Hudson (Haven Lodge) Limited

# Haven Lodge Care Centre

## Inspection report

4 Haven View
Harbour Road, Portishead
Bristol
BS20 7QA

Date of inspection visit:
10 November 2016
11 November 2016
14 November 2016

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02 February 2017

## Ratings

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| Overall rating for this service | Inadequate |

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| 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

This inspection took place on 10, 11 and 14 November 2016 and was unannounced. The home was last inspected in December 2015 where we found breaches of the regulations in relation to person centred care, consent, good governance and staffing. The provider sent us an action plan outlining improvements they said they had made, or planned to make, to become compliant with the regulations.

During our inspection, we found that not only had there been no improvements made, there were more concerns and many of those were of a higher risk. For example in relation to person centred care and staffing we found that there had been further deterioration and the risks posed to people had increased. We also found further breaches of the regulations in relation to nutrition and hydration, and dignity and respect.

The home still did not have a manager registered with the Care Quality Commission. The home had been without a registered manager since 2015. Two managers had been in post since that time and one had been in the process of registering with the commission but had left the service in August. Since August 2016, the provider had placed two support managers and a support deputy manager from their other homes, in the service to assist staff and run Haven Lodge until a new manager could be recruited.

The service is required to have a registered manager and was therefore in breach of this regulation. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. We had been made aware of a number of people who had left the service and a number of staff currently within the home were working their notice to leave, this included a senior carer, unit manager and a number of care staff.

This inspection found that people's safety was being compromised in a number of areas. Care plans did not reflect people's care needs and care delivery was not person specific or holistic. We found that care plans for people with specific health problems such as diabetes, pressure areas, and wounds were not up to date and did not have sufficient guidance in place for staff to deliver safe treatment. The delivery of care suited staff routine rather than individual choice.

During this inspection, we followed up on information of concern we had received regarding people's food and fluid intake. We found that people were not being supported or prompted to have sufficient fluid or nutrition. We reviewed the information and support available to ensure people received enough nutrition and hydration. We found that records kept to monitor people's intake of food and fluids were poorly completed, inaccurate and did not outline why people were being monitored which meant people were placed at risk.

We looked at risk assessments and saw there was little up to date comprehensive information to identify

what the risks were to people. How staff protected people from risks did not always reflect recent advice from other health care providers. People were not always supported in line with their care plans. We therefore found the home was in breach of the regulation in relation to safeguarding and improper treatment.

At the last inspection in December 2015, we found there were not enough qualified skilled or experienced staff to meet the needs of the people using the service. We checked and found that the provider had still not ensured there were enough suitably trained or qualified staff deployed to meet the needs of people who used the service. We found the home was still in breach of the regulation relating to staffing. The lack of suitably qualified and experienced staff impacted on the care delivery and staff were unable to deliver care in a safe manner. Shortcuts in care delivery were identified particularly in respect of personal care.

People and visitors we spoke with were complimentary about the caring nature of some of the staff. However, the constant changes to staff, use of agency staff and staff leaving had impacted on how the home was run. Many people were supported with little verbal interaction, and many spent time isolated in their rooms. Staff told us they thought that communication systems needed to be improved and they required more support to deliver good care. They felt that the lack of permanent staff and high staff turnover had raised issues. Their comments included, "Staff leaving and not showing up for work has been really difficult, we don't always know who is supposed to be on duty."

Due to the level of risk, we found during the inspection, we made the local authority and Health Service aware of the concerns we had which included the staffing levels at the home. The Council liaised with the provider and ensured there was an extra nurse available on shift to support the home over the weekend. We also asked the provider to send us an emergency action plan outlining what they were doing to safeguard the people at the home along with some additional information.

At the last inspection, we found there was, 'no system in place to assess people's capacity to consent to care and consideration was not given to the principles of the Mental Capacity Act 2005.' At this inspection, we saw that the provider had begun the process of assessing the capacity of people who were most at risk but found evidence of people receiving care and treatment without their consent. This meant the provider was still in breach of this regulation. Mental capacity assessments and best interest decisions were not completed in line with legal requirements.

Staff were not always following the principles of the MCA. There were restrictions imposed on people that did not consider their ability to make individual decisions for themselves, as required under the MCA Code of Practice. There was confusion over whether deprivation of liberty safeguards (DoLS) were in place for people. The management list of DoLS was not up to date or accurate.

At the last inspection in December 2015, we found breaches in relation to good governance. This was because, there was a lack of leadership and management within the home which meant quality audits were not being completed and the quality of care being delivered was compromised as a result. At this inspection we found no improvement because systems already established were not being used to monitor or manage the quality of service provided either at service or provider level. Quality assurance systems were in place but had not identified shortfalls in care delivery and record keeping. We could not be assured that accidents and incidents were consistently investigated with effective action planning to prevent a re-occurrence. This was a continued breach of this regulation.

Though people spoke highly of the food provided by the kitchen at Haven Lodge, we found meal times were

task orientated activities that did not promote people's independence or enjoyment.

Care plans lacked sufficient information on people's likes and dislikes. Information in respect of people's lifestyle choices was not readily available for staff. The lack of meaningful activities impacted negatively on people's well-being. At the last inspection we saw examples of staff interacting with people in positive and caring ways but it was clear that at times they were simply too busy and some interactions were rushed or missed. We found the same thing occurred at this inspection, which meant some people received poor care and treatment.

We also found that training had not been delivered where identified and staff had not received regular supervision and had not had an appraisal on a yearly basis.

We found a number of concerns in relation to medicine management. These included people not receiving medicines in line with their prescription, missing pain patches, medicines of people who were no longer living in the home were still accessible to staff and staff were not keeping a record of when, where or why they were administering creams. We also found that those medicines that required more security were not stored safely or securely.

The recruitment system was not always safe or effective. The staff files we looked at contained a completed application form, listing work history as well as skills and previous qualifications and all nurses had up to date registrations with the nursing midwifery council (NMC), however, we found and we were told by the support manager and deputy manager that they did not have copies of Disclosure and Barring certificates or a record of the certificate numbers for 10 staff working in the service. This meant the provider did not ensure that persons employed were of good character and had satisfactory checks in place. This placed people's safety and wellbeing at risk.

People had access to appropriate healthcare professionals. Staff told us how they would contact the GP if they had concerns about people's health.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to ensure that providers found to be providing inadequate care significantly improve. Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action. 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.

People's risk assessments were not always up to date and the management of people's individual safety was poor and placed people at risk.

People were not supported by enough suitably trained or qualified staff to meet their needs. People's needs were not taken into account when determining staffing levels.

The management and administration of medicines was not always safe.

People were at a higher risk of abuse because not all staff had received training in how to safeguard people from abuse and not all staff were confident about how to respond to allegations of abuse.

### Is the service effective?

**Inadequate**

The service was not effective.

People at risk of dehydration, malnutrition and acquiring pressure had not had their care and treatment effectively assessed, planned and responded to.

People were not supported by staff who had regular supervision, to provide guidance and support in their roles.

People were supported by staff who did not receive regular training to equip them with the skills they needed. This placed people at risk of not have their health, welfare and safety needs met.

### Is the service caring?

**Requires Improvement**

The service was not always caring.

People and their relatives were not fully involved in decisions about their care

People were not always provided with positive support and companionship as staff did not have sufficient time allocated to spend with them.

People were not always treated with respect and care provision was not consistent.

Staff morale was low which impacted on the quality of care people received

## Is the service responsive?

**Inadequate**

The service was not responsive.

People did not receive care and support that considered their individual needs and preferences.

People's complaints were not handled in line with the provider's policy.

People did not always get a full response to their concerns.

People were not provided with enough activities to ensure their positive physical and mental well-being.

## Is the service well-led?

**Inadequate**

The service was not well-led.

The lack of leadership, management and governance from the registered provider had compromised the quality and safety of the care for people.

The provider had failed to take effective action to improve the service since the last inspection and the quality and safety of care had got worse.

The providers own systems for monitoring the quality of the service were not effective to ensure people were being supported safely and appropriately.

The provider had failed to ensure people's views were collected and used to develop the service.

Most people and their relatives were not happy with how the service was run.

# Haven Lodge Care Centre

**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 10, 11 and 14 November 2016 and was unannounced. On the first two days, the inspection team included two adult social care inspectors and a specialist professional advisor. A specialist advisor is a person with specialist skills and knowledge in a particular area. The specialist advisor we used was a specialist in care of older people 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. The final day of the inspection was carried out by one adult care inspector.

Due to concerns raised, this inspection was brought forward and we did not ask the provider 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. We took this into account when we inspected the service and made the judgements in this report.

Before our inspection, we reviewed the information we held about the home, information from the local authority, the Clinical Commissioning Group (CCG) and the Nursing Home team. We also looked at notifications we had received from the service and reviewed action plans sent to us by the provider after the last inspection with the improvements they said they were going to make.

During the inspection, we spoke with 27 people who used the service and 11 visiting relatives. We observed how staff and people living in the home interacted. We spoke with 12 staff including the provider, two support managers and support deputy manager who had been brought from the providers other homes to provide the management of the home, agency nurse and carers. In addition, we spoke with the cook and six healthcare professionals.

We observed support provided to people in the communal areas, including the dining room and lounges

during lunch, during the medication round and when people were in their own rooms. We reviewed 14 people's care files, including medicine records and looked at care monitoring records for personal and nursing care. We also looked at the recruitment records of nine members of staff.

Inadequate

# Is the service safe?

## Our findings

The service was not safe. Although some people told us they felt safe, we found many examples of care practice which were not safe.

One person told us they felt safe, "I think I'm safe" and one relative told us "I feel that my relative is safe". However, other relatives said, "We are really concerned for our relative, but think she is too frail to move to another home"", and "About a month ago there was no-one to administer medication, so a relative had to be called to administer it".

At the last inspection in December 2015, the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. They had failed to provide sufficient staff to meet peoples' needs and to keep them safe. At this inspection, we found that the provider had not made the improvements necessary to meet the requirements of the regulation and the situation was now worse.

There were not sufficient numbers of suitably trained staff to keep people safe and meet their individual needs. Haven Lodge was divided into two units over two floors, Sycamore and Willow and there were two staff teams to cover 24-hour care. The ground floor accommodation provided care and support specifically for those living with dementia. The staffing teams were separated into two teams during the day and two teams at night. On the first day, the staffing numbers were not as stated by the providers' rota and were short by two care staff. The only permanent registered nurse (RN) who worked the day shift was on leave, and the service was reliant on an agency nurse. The support manager, who was a registered nurse, was also having to cover procedures that the agency nurse could not, for example taking blood from people. There was no RN on the dementia floor (Willow) despite there being five people who required nursing care. We were told the RN who covered the nursing floor (Sycamore) was also expected to attend the people on Willow floor. However, we saw that the RN did not spend any time on Willow directing and supporting the care staff. One care staff member said, "I don't know who is in charge today, we just get on with it." This meant that people were not having their nursing needs met.

We were informed the staff shortages were an on-going problem due to staff leaving. There was a reliance on agency staff to complete the numbers of staff needed as identified by the provider. The lack of staff numbers negatively affected the outcomes for people. People did not receive the level of personal care required to fully meet their needs. Personal care is washing, changing of clothing and oral care. We observed people calling out to staff who were too busy to stop. One person who, according to their care plan, should have been observed every 15 minutes had not been seen for three hours according to the records in their room. Staff told us that due to the lack of staff they had not been able to give people the showers or assisted washes that they were required to have. One staff member said, "It's not fair on our residents, but if staff don't turn up what can the manager do?" and "We just haven't got time to do the things we needs to, it's not that we forget there just isn't enough time". People and their relatives also commented "They are always rushing" and "Sometimes my relative has to wait a really long time for anyone to come when they press their call bell, I worry about that."

We asked the support manager if they felt the staffing levels were sufficient to provide safe care to people. They told us that they felt it was unsafe and said they thought two nurses were needed. The staffing levels at night, again according to the support manager, were also not sufficient to ensure people's safety and well-being. The staffing levels at night were one registered nurse for both floors and five care staff. For four nights a week, that was an agency nurse and five care staff. The agency RN on Sycamore told us they was responsible for two floors, 48 people and stated that this was not sufficient to manage an emergency situation. They also told us they felt there were not enough nurses. They said, "Things get missed, systems don't work, two nurses are needed here to ensure patient safety." A visiting professional told us that they "Had not seen a regular nurse on duty for a while which means information is not passed over. The nurses do not know the residents well and records are not current. On the first day of the inspection, we asked the support manager what they had done to ensure there were enough nurses on duty. They told us they were working with an agency to block book staff in order to fill the gaps on the rotas. They told us they tried to get the same staff to ensure continuity but it was proving difficult to this. This meant that the home had not had permanent nursing staff for over a year. Lack of regular nursing staff meant that people's nursing care was not consistent as the standard of nurses provided by the agency, according to the support manager, was variable. We checked to see what impact this had had on the people who used the service. We found it was high.

One staff said, "It's really hard work, I have to keep calling for help as most people need two staff. The morning is terrible, we can't make sure everyone is clean and comfortable because the nurse and often the senior carer are busy with some medicines." We observed three people during the first morning of our inspection, who were in a distressed state as staff had not yet been able to respond to their needs. One person's bed was wet and they had pulled the sheet away and were sitting on the plastic mattress. We immediately informed the nurse in charge who said, "Staff will be back in a minute they are collecting the breakfast trolleys." It took 20 minutes for staff to attend to this person's needs. Another person was slumped in a chair in distress as they were unable to reach their drink, we rang their bell and it took a member of staff 10 minutes to attend. Another person was shouting out to staff and we saw staff ignoring them on at least three occasions. We spoke to people about the lack of staff and they told us how long they needed to wait for help from staff. One person said "[we are] waiting all the time". One relative showed us the state of their loved ones room "Look at this bed it hasn't been made since this morning and there is a wet pad in a bag over there, they are just too busy to do one thing at a time".

We considered that there were not sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in order to meet the needs of people who used the service. This was a further breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed medicines being administered by the nurses safely in the morning and lunchtime. Nurses who administered medicines carried out the necessary checks before giving them and ensured the person took the medicines before signing the medication administration record (MAR) chart. The nurse however did not ensure medicines were swallowed before signing the MAR chart and ensured the trolley was locked when not in use and fixed to the wall by a secure chain. This meant that the nurse could not be sure that the person had taken their medicines correctly which could impact greatly on their health.

Our inspection identified that there were areas that needed action immediately to reduce the risk of unsafe medicine practices. This included the lack of signatures or dates of discontinued medicines, lack of details of amount of as required (PRN) medicines given, expired medication in the controlled drug cupboard and poor record keeping of the controlled drug record book. The medicine rooms were cluttered. There were boxes of food supplements piled up in a corner and several cupboards with dressings in. The nurse was unable to find what they needed, and this could impact on the care of people if a dressing was needed quickly. There

were no records of any stock management being recorded, which meant no one knew what was missing or needed, which meant people could have to wait whilst staff tried to find the item they need. We saw that there was a blood sugar testing device with no record of calibration having been done, which is needed to ensure that blood sugar readings are accurate so that the right dosage of diabetes medication can be given. This meant people could be at risk of not getting the right amount of medication.

We looked at the medicines that needed secure storage on Sycamore and found that medication for one person who was no longer living in the home were still in the cabinet and should have been returned to the pharmacy in line with the homes' medicines policy. There were two boxes of Diamorphine injection 10mg for one person as well as a box of midazolam, which had not been recorded in the official register. These medicines need extra security and are subject to more stringent storage rules. Checks of the medicines that needed extra security did not correlate with the official register but were noted in a separate book, which asked staff to check them at midnight. This meant there was no consistency in checking these medicines .The nurse in charge could not explain why this had taken place or if any of these medicines were missing, which meant people were at risk of not receiving their prescribed medicines.

Whilst checking the register, it was recorded that a person had 6 x pain relief patches but there was nothing in the cupboard. The nurse stated she thought it might be someone who had died. We found the patches in the other medicines cupboard on a different floor however there were two missing. The patches were not recorded in the official register on this floor; they were only recorded on the medicines administration records (MARS). This meant the person could be left in pain, as the patches prescribed were not available on the floor they lived on. It also meant that medicines for people were not being handled safely and were moved within the home for no apparent reason. The keys to the secure storage cupboard were left out in the medicines room, which could easily be accessed by other staff members, people or their relatives.

We also found that one person had been prescribed "Forsip" (a nutritional build up drink) by the dietician. However, in a letter from the dietician dated August 2016, they had been discontinued and four "Cal shots"( small high calorific nutritional drinks) put in their place as the person was at high risk of becoming malnourished and was losing weight. Three months later this person was still being given the "Forsips". We informed the support manager and the "Forsips" were stopped but we saw in the records that only two of the prescribed "Cal Shots" were being given. We pointed this out to one of the support managers who assured us that all four "Cal Shots" would be given. This meant this person was not being given the correct nutritional support and could place them at risk of losing further weight.

There were people in the home the provider identified as being at high risk of developing pressure areas. We identified that one person, who was unable to reposition themselves without staff support, had six pressure areas identified on a body map in their care plan. Only one pressure area had a wound care plan in place that we saw had developed into a wound. This wound care plan was for staff to refer to when treating this wound. However, after over three weeks, we saw that the wound care plan had not been re-evaluated and the care plan stated that the treatment being given was for two different pressure wounds. However, the second pressure wound was not recorded on the wound care plan so the information for staff to provide the correct support was not up to date.

During the inspection, one of the pressure wounds was checked by an agency nurse who was the only nurse on shift. They were not aware, because it was not written in the person's notes, of how serious the wound had become, despite their photographs showing the deterioration of the wound which we found in the care plan. The wound care plan stated that the dressing should be changed every two days However, it was not clear which wound dressing should be changed and therefore staff did not have clear instructions to follow. This person's care plan also stated they should be repositioned every two hours to reduce the risk of

pressure wounds. However, the records to show if this had happened could not be found and therefore no one in the home could be assured this was happening.

People were at risk of developing pressure related wounds because special air mattresses were not set correctly. There were a range of air mattresses in the home; they had different settings such as being set to the weight of the person or reading low, medium and firm. However, no individual instructions or guidance were in place for staff. A person who had a significant wound had their mattress set at firm. An agency nurse could not say what setting the mattress should be on and there was no guidance in the person's care plan. Throughout our inspection, several other mattresses were found incorrectly set for people. Both support managers were aware mattresses should be inflated to people's weights but could not explain why this information was not available for staff and why there were no records of mattress checks.

Staff told us five people were unable to change position and relied on staff repositioning them in their beds or when sat in chairs to prevent pressure areas developing. We found people were at risk of not having their care needs met when they required repositioning and during our inspection three people did not receive the support they required

For example, one person on the first day was observed in the same position for five hours on their right side in bed. The person's care plan stated two hourly repositioning was required due to being at risk of pressure ulcerations. Records stated that during this time the person had been moved three times, onto their back, right hand side and sat up during this time. This meant that staff were recording they had repositioned someone when this had not happened.

On the second day, we observed for four hours the person remained on their left side. Records stated during this time the person had been moved twice, onto their back and right hand side. Our observations did not reflect the records. Staff told us that this person was on two hourly turns. This person required their position changing 12 times during a 24-hour day and records seen and our observations showed this was not happening. We asked staff on the second day of our inspection to reposition the person so that we could check their feet and legs for any changes to their skin. After staff had provided this care, we reviewed the person's skin and found where they had been lying in one position for over four hours the left side of their feet was pink. This meant due to not having their position changed they were being placed at risk of developing a preventable wound.

We also found two other people who were not receiving the support they required which was to be repositioned every two hours. Our observations showed people remained in the same positions for longer than two hours and records had been made to suggest the turns were happening when they were not. This meant people could be at risk of developing pressure ulcerations due to not having their position changed when required and staff failed to follow care plans to protect people's health and welfare .

People's personal emergency evacuation plans (PEEPs) were generic and did not change for decreased staffing levels at night. The PEEPs did not include the information necessary for staff to follow to move people quickly and safely. Some identified that a hoist was needed and two staff or wheelchair but these could not be used for a fast evacuation and at night due to decreased staffing levels. This may potentially slow an emergency evacuation and place people at risk.

We found that accidents, incidents and safeguarding issues had not been analysed since August 2016 to identify whether there were any trends and see whether any lessons could be learned to reduce risk. The provider assured us that this would a priority moving forward.

People's care plans did not always contain risks or support plans and guidance for staff to follow. For example, one person was at risk of choking. We were told that they required their diet to be modified however; there was no risk assessment or support plan in place to confirm what support staff should be providing. We raised this with the manager. They were unable to find any care plan or risk assessments. For another person who was at risk of pressure damage to their skin their care plan did not state what equipment was to be used to help mitigate the risk to the person skin. Staff told us that they usually left people in bed and assumed they were just on turn charts.

All of the above issues demonstrated that people were not protected against the risks of receiving care or treatment that is inappropriate or unsafe and this was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not have an effective recruitment procedure to ensure people of the right character were employed. We checked nine staff records and saw that each file had a completed application form listing their work history as well as their skills and qualifications. Nurses employed all had registration with the nursing midwifery council (NMC) which was up to date. However, we saw and the provider confirmed that ten staff had been working without a Disclosure and Barring Service check (DBS). They could not provide us with a reason this had happened . A DBS is to help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. This meant people were at an increased risk of abuse because there were no systems in place to help to prevent unsuitable staff working with them.

This is a breach in Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The training schedule identified that not all staff had received safeguarding training and staff confirmed this. Not all staff we spoke with had a clear understanding of abuse and they were not aware of the safeguarding procedures to ensure people were protected. We asked a member of staff what they thought abuse was and how they would respond to the suspected abuse, they could not tell us what they thought abuse was or what to do. They told us that they had not had any training in keeping people safe. Another member of staff stated, "I haven't had any up to date training on safeguarding for a long time, I suppose it's still the same thing".

Safeguarding policies and procedures were in place and were up to date and appropriate. However, staff were aware of how to whistle. Whistleblowing is the process of a member of staff alerting a person in authority or the public to wrongdoing within an organisation.

Risks to the environment, such as the safety of the premises and equipment, had been regularly assessed and there were safety certificates in place. The maintenance person told us, and the records confirmed, that minor repairs had been carried out swiftly if they were reported by staff. Other work, such as building repairs was carried out by contractors as and when needed.

Inadequate

# Is the service effective?

## Our findings

The service was not effective.

At the last inspection in December 2015, the provider was in breach of Regulation 11 and 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was failing to safeguard people living at Haven Lodge from improper treatment including inappropriate deprivation of liberty under the terms of the Mental Capacity Act 2005. At this inspection, we found that the provider had not made the improvements necessary to meet the requirements of the regulations.

People's consent to their care, treatment and support was not always sought by the service. We found that care files lacked consent forms to demonstrate that people, or another responsible person such as a family member, had given their consent to the content of those files. In addition, we saw that each individual care plan had an area for people to sign to say that they agreed to the content of that plan, however; none of the care plans we looked at had been signed. Neither people or staff members were able to tell us how people's consent to the content of their care plans had been sought or recorded. This meant that people received care, which was not provided with their consent, or the consent of another relevant person.

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

The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that DoLS applications had been made to the local authority but had not been completed correctly and had included every aspect of care, for example personal care and activities within the home. This meant the law and guidance were not being correctly applied to people and their care. We also found that the home had not been using the correct paperwork or completing the forms correctly for over six months. This meant people were at risk of having their liberty deprived unlawfully.

The principles of the MCA were not always being followed. Staff members told us that they thought there were MCA assessments in place, which found people lacked capacity, when they felt the person was able to make decisions for themselves. One staff member said, "I don't know why they have one [MCA assessment], they can tell you what they want." This meant people were at risk of having decision made for them and their movements restricted unnecessarily and unlawfully.

Records showed that MCA assessments were not carried out in an effective and consistent manner. We saw that these assessments were not always decision-specific; rather they gave an overall finding that the person

lacked capacity. This is contradictory to the guidance in the MCA and may have prevented people from being able to make decisions for themselves. The assessments also failed to provide evidence of how the person had been found to lack capacity, or what staff did to help provide people with information about the decision in question. There was also a lack of evidence that a best interests' approach was taken when decisions were made on people's behalf. 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. When MCA assessments were carried out, they did not show any evidence of how the decisions had been arrived at. The documentation was incomplete and did not fully include who had contributed to the decision. It was unclear whether the decision reflected the person's best interests.

As care and treatment was not always provided or planned with people's consent and the principles of the Mental Capacity Act 2005 had not been adhered to this was a further breach of regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff members told us and we saw the evidence that they did not receive regular supervision sessions from the service. Supervisions are an opportunity to talk about their performance, raise concerns about the care that people received or any learning and development needs they may have. They told us that they did not always receive supervisions with senior or management staff, to provide them with the forum they needed to discuss the service. One staff member told us, "I haven't had supervision since I started here over a month ago and I was told I would have it weekly at first." Another staff member told us that they had not received any form of supervision since the last manager left which was at the end of August.

Some staff members did tell us that they felt they could approach the support managers if they needed to; however there were no records to show that concerns were raised by staff, or acted upon by the manager, either formally or informally. We spoke with one of the support managers, who confirmed that supervisions for staff members had not been conducted on a regular basis since they started at the service, however, they did show us three observed sessions but these were to let staff know they were doing things wrong . The support manager acknowledged that staff needed to have positive interactions too. There were no systems in place to ensure that staff received one-to-one sessions on a regular basis. This meant that staff did not always have allocated time to discuss any concerns they may have. The support manager also told us that they had staff meetings on occasions and we saw that one was planned for later in the month.

Staff also told us that they had not received a yearly appraisal for some time and the support manager could not provide us with any evidence to the contrary. Appraisals are meetings involving the review of a staff member's performance, goals and objectives over a period of time, usually annually. These are important in order to ensure staff are adequately supported in their roles.

Staff members at the service did not benefit from receiving a formal induction when they started. The support manager told us that there was not a formal induction process in place, however; when new staff members started, they were shown around the service and started by shadowing staff that are more experienced before being allowed to work independently. Staff members confirmed that this took place, but told us that they had not received a specific induction to help them settle into working at the service. There were no records to show that staff members received an induction at the service, or to show that they had been assessed as competent to perform their roles without close oversight from another staff member. Staff members were not provided with sufficient management oversight to ensure they had the knowledge, skills and support to perform their roles.

Staff also told us, and records confirmed that they received little training from the service; to help equip

them with the skills they needed to perform their roles. One staff member said, "I have only done manual handling training since I started and that was 3 weeks ago, I haven't had any more yet." Another member of staff told us that they had had quite a lot of training but that was "Ages ago, I haven't done that much recently and I'm not sure I am up to date with a lot things anymore". The support manager showed us the training matrix, which did not show all staff members on it, including the new members of staff we had spoken with, but did show when staff completed training courses and when they needed to be booked in for additional or refresher courses. We saw a number of staff had not completed training or refresher training when required in line with the providers training policy and in line with the needs of people living in the home. For example, out of 55 staff at the home no members of staff had completed any training on looking after people with Diabetes, only four staff had completed Dementia awareness, no staff had completed Tissue Viability Training, two staff had completed Equality, Dignity and Enablement training, 3 staff had completed End of Life Care and 15 staff had completed Mental Capacity Act and Deprivation of Liberty Safeguards training.

This was a breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw people had access to health care professionals such as GPs, district nurses, dieticians, speech and language therapists and physiotherapists. A health professional who was visiting a person on Willow floor told us staff had taken on board their instructions regarding positional changes for their patient and staff contacted them if they had concerns. However, we saw from observations of practice that advice regarding treatment was not always followed by staff. For example, people on Sycamore floor that required support in moving especially whilst in bed, were not supported to change position as prescribed by the relevant health professionals.

There was a lack of effective systems in place to ensure the safe management of people's nutrition and hydration needs, in particular for people assessed as being at risk of inadequate intake of nutrition and hydration. Our observations showed a number of people who were exhibiting signs of potential dehydration with dry mouths and lips. Records we reviewed for one of these people indicated that over a three-day period they had consumed a maximum of 430mls of fluid and a minimum of 85mls within a 24-hour period. This low intake of fluid placed them at risk of dehydration, which had the potential to impact significantly on their health and wellbeing. For this person we also observed a half glass of milk remained in the same position in their room from 10.45am until 5.00pm when it was finally refreshed. No assistance was provided by staff to help then consume this drink. We noted that fluid monitoring charts had not been fully completed to calculate within a 24-hour period the amount of fluid a person at risk of insufficient fluid intake had consumed. Therefore, the charts were not effective in identifying and providing evidence that action had been taken to protect people from the health risks associated with insufficient fluid intake. This demonstrated a lack of clinical oversight and a lack of action to protect people from inadequate hydration.

We found a further three people were at risk of either not receiving a diet adequate to their needs; not receiving their prescribed food supplements; not having adequate assistance with their drinks; or having their hydration needs met. For example, one person had been assessed as requiring a set level of fluids each day. Their records confirmed a daily target of 1146mls. They were receiving between 130mls and 500mls. Their care plan evaluation identified that 'they needed more prompting' however we observed this person required full assistance from staff to maintain their hydration and on one occasion we saw a staff member syringe fluid into their mouth. The staff member confirmed this was the only way they could get the person to have fluids showing the person required full support from staff to have their hydration needs met. Their care plan did not confirm how often staff should be prompting them with their fluids. This meant the person was not receiving care and support that ensured they had their hydration needs met.

One person was at risk of not having their nutritional needs met due to inadequate monitoring of their weight and not receiving food supplements. Their records confirmed they had lost 15.2KG in the last nine months. We asked the agency nurse if this person was on any prescribed food supplements. They said, "They are not". We discussed this weight loss with the manager who was unable to confirm if any action had been taken following this person's weight loss. This meant the service had not taken action when this person had lost a significant amount of weight and was at risk of malnutrition and possibly the deterioration in their overall health

We observed those people who needed support to eat in their rooms were made to wait for their meals. The food was brought down from the kitchen by the cook who showed us the temperature of the food was within optimal limited for hot food; however, people had to wait to be served. One staff explained that there was not enough staff to support people eating in the dining room and support those people who remained in their rooms in a timely manner. Therefore, people were having their lunchtime meal at 2.40 pm and the food was at an optimum temperature. This meant people who were already at risk of malnutrition were not supported effectively with their nutritional needs.

This demonstrated a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People who were able to mobilise to the dining rooms were happy with the food and drink they were given at the service. They told us that they enjoyed the food and were given a choice of what they wanted to eat and drink on a daily basis. One person told us, ""I like it here; you can come and get a nice lunch". Another said, "It is nice, but I'm not a big eater." Staff told us that people were supported to choose what they wanted for each meal. During the inspection, we saw that people were given a choice of what to eat and drink, as well as where they had their meals and drinks, including the option to eat in their rooms if they wanted to. On the first day, we observed lunchtime on Sycamore floor, and saw that people were moved into the dining room by staff over an hour period to wait for their lunch.

Requires Improvement

# Is the service caring?

## Our findings

The service was not always caring.

We carried out observations in the home over both floors and spoke to people about their care and treatment. One person said, "You get to know them - then they change" and "I have been told by the staff to stop using the bell in my room, they used to answer it really quickly and were nice to me". A relative told us "They are still short of staff at times and everything seems to be done to my loved one, whereas before they used to be so caring and involve her in what they were doing"

We found some staff interacted well, but others did not. We also found people were not involved in aspects of their care and some were not treated with dignity. For example, during our observations, we saw one person was sat in the dining area of the communal room alone and away from other people. We asked the person why they were sat alone. They replied, "They just plonked me down here, I don't know why, I usually sit in one of the chairs with the others." Another person who was sitting in the lounge area upstairs told us they would rather be in their room. They said, "I have to sit here listening to the radio, I hate it but they won't let me stay in my room". We asked a staff member about this and they stated, "I would move them but there aren't enough of us to do it at the moment, we are trying to finish lunch, I will see to it later." We checked an hour later and the person was still in the lounge.

When we arrived on the first day of inspection, we arrived early in the morning so we could ensure there were the correct numbers of staff on duty to support the needs of the people living at the home. We observed on Sycamore floor there were three care staff and one nurse. We also observed one person dressed in their daytime clothes and in bed. The nurse was unable to tell us why so we asked the care staff. They said that it was usual practice but no one could say why. We found six people had been woken, washed, dressed and put back to bed. When we asked staff whether the person we had seen minded being woken up we were told that the person was unable to communicate so was not asked. This meant the staff had not tried to find different ways to communicate with this person in order to understand their wishes.

Whilst observing mealtimes on both floors, we observed some compassionate care from staff. For example, we saw staff gently talking to someone who appeared distressed, this calmed them down and we saw another staff member get someone some toast because that's the only thing they wanted to have for lunch. However, on Sycamore floor, we saw one person during breakfast was asking questions and they were ignored by the staff and they looked distressed at being ignored. When a member of staff eventually did answer the question, after we prompted them, they did it in a caring manner and we observed that the person's appeared relaxed

The following day we observed the same person being, 'told off' in front of other people and relatives by the same staff member whilst the person was trying to get their attention to ask the same questions to gain reassurance This person was living with dementia and had forgotten what they had been told the previous day.

Whilst speaking with the support deputy manager, we both observed two members of staff, one a senior care worker and one agency staff member help a person out of their wheelchair using hoisting equipment and into a chair in the lounge. They did this without once making eye contact with the person, without any explanation of what they were doing and moved the equipment over the cable attached to the handset for the chair, which caused the person to be "jerked" around. The maintenance man managed to move the cable to prevent further discomfort to the person. The support deputy manager acknowledged that this was not acceptable and told me they would speak to the senior member of staff about this and look at their practice around moving and handling people within the home. Later that day, we saw the support deputy manager meeting with the senior care worker to discuss what we had witnessed.

We found the lack of consideration for the dignity of and lack of respect for people's wellbeing was a breach of Regulation 10 (1, b) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

# Is the service responsive?

## Our findings

The service was not responsive.

At the last inspection in December 2015, the provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014. We found that those people who remained in their rooms were at risk of social isolation due to the lack of activities provided by the service for them. At this inspection, we found that the provider had not made any improvements necessary to meet the requirements of the regulation.

We saw the support people received did not always reflect their preferences and care needs. People were not always given person centred care because staff sometimes focused on tasks rather than on the needs of people as individuals. For example, we spoke to one person who said they would like to go out of the home for a walk but they told us that there was never any staff available to take them out. We spoke with one staff member about this and they told us "I would love to take people out but there is never any time, I am just too busy".

People told us that staff did not always respond promptly to their care needs. One person told us, "When I press the call bell they take a long time." Another person said, "I used to enjoy reading the paper but they no longer bring it in for me." Staff did not always respond promptly when people required support. We noted that one person sat for an hour after finishing their lunch before staff removed their protective plastic apron and we did not see any members of staff support people in their bedrooms to engage in their personal interests and prevent them from becoming bored. Staff told us that they did not have time to do this and it had not been done since the activities person left which had been over a month ago.

One member of care staff told us that they did not have enough time to support people to take part in activities. They told us, "The activities coordinator used to take care of that sort of thing but they have left." In addition, "We have always been told that there is no money for activities." We spoke with one of the support managers about this and they showed us the budget for activities, stating there is always money for activities, "The staff must have been misinformed." However, they agreed that there were no activities or one to one time for those people who remained in their rooms.

One person, who was being supported in bed, told us they wanted to sit out of bed. They told us, "I would like to get out more but there is no one to help me". We observed people on Sycamore floor sat in chairs in their rooms with little or no stimulation. Being supported in bed or in chairs within their rooms did not necessarily reflect the choice and wishes of some people who used the service. There were no plans to ensure that people who remained in their bedrooms would be included in events or activities. This meant people were at risk of being isolated.

We found little evidence of assessments of people's care needs and preferences. Records were not always updated as people's care needs changed or reflected the latest advice and guidance from health professionals. For example, we saw one person's plan did not reflect the most up to date advice regarding

their dietary needs.

Although people's care plans identified the gender of staff they wished to be supported by, staff we spoke with said there was not always the necessary staff on duty to accommodate these preferences. Therefore, people's preferences were not being followed. There was little evidence of the person, or where appropriate their families, being given the opportunity to sign in agreement with the contents of their own care plan. One relative told us "I haven't seen a care plan since my relative moved in".

We observed a new physiotherapy activity being undertaken in Willow floor lounge. Most peoples' facial expressions and body language indicated that they were enjoying the activity. It was person- centred and encouraged every individual person present. The person running the activity had been brought in by one of the support managers. They told us that they intended to co-ordinate with care plans and that pre-existing conditions that may hinder people's participation had been checked out prior to the session. One person told us, "I'm enjoying this". However, staff and people told us that this was the only activity available within the home, only on Willow floor and once per week.

There was no other evidence that people received support with any other individual activity interest. Activities were not meaningful to people, and did not reflect the skills and abilities of all the people who used the service.

The failure to ensure that people received person centre care, which reflected people's individual needs and preferences, is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a complaints process and we saw this displayed around the home. However, one person told us that it is "Best not complain as nothing is done and I don't want to get anyone into trouble". Relatives told us that concerns that were reported were not always being followed up or they were not told the outcome. We saw that complaints were not handled consistently or in line with the provider's policy. For example, the providers policy stated that written complaints should be responded to in writing and once investigated, a follow up letter sent with the outcome. We found that this had not happened since the previous manager had left. We discussed this with one of the support managers who said that there had been some difficulties following the departure of the previous manager but they were working hard to rectify the problems regarding complaints and how they responded to them.

Inadequate

# Is the service well-led?

## Our findings

The service was not well led.

At our last inspection, we identified a breach Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because they had not ensured appropriate checks were done to monitor and improve the quality of the service. We found the situation had become worse and there continued to be a breach of this regulation. We identified major concerns about the service and found no progress had been made in driving forward improvements to ensure that people were supported in a person-centred way that promoted their safety and ensured that they received good care and treatment.

We checked the audits, which had been carried out and found despite some good systems for recording and monitoring the quality of the service these had not been used consistently or at all at times. This meant the provider had no oversight of the issues within the home. This had resulted in a breakdown of trust between the staff, families of people who use services and the provider, as demonstrated by the information we received during the inspection from people, their relatives and staff. For example, staff told us that they felt they couldn't speak with the support manager or provider about problems they saw or issues with other staff members, as they didn't think that these issues would be taken seriously or investigated. One member of staff told us "I am leaving and going to another home, where I know I can trust the manager". One relative told us "I no longer trust anything that comes out of their [managers] mouths".

The registered provider and current support manager had not always maintained oversight of the service and effectively resolved failings to keep people safe or ensure their needs were met. The provider had not taken effective action to ensure concerns were resolved in a timely manner. We found that requirements and improvements identified at the previous inspection had not been addressed. The provider told us they had started to address these issues. Previous concerns related to failures to address identified risks to people had not been prioritised and were still outstanding or only partially addressed. This meant people had received an inadequate service since the previous inspection.

People still had to endure delays before staff responded to requests for support and staff were not always present in communal areas to oversee people's safety and welfare. People's care needs and wishes were not consistently known by staff or recorded in their care plans. The reviews of people's care plans were not effective, as they had failed to identify that people were not always supported in line with their current care needs or that records were not always fully completed. This meant people were placed at risk of harm and their needs were not being met effectively

There was no system in place so the provider and support managers could monitor and review if improvements to the service had occurred as planned, had been effective and sustained. This did not allow the provider to monitor if the quality of the service was improving.

People we spoke with had mixed views about the leadership at the service. Few people were happy to be supported by the service and several people and their relatives raised concerns about communication and

that staff were not always managed appropriately. Comments included, "Some staff just don't come in for their shifts without informing management." Comments from staff included; "Some staff are not properly trained, there is room for improvement on the management front." "Things aren't addressed at staff meetings. We have supervisory meetings but not often."

Systems in place failed to assess, monitor and manage risks to people using the service. The registered provider had not taken appropriate action to ensure staff provided care in line with people's care plans. Staff did not follow instructions from health professionals. The registered provider had failed to identify and address the risk of people not having their nutritional needs met. They did not identify that staff did not always provide care in line with people's nutritional plans and the issue that mealtimes were not always a positive events, which people could look forward to and enjoy.

The registered provider had taken little action to improve how people were safeguarded from the risk of abuse and risk of harm. We found that they had not made sufficient arrangements to ensure there was adequate staff on duty to safeguard people.

The provider had failed to recognise that the previous and current support managers had not responded to complaints in line with their own policy.

We found no evidence of people's involvement with the continual development and improvement of the service. We found no recent surveys given to people, their relatives or staff. This meant that people, their relatives and staff could not feedback on any aspects of the service and the provider make changes accordingly. We asked one of the support managers about this, but they did not know why this had not happened.

We saw that some notifications had been sent to the CQC when required. However, a number of the issues that were identified during the inspection had not been. This meant they were not informing us of all untoward incidents or events which happened within the home in line with their responsibilities under the Health and Social Care Act 2008 and associated Regulations.

We found the lack of a registered manager within the home and the lack of leadership, management and governance from the registered provider had compromised the quality of care in all aspects of service delivery. Large improvement was needed in all areas to ensure people received safe, effective, responsive and well led care. The provider had not ensured effective systems for monitoring the safety and service provision were operated which had resulted in a risk of harm to some of the people who used the service.

We considered this to be an extreme risk because of the provider's continued non- compliance with this regulation and lack of understanding of the impact this had on all aspects of service provision and people's health and wellbeing. It was a concern to us that there had been no registered manager for over a year so we asked the provider to send us information about how the home was to be managed. They told us that the support managers would be managing the home until another interim manager was appointed. We also asked the provider to send an urgent action plan detailing how they would mitigate some of the highest risks within 48hrs. The provider responded to this request and took adequate steps to reduce the most extreme risks found during the inspection.

This was a continued breach of Regulation 17 (1) with reference to (2) (e, f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>There was no other evidence that people received support with any other individual activity interest. Activities were not meaningful to people, and did not reflect the skills and abilities of all the people who used the service. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>Records showed that MCA assessments were not carried out in an effective and consistent manner. We saw that these assessments were not always decision-specific; rather they gave an overall finding that the person lacked capacity. This is contradictory to the guidance in the MCA and may have prevented people from being able to make decisions for themselves. The assessments also failed to provide evidence of how the person had been found to lack capacity, or what staff did to help provide people with information about the decision in question. There was also a lack of evidence that a best interests' approach was taken when decisions were made on people's behalf. 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. When MCA assessments were carried out, they did not show any evidence of how the decisions had been arrived at. The documentation was |

incomplete and did not fully include who had contributed to the decision. It was unclear whether the decision reflected the person's best interests.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Numerous issues regarding safeguarding, risks to people being documented, safe medication, people being given correct food and fluid and correct food suuplements. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs<br><br>We observed those people who needed support to eat in their rooms were made to wait for their meals. The food was brought down from the kitchen by the cook who showed us the temperature of the food was within optimal limited for hot food; however, people had to wait to be served. One staff explained that there was not enough staff to support people eating in the dining room and support those people who remained in their rooms in a timely manner. Therefore, people were having their lunchtime meal at 2.40 pm and the food was at an optimum temperature. This meant people who were already at risk of malnutrition were not supported effectively with their nutritional needs. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>We considered this to be an extreme risk because of the provider's continued non-compliance with this regulation and lack of understanding of the impact this had on all aspects of service provision and people's health and wellbeing. It was a concern to us that there |

had been no registered manager for over a year so we asked the provider to send us information about how the home was to be managed. They told us that the support managers would be managing the home until another interim manager was appointed. We also asked the provider to send an urgent action plan detailing how they would mitigate some of the highest risks within 48hrs. The provider responded to this request and took adequate steps to reduce the most extreme risks found during the inspection.

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>The provider did not have an effective recruitment procedure to ensure people of the right character were employed. We checked nine staff records and saw that each file had a completed application form listing their work history as well as their skills and qualifications. Nurses employed all had registration with the nursing midwifery council (NMC) which was up to date. However, we saw and the provider confirmed that ten staff had been working without a Disclosure and Barring Service check (DBS). They could not provide us with a reason this had happened . A DBS is to help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. This meant people were at an increased risk of abuse because there were no systems in place to help to prevent unsuitable staff working with them. |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Staff also told us, and records confirmed that they received little training from the service; to help equip them with the skills they needed to perform their roles. One staff member said, "I have only done manual handling training since I started and that was 3 weeks ago, I haven't |

had any more yet." Another member of staff told us that they had had quite a lot of training but that was "Ages ago, I haven't done that much recently and I'm not sure I am up to date with a lot things anymore". The support manager showed us the training matrix, which did not show all staff members on it, including the new members of staff we had spoken with, but did show when staff completed training courses and when they needed to be booked in for additional or refresher courses. We saw a number of staff had not completed training or refresher training when required in line with the providers training policy and in line with the needs of people living in the home. For example, out of 55 staff at the home no members of staff had completed any training on looking after people with Diabetes, only four staff had completed Dementia awareness, no staff had completed Tissue Viability Training, two staff had completed Equality, Dignity and Enablement training, 3 staff had completed End of Life Care and 15 staff had completed Mental Capacity Act and Deprivation of Liberty Safeguards training.