided. Although some improvements had been made in relation to some aspects of medicine management and care plan documentation since our last inspection, the provider continued to be in breach of a number of Regulations of The Health and Social Care Act.

At this inspection there continued to be no registered manager although a person had been employed and had been working as the manager since February 2016. The application to register with us had not been made and a registered manager is a requirement of the provider's registration.

The manager was able to produce two audits they had completed, accident analysis in March 2016 and a weight loss action plan date July/August 2016. The weight loss action plan recorded that some people had been referred to the doctor and the dietician when weight loss had been identified. We were unable to see and check any other quality and monitoring documents to ensure the safety of the service because the manager and the provider told us the quality assurance file had 'gone missing'. This meant there was no assurance that concerns or issues would be identified in a timely way in order to maintain people's safety and well being.

We found that no action had been taken since our previous inspection to ensure there were sufficient adequately trained waking night staff to ensure people could receive their prescribed medications in a safe and timely way during the night if they required them. There was failure to observe the express instructions of health professionals when treatments had been prescribed for specific health reasons. This meant that people experienced delays, discomfort and distress because of the lack of action, insufficient leadership and guidance of the care staff.

Risk assessments were completed but were not reviewed and updated in a timely way in regard to the current or a person's changing levels of need. Staff actions did not always correspond with either the risk assessments or support plans. For example the equipment needed when identified during the risk assessment and the equipment used daily by the care staff such as wheelchairs for people with poor mobility. Staff were not adhering to the instructions recorded in care plans and risk assessments, incorrect equipment and unsafe manual handling techniques placed people and staff at risk of harm and injury. This meant some people were at risk of harm to their safety and wellbeing because their support needs were not being effectively monitored by the manager or the provider.

We had concerns about the unsafe care that was provided. We observed that a person had been provided with, and had slept in, an electric profiling bed that had been condemned and labelled clearly, 'do not use' since 2015. The provider and the manager had not identified this high level of risk for this person over this long period of time. This person was at high risk of harm to their safety and wellbeing.

We found issues and concerns with the infection control. Controls were not in place to ensure the

equipment in use and the environment was clean and hygienic. Slings used with the mechanical hoist for the purposes of transferring people were shared between people. Toilets, bathrooms, showers and commodes were not clean and hygienic for people to use. Soiled laundry was not attended to in a timely way. The provider and the manager had not identified these areas of concern or taken action to reduce the risks to people. People were at risk of cross infection and there was an immediate risk to the people's health posed by the extremely unhygienic physical conditions.

There were insufficient staff to support people with their individual care and support needs in a timely way. People experienced delays in receiving the support they needed which often meant people were embarrassed, uncomfortable and distressed. People were at risk of dehydration and falls because of the lack of staff. People had been recruited to work at the service without all the necessary checks being in place. Care staff worked without induction, training, supervision or competency assessments. We saw agency care staff worked at the service, however the provider and the manager confirmed they did not have any information regarding the agency workers suitability, skills or experiences.

People's freedom and liberty was being compromised and care was not being delivered in accordance with consent or the principles of the MCA. The manager told us that DoLS referrals had been submitted to the local authority for their consideration. However the file containing the details of the referrals was missing so we were unable to ascertain any further information. There were no systems in place to ensure that the manager and provider were able to be sure people were not being unlawfully restricted of their liberty.

People's health care needs were not consistently met. Guidance from professionals and treatment plans was not followed. People's healthcare needs were not being effectively monitored by the manager or the provider.

Some people were at risk of malnutrition and dehydration; we saw monitoring documents had been put into use. Not all monitoring documents were completed following interventions so we could not be assured that people received sufficient daily nutrition and fluids to fully meet their needs. This meant that the provider did not have effective systems in place to monitor adequately people's nutritional needs effectively.

People's rights and expectations for care and support to be provided with dignity and respect were compromised. We saw occasions when there was a lack of attention and regard to preserving people's dignity during care interventions. There was a lack of person centred care and institutional practices that was not conducive to the provision of a caring and compassionate service. There was no clear leadership and direction offered to staff whilst completing their duties which led to poor practice being observed.

The provider and the manager confirmed there was no building and maintenance plan in place to ensure the continual improvement and safety of the environment. The provider told us the maintenance work was attended to as and when it was needed and identified. We saw thick mud outside a person's bedroom because the nearby 'pond' overflowed each time it rained. The bedroom door opened onto this area, a new carpet was being fitted and the bedroom furniture had been placed outside in the mud. This work was not well planned and organised.

Systems and processes were not in place to effectively monitor and improve the quality and safety service or to mitigate any risks relating to the health, welfare and safety of people who used your service.

These issues constituted a continued breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.