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Threen House Nursing Home

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

Summary of findings

Overall summary

This inspection took place on 24, 25 and 26 July 2016. The visits on 24 and 25 July were unannounced and we told the provider we would return on 26 July to complete the inspection.

We inspected the service on 21 July 2015 and found breaches of regulations covering safeguarding people using the service, recruitment procedures, staff training, the management of complaints, safe care and treatment and failure to notify the Care Quality Commission of significant events affecting people using the service. We placed the service in special measures and took enforcement action. This included issuing four Warning Notices and imposing a condition on the provider's registration on 01 September 2016 that prevented them from admitting new people to the service without the written agreement of CQC. The provider sent us representations against the imposed condition but we did not uphold these and confirmed the condition on their registration on 16 June 2016.

We also carried out a further inspection on 12, 13, 17 and 18 January 2016 to monitor the provider's progress in meeting the requirements we made following the July 2015 inspection. At this inspection we found medicines were not being managed safely, people were not always receiving their medicines as prescribed, staff had completed some training but there was no evidence the provider had checked staff understood the training they completed and applied it to their daily work, the provider did not have systems to support staff through the use of supervision or appraisals and the provider did not operate effective systems for planning the care and support people received.

As the provider had not demonstrated improvements and the service was still rated as Inadequate, it remained in special measures. We also took enforcement action and issued a Notice of Proposal to cancel the provider's registration. The provider sent us representations against our proposal to cancel their registration and we have carried out this inspection to continue monitoring the provider's progress in addressing the issues we have identified at previous inspections.

At this inspection we found the provider had improved the management of people's medicines and had started to meet the requirements of the Deprivation of Liberty Safeguards (DoLS). However, concerns remained about standards of care planning, risk management, staff recruitment and training and some care practices.

Threen House is a registered care home for older people who require nursing or personal care, some of whom are living with the experience of dementia. The service can accommodate up to 26 older people, in single or shared rooms. Following the inspection in January 2016 we placed a condition on the provider's registration that prevented them from admitting new people to the service without our written agreement. When we inspected, 15 people were living in the service.

The service did not have a registered manager. 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 legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The previous registered manager resigned from her post in May 2016. The provider appointed a new manager who applied to register with CQC on 8th June 2016. However, the manager resigned shortly before this inspection.

We found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. All six breaches were repeated breaches of those we found at our inspection in January 2016. The provider did not mitigate risks to people using the service, staff did not move or transfer people safely, staff recruitment checks were incomplete, the provider did not assess the competence of staff to carry out their work, staff did not have access to supervision or appraisals of their work, staff did not always obtain people's consent to the care they received, the provider did not arrange appropriate activities for people and did not monitor quality in the service and make improvements.

The overall rating for this service is 'Inadequate' and therefore the service remains in special measures. We do this when services have been rated as 'Inadequate' in any key question once they have been placed in special measures.

People using the service were not always safe as the provider did not produce risk management plans to mitigate risks to people using the service and staff did not have guidance on how to manage risks to people.

People may have been at risk of unsafe care as the provider did not always carry out pre-employment checks before staff started to work in the service.

People were at risk because staff did not follow manual handling assessments or guidance and people were not always transferred safely, for example from an armchair to a wheelchair.

We could not be sure people were supported by staff that had the correct skills as the provider did not follow systems to assess their understanding of the training they completed or their competence. Also, staff did not always have access to supervision and appraisal of their performance.

People told us they enjoyed meal times and the food provided in the service. However, the observations we carried out at lunchtime showed some people did not have a positive experience and there was little interaction with staff. Throughout the inspection we saw little interaction between staff and people using the service, although people told us staff were caring. Staff told us they did not have enough time to spend with people as they had to carry out household tasks.

Most of the care we saw was focussed on meeting people's personal care needs in a regimented, rather than a person-centred way. For example, people's care records showed they were supported to use the toilet every three hours, rather than when they felt they needed to.

The manager had made some improvements to care planning but this needed to be completed for each person using the service. Care records focussed on people's health and personal care needs and there was limited information about their social care.

There was a lack of meaningful activities for people using the service. Following our last inspection, the provider told us they would appoint a part-time activities co-ordinator but this had not happened. We saw little evidence of meaningful activities during the inspection and people were left for extended periods of time with no interaction or activity.

People using the service told us they had no complaints. Staff told us they would raise any concerns with the provider and they felt he would listen and respond.

The provider is registered with the Care Quality Commission (CQC) as an individual and does not require a registered manager. The provider held the Registered Manager's Award but had always appointed a registered manager to manage the service. The last registered manager left the service in May 2016. The provider appointed another manager in May 2016 but they left in July 2016, shortly before this inspection. The provider appointed a new manager in August 2016 and told us they would apply for registration with the CQC.

The provider was unable to evidence that they had carried out audits of quality in the service or had taken action to address issues they identified.

The provider had made changes to the service's medicines management procedures since the last inspection and people now received the medicines they needed safely.

The provider assessed and recorded people's health care needs and people using the service had access to the healthcare services they needed, including the GP, dentist, optician, hospital and clinics.

The provider had completed some health and safety audits and they were able to show us reports that analysed responses to questionnaires sent to people using the service, their relatives and professionals involved in their care.

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.

The provider did not produce risk management plans to mitigate risks to people using the service.

The provider did not always carry out pre-employment checks before staff started to work in the service.

Staff did not always support people in line with manual handling assessments and guidelines.

People received the medicines they needed safely.

Is the service effective?

Inadequate

The service was not effective.

Staff completed training the provider considered mandatory but the provider did not follow systems to assess their understanding and competence.

Staff did not always have access to supervision and appraisal of their performance.

People told us they enjoyed meal times and the food provided in the service.

People using the service had access to the healthcare services they needed.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

There was little interaction between staff and people using the service, although people told us staff were caring.

Staff told us they had no time to spend with people as they had to carry out household tasks.

Most of the care we saw was focussed on meeting people's

personal care needs in a regimented, rather than a person-centred way.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There had been some improvement to care planning but this needed to be completed for each person using the service.

There was a lack of meaningful activities for people using the service.

People using the service told us they had no complaints. Staff told us they would raise any concerns with the provider and they felt they would listen and respond.

Is the service well-led?

Inadequate

The service was not well led.

The registered manager left in May 2016. The provider appointed another manager in May 2016 but they left in July 2016, shortly before this inspection. The provider has appointed a third manager and told us they will apply for registration with the Care Quality Commission (CQC).

The provider was unable to evidence that they had carried out any audits of quality in the service or had taken any action to address issues they identified.

The provider had completed some health and safety audits and they were able to show us reports that analysed responses to questionnaires sent to people using the service, their relatives and professionals involved in their care.

As this service remains rated overall Inadequate, we have judged that the service is not sufficiently well-led because, despite previous inspection findings clearly setting out the required improvements to this service, the provider had failed to respond sufficiently to these and had not demonstrated sufficient evidence of the service improving for people who are using it.

Threen House Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 24, 25 and 26 July 2016. The visits on 24 and 25 July were unannounced and we told the provider we would return on 26 July to complete the inspection. 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. The expert-by-experience for this inspection had experience of caring for a family member living with dementia.

Before the inspection we reviewed the information we held about the provider and the service. This included the last inspection report, the provider's action plan and statutory notifications the provider sent us about significant events affecting people using the service.

During the inspection we spoke with nine people using the service, two visitors and eight members of staff. This included the provider, nurses and care staff. We reviewed care records for eight people using the service, reviewed medicines management records for 15 people and four staff recruitment files. We used the Short Observational Framework for Inspection (SOFI) to observe the care and support people received at lunchtime. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

At our last inspection in January 2016 we found that some aspects of the service were not safe. Staff did not manage people's medicines safely, people were not always receiving their medicines as prescribed, the provider did not manage possible risks to people using the service and did not always deploy staff effectively to make sure people were cared for safely. The provider sent us an action plan on 6 April 2016. They told us they had already taken action to address issues raised in the report and these would all be completed by 30 June 2016.

At our last inspection we also found the provider did not manage risks to people using the service. Some of the care records we saw did not include assessments of possible risks to people using the service or guidance for staff on how to mitigate risks. Where staff had completed assessments of possible risks, they did not always put in place plans to make sure people were cared for safely. The provider sent us an action plan on 6 April 2016. They told us they had already taken action to address issues raised in the report and these would all be completed by 30 June 2016.

At this inspection we found staff had completed some risk assessments but only one included risk management plans that included guidance for staff on how to mitigate the risks they identified. There was evidence that one person at risk of falls was appropriately assessed and measures put in place to prevent further falls. This included a referral to the GP and a protection plan for staff to follow, including a pain chart and a thorough moving and handling assessment. The GP notes and care notes were thorough and included details of the person's visit to hospital and what treatment had been prescribed.

Other people's care records included a general risk assessment and some also included specialist assessments for pressure area care, falls and nutrition. However, where these assessments identified risks to people using the service, the provider did not always produce a risk management plan with guidance for nurses and care staff on how to mitigate the risk. For example, where people were at risk of falling, there was limited guidance for nurses and care staff on how to reduce the risk. Therefore, people may have been at risk of unsafe care as staff did not have the information and guidance they needed to support them safely. We did see a falls risk assessment in place for one person. Their care plan reflected this and there was a very good manual handling assessment and plan with guidance for staff to follow to prevent the person from falls. However, this was the only example we saw of risk assessment and management that allowed staff to care for the person safely.

This meant that the provider had not responded to the findings of our last inspection and had not completed the actions they said would be completed by 30 June 2016 in their action plan. These failures meant that the provider continued to expose people to a high risk of unsafe care.

People were at risk of injury because the staff did not follow safe and approved practises when supporting them to move. One person's risk assessment said they needed support from two members of staff who should use a hoist and 'gentle lifting' for all transfers. The assessment lacked information on which equipment staff should use and no explanation of 'gentle lifting.' During the first day of the inspection we

saw two care staff lifting the person under the arms from their chair into a wheelchair. When we asked staff why they had lifted the person, one said, "That's what I have been shown. I knew it wasn't right and they should use a hoist, but I didn't say anything", and the other said, "It's my first day. I am shadowing. Maybe they do it because it is quicker." Later the same day, we saw the provider lift the person under the arms into a wheelchair. We discussed this with the provider who told us the person would not allow staff to use the hoist. There was no evidence that this method of moving the person had been assessed and approved as safe by a relevant health care professional. The provider was unable to explain why the person's care plan and risk assessment had not been updated to reflect this or why they had not asked for an assessment by a qualified healthcare professional to ensure staff had up to date guidance on how to support the person safely. This was further evidence of the provider continuing to fail to identify, and take appropriate action in relation to, risks for people using the service which resulted in the person in question being placed at a high level of risk through unsafe care being provided.

Another person's risk assessment identified them as at risk of falling. However, the risk management plan only stated "To have a safe transfer at all times" and did not give staff clear guidance on how to achieve this. Therefore, the staff did not have enough information about how to support the person so they did not fall. This meant the person was at risk of receiving inappropriate care, falling and injuring themselves.

A third person's risk assessment was not dated. Staff we spoke with were not able to tell us when the assessment was completed and it was not possible to tell if the information was up to date.

The lack of guidance for staff on how to manage risks to people using the service and their failure to follow risk management plans clearly placed people at risk of unsafe care.

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

People using the service were at risk of unsafe or inappropriate care as the provider did not always carry out checks on new staff to make sure they were suitable to work in the service. One of the three staff recruitment records we looked at did not include references from the member of staff's previous employer or a second referee, a requirement of the provider's recruitment policy. We discussed this with the provider who said they could not explain why the person had started work in the service before pre-employment checks were completed.

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

At our last inspection in January 2016 we found people were at risk of unsafe care as the provider did not deploy staff effectively to meet people's needs. The provider sent us an action plan on 6 April 2016. They told us they had already taken action to address issues raised in the report and these would all be completed by 30 June 2016. Shortly before this inspection we received information that the home was short staffed, especially at the weekend. In response, we made an unannounced visit to the home on a Sunday afternoon. The rota showed there should have been two qualified nurses and three health care assistants (HCAs) on duty. We saw two nurses and two HCAs were present in the service and the provider told us they had completed all of the required training and were working as the third HCA. During the rest of the inspection the staff shown on the rota were present and working in the service.

However, during the inspection we saw there was sometimes a shortage of staff for the number of people using the service. Although there was a volunteer assisting in the communal lounge, nurses and care staff

were often not present as they were supporting people with personal care, their meals or transfers on other floors. On the first day of this inspection, we heard one person called 'nurse' four times in a six minute period. We asked the person if they needed help and they said they wanted to go to the toilet. We told the volunteer and two care staff came to support the person several minutes later. At other times during the inspection we saw there were no staff present in the lounge and conservatory, apart from the cook who was preparing food in the adjacent kitchen. While we spoke with one person, the person next to them started coughing, their eyes started watering and they appeared to be choking on a piece of biscuit. The person recovered but at the time of the incident, there were no staff in the conservatory to notice or offer support and reassurance.

This evidence again shows that the provider failed to respond to issues raised in our last report and failed to complete the actions specified in their action plan. This clearly placed people at risk of harm because staff were not present and were not able to respond quickly when required.

People had mixed views on whether or not there were enough staff to support them. Their comments included, "I have never ever waited for anything," "There is always somebody around," "I would say now I don't know where people [staff] are," "Enough [staff] at night, I have never had to call one," "If I need them [staff] at changeover time it's short" "About four of us like to have an early night, but we can't always do it," "they have just enough staff to do the things they have to" "you can't get to bed until gone 7 pm," "As soon as someone is free I will ask them to take me over to the TV now," "No [there are not enough staff] they are all doing something all the time," "8 pm is when there is a hiatus, you can't find anybody" and "last night there was a hiccup, I was waiting for my tablet from the nurse and I just wanted to know how much longer did I have to stay up before I got a tablet."

Staff comments included, "There are times we could do with an extra person" and "You rely on people turning up and we have the odd day they could do with an extra person." A relative told us, "There are always people around" and "I do appreciate it is a financial thing, some days it is fine."

People may have been at risk of unsafe care as they did not always have the support they needed from staff, especially at night. When we asked people if they were able to use the aid call system to call for staff if they needed assistance, their responses were mixed. Their comments included, "Yes, there is a bell but I don't know if I have ever used it," "There's a bell on the wall in your bedroom, near the bed. I have never used it, I callout," "Usually there is someone in the corridor having a break or chatting and I call out to them," "If someone calls out and their room is nearer the back, then I will call out - we do an echo system," "Yes, there's a bell behind me. It varies during the day, at night you are lucky if anyone comes to answer it," "Yes, but it doesn't always work. Last night for instance I was ringing it last night and no one came" and "They are always afraid that they will be asked questions that are not important."

This evidence shows that people remained at risk of unsafe care despite the issues we had previously raised with the provider.

At this inspection we found that the provider had changed the pharmacist they used to supply people's medicines, they had improved the management of medicines and people received their medicines safely. There was a medicines policy and procedure in place. There was a procedure for the receiving and disposing of people's medicines. The medicines folder contained a record of names and signatures of all staff trained to administer medicines. This was up to date. There was a front sheet for each person using the service that included their name, date of birth, medicines details, photograph and allergy status.

We checked the Medicines Administration Record (MAR) charts for all 15 people using the service. These

were clear and completed correctly. There were no gaps in signatures. Most medicines were delivered in blister packs and colour coded for morning, lunch time, tea time and evening. Some people received medicines to be given PRN ("as required") such as paracetamol. There were PRN medicines plans in place. These included the name of the medicine, the interval needed between doses, the reason for taking and how many doses could be given in 24 hours. We checked a random sample of seven boxes of these medicines and saw that the amount left corresponded to the amount recorded as given. There was a separate Warfarin chart for a person, and we saw that the dose was adjusted and recorded following regular blood test appointments. The pharmacy issued the MAR charts, carried out yearly audits of medicines and offered training for staff. We observed two nurses preparing to administer a controlled drug. The quantity was measured accurately using a syringe and was checked by both nurses. The record of administration was signed by both nurses. Controlled medicines were stored appropriately, in a double locked cupboard in a locked office.

The Clinical Commissioning Group's (CCG) Head of Medicines Management also reviewed the service's systems for managing people's medicines in July 2016 and concluded, "Medicines are being delivered safely."

The provider had a policy and procedures for safeguarding people using the service and they had reviewed these in December 2015. The procedures referred staff to the local authority's safeguarding adults team and the Care Quality Commission. Training records showed staff had completed safeguarding adults training and had a good understanding of how to keep people safe. They were able to describe different types of abuse and told us they would report anything of concern. Some of their comments included, "It's about protecting people. Protect them against injury, and people who might treat them badly," "I would report any concerns to the manager, or CQC," "Safeguarding includes everything like medication, moving and handling, abuse etc. If I saw abuse, I would get the information from someone and would call the right agency to report it," "If I saw a staff member mishandling people, I would report. I would not hesitate to report," "We have to be careful, look after people, protect them. It's all about safety", "I think people are very safe here" and "[provider] is the most caring man. He wants to do everything by himself. He wants to know everything and do everything for people."

The provider carried out safety checks in the service to make sure equipment and the premises were maintained and safe for people to use. We saw the provider reviewed their Fire Safety Risk Assessment in January 2016 and had completed Personal Emergency Evacuation Plans (PEEPs) for each person using the service, also in January 2016. The provider had current service certificates for gas and electrical safety, fire safety equipment, door openers, the passenger lift and emergency lighting. The provider carried out daily safety checks of each person's bedroom and they told us this included opening restrictors fitted to windows, although these were not included in the checklist they completed.

Inadequate

Is the service effective?

Our findings

At our last inspection in January 2016 we found that, although records showed staff had completed some training, there was no evidence the provider had checked staff understood the training they completed and applied it to their daily work. The provider sent us an action plan on 6 April 2016. They told us they had already taken action to address issues raised in the report and these would all be completed by 30 June 2016. In their action plan the provider told us, "Some of the courses may not include the UK legislative requirements and this will be reviewed. Other forms of training and induction will be sought and set in place."

At this inspection we found that staff did not receive support to complete training they needed to care for people using the service safely. When we asked if they had completed practical training to enable them to move people safely, they told us this was not available and they learnt by shadowing other staff. The staff we spoke with understood this also meant they were not always learning safe practices and were putting people and themselves at risk.

This is further evidence of the provider failing to respond to issues we raised following our last inspection and failing to complete actions as stated in their action plan. This clearly placed people at risk of harm through inappropriate and unsafe care because staff were not provided with the training they needed to enable them to care for people safely.

The provider's training procedures required staff to watch a training DVD, complete a workbook which was marked by the provider's administrator and then discuss the training with the service's manager to assess their understanding and discuss how they would implement this in the service. Training records showed staff had completed training in areas the provider considered mandatory, including manual handling, infection control and managing medicines. However, for one member of staff, the provider could not show us any completed assessment workbooks and we saw no evidence the provider had assessed staff competence, once they had completed the training. We asked staff about manual handling training and they told us they had watched a DVD.

People using the service were at risk of unsafe or inappropriate care as not all staff had the knowledge and skills they needed to support people safely. Most of the care staff on duty during the inspection were new and had only worked in the service for a short time. They told us they had not had time to read people's care plans and had been told to work with more experienced staff to learn how to care for and support people. We saw this led to unsafe care on two occasions when the provider and staff lifted a person to transfer them to a wheelchair when their care plan said staff should use a hoist for all transfers. Two new members of staff we spoke with also said they had not received any induction training and they were not aware of the provider's training systems or when they would complete training the provider considered mandatory.

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

People using the service were at risk as the provider did not support staff through regular supervision with a suitably qualified person. In their action plan following our last inspection in January 2016 the provider told us, "Regular one to one supervision at 6 weekly intervals will include the testing of knowledge staff have gained and by discussion / familiarisation of policies." However, at this inspection we saw the provider did not have effective systems to support staff through the use of supervision or appraisals. Staff records showed one member of staff had an appraisal of their performance and one supervision meeting in April 2016. Other staff files we reviewed included no records of supervision or appraisals.

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

This is further evidence of the provider again failing to respond to issues raised at our last inspection and failing to complete actions specified in their action plan. This placed people at risk of inappropriate or unsafe care because the staff supporting them were not receiving sufficient levels of support and monitoring.

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

At our last inspection we found the registered manager did not fully understand their responsibilities in relation to the Mental Capacity Act and the Deprivation of Liberty Safeguards. People's liberty was not restricted unlawfully but the registered manager did not always follow the principles of the Mental Capacity Act 2005. At this inspection, we checked whether staff were working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw that, before they left in July 2016, the previous manager had started to assess people's capacity to make decisions about their care and treatment. Where people lacked capacity, the manager had applied to the local authority for authorisation to restrict people's liberty, where it was in their best interests and there was no less restrictive way to care for people safely.

People may have been at risk of being deprived of their liberty unlawfully as nursing and care staff had a limited understanding of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). One member of staff told us, "Some of them have dementia, some don't. I would go with them if they wanted to go out." Another said, "If someone has no capacity, we are not allowed to let them go out by themselves. They have an assessment by the social worker." A third care worker said, "It's when people have mental health problems or dementia." One of the care workers told us they did not know anything about this.

Although we saw 'consent to care and treatment forms' on some people's care records, two people told us staff did not ask for their consent before assisting them with personal care or supporting them. We also saw examples during the inspection where staff did not explain to people the support they provided at lunchtime or when they helped people to move around the service.

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

This evidence shows continued issues despite the findings of our last report in relation to the provider's action to fully implement and comply with the Mental Capacity Act 2005 (MCA). This placed people at risk of not having their rights under the MCA upheld.

People told us they enjoyed meal times and the food provided in the service. Their comments included, "You couldn't get better and there's no problem in asking for another little bit," "Sometimes they try and advise you to have a drink," '[The food] is fine. We have a new cook, so far it's alright," "There's choice to a certain extent, if you said you didn't like cabbage they would give you something else," "The meal is put in front of you. If you are a vegetarian you could ask for something else," "It's alright but not inspiring. The man who does the breakfast is new," "[The food] is reasonable and there's enough" and "They come around about 10.30 asking what you want." People's relatives told us, "They always ask him what he likes or what he fancies. They will give him a choice," "They are happy to change his meals around so a lighter lunch and heavier evening meal" and "they will offer him a sandwich before he goes to bed."

We saw that people had a choice of food at lunchtime and the cook spoke with each person during the morning and asked them what they wanted to eat. The provider completed nutrition risk assessments and monitored and recorded people's weight each month. These records showed no concerns or significant changes in people's weight.

People using the service had access to the healthcare services they needed. Their comments included, "Yes I can talk about my health, they are open for anything like that and It's not just to listen, action would be taken," "I have had conversations with them about the lack of physiotherapy and they said I should do more walking," "I ended up in hospital and they came to see if I was alright" and "The dentist comes here."

Care records showed staff supported people to access healthcare services and attend appointments. These included attending the eye clinic, the warfarin clinic and regular GP appointments. Visiting healthcare professionals recorded their notes in people's files for each visit. We saw records of visits by the GP, dentist, speech and language therapist and optician. We also saw evidence that appropriate referrals were made when a health care need was identified. This included a referral to the GP and the district nurse for a person whose skin was at risk of deterioration. We saw that this person had been supplied with pressure relieving equipment.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in January 2016 we noted, "At times there was no personal interaction between residents and staff and no attempts made to engage with or converse with people either in communal areas or with individuals in their rooms, except when delivering personal care or assisting with meals."

During this inspection we found that there had been little improvement in the ways staff interacted with people using the service, although people told us staff were caring. Their comments included, "Oh yes they are excellent," "They do anything you ask," "If you ask, you get what you want you don't ask for the impossible," "I do ask for help as I don't see so well going up and down and down stairs. I will ask [the provider] to get the opticians in," "They [the staff] will help you, they couldn't be better" and "I like living here, it's quite a good place to live." A relative told us, "They [the staff] are lovely to him, very friendly."

Staff we spoke with thought the care was very good and said they treated people with dignity. Their comments included, "The care is good. The residents are fed, cared for, assisted with toileting. We talk to people. Staff are very kind to the residents", "I close doors when I assist a person. I make sure I respect their dignity", "Very caring staff. Very well looked after", "It's lovely. The team, the place. It's homely, it's not strict. The residents are very nice" and "Yes it is nice here. Staff are nice. I have seen people being fed, staff were soft and nice".

However, staff also told us they were too busy to do anything apart from supporting people with their personal care needs. One member of staff said they had to do people's laundry as well as supporting them with their personal care and this left them with no time to spend talking with people. On all three days of the inspection we saw staff were busy supporting some people in their rooms and other people were left to sit in the lounge or conservatory for extended periods with no supervision or interaction with staff. When we asked people if they were able to move around the service they told us, "Yes, I am one of the lucky ones they take me to the park which is marvellous," "Not really because they are waiting for me to see if I fall. Yesterday I was on my way out to the garden and someone saw me and stopped me," "Yes, it was very hot and we sat in the garden yesterday" and "I go out sometimes, down to the local park."

We asked a member of staff if people's cultural needs were respected, in particular for one person whose first language was not English. They said, "Nothing is done to meet their cultural needs. No celebrations of events. We have people from Ireland and Scotland, but we don't celebrate things like St Patrick's Day." Following the inspection the provider told us, "We do celebrate St Patricks day, we do have friends of Threen House that organise various functions and celebrations within the home, we even have pictures to show that residents that residents cultural differences is celebrated within the home. We even have a DVD to show these celebrations."

Most of the care we saw was focussed on meeting people's personal care needs in a regimented, rather than a person-centred way. For example, all of the care records we saw said that the person should be supported to use the toilet every three hours. When we told the provider one person had called out on four occasions for staff to help them to the toilet, they told us they had supported the person with their personal care in the

morning and they had used the toilet, so did not need to go again. All of the daily recording in people's care records was health or personal care based and there was little mention of social care, activities or visitors. One person's care plan said that they could walk with a walking frame, with support from a member of staff but we saw the provider used a wheelchair to take this person to the visiting hairdresser. Following the inspection the provider told us, "The resident in question can walk limited distances, she does not like walking into a moving lift therefore a wheel chair is used, where we take her to the basement hairdressing room." However, the level of support the provider describes was not stated in the person's care plan.

At lunchtime on the second day of this inspection we used the Short Observational Framework for Inspection (SOFI) to observe the care and support people received in the service's conservatory area. We saw that most people did not have a positive experience during this time. People sat in armchairs or wheelchairs with an over bed table in front of them. The TV was on throughout lunch. There was very little interaction between staff and people, apart from the provider who spoke with one person. For most of the time, people were left on their own. Most staff only spoke briefly with people when they gave them their meals and did not ask people if they were enjoying their food or if they wanted more. One person appeared confused and tried to stand up. We called a member of staff who came immediately and gently encouraged the person to sit back down. The member of staff then stood over the person and fed them their meal. We did also see one member of staff who cut up a person's food after they had explained what they were doing and they then encouraged them to eat independently. This staff member also asked another person how they were managing with their food.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection of the service in January 2016, we found that the provider's care planning systems did not provide sufficient information about people using the service, their care and support needs and how the service would meet these. The provider sent us an action plan on 6 April 2016. They told us they had already taken action to address issues raised in the report and these would all be completed by 30 June 2016. In their action plan the provider told us, "All care plans will be reviewed to reflect people's needs and preferences in accordance with a 'person centred' approach. Care plans will be updated every six months or as often as the situation requires it to reflect the current situation and mark any improvement achieved. The quality of written records will be monitored by [the provider / registered manager] and the independent quality assessor."

Following our last inspection the registered manager left the service. The provider appointed a new manager who also left in July 2016, shortly before this inspection. During this inspection we saw that, before they left, the new manager had started to review and update some people's care records and these contained some good information about people's care and support needs. These records included a "This Is Me" form that detailed people's life story, significant people, dates and events, routines and preferences. This information was recorded in a person centred way. For example, one record included, "I like to sit in my favourite chair in the conservatory," "I like traditional English food like roast dinners and puddings" and "I don't like tomato in my sandwiches." Another record included, "I am able to feed myself," "I enjoy reading the newspaper," "I like to have my hair done regularly" and "I do not like a light on at night." However, the daily care notes staff completed concentrated on people's personal and healthcare needs and it was not possible to see if people received support in line with their preferences recorded on the "This Is Me" form. Throughout the inspection we saw that staff did not support people in the ways they said they preferred in their care plans. Staff told us they did not have time to read care plans and they failed to follow risk assessments and risk management plans, where these were available. Staff also told us they only had time to support people with their personal care and did not have time to arrange activities or spend time talking with people.

This evidence shows that the provider failed to respond effectively to the issues raised at our last inspection in relation to care plans not providing sufficient information to enable a person-centred approach to be adopted by staff providing care. There is clear evidence that people were not receiving care in ways they preferred to receive it.

We recommended in our last inspection report that the provider should refer to guidance on the provision of meaningful activities for people living in care homes. In their action plan the provider told us, "The services of a part-time Activities Co-ordinator will be engaged to ensure the structure of activities and events is managed in accordance with the comments made in the CQC report of January 2016." We spoke with the provider about the provision of activities and they told us they had not appointed the part-time Activities Co-Ordinator. They also told us there was a programme of activities but we saw no evidence these took place.

People using the service told us there were few activities organised for them. Their comments included, "There's nothing to do, I just sit here and look at the TV," "There is no one much here helping," "This is the longest time I have not done anything," "This is the first time I have been left out here [the person was in the conservatory]. Normally I am left in my room and I do my own thing," "I watch TV a lot, I like a noise, I don't like a silent room," "There's music one afternoon a week and a film once a week" and "There are about two afternoons a week that are occupied, nothing at weekends."

Staff told us people should have activities and they did have some, although not enough. One staff member said that they did not get time to do activities with people. Another member of staff told us, "Residents rarely go to the garden, there's no time." Another said, "Not a lot goes on here. No activities. People are bored. Lack of time." However, one member of staff said, "They have activities. A singer came last week. We look at pictures with them, we chat with them." Another member of staff told us, "They go out in the garden and we have had someone coming to sing. If we could improve, it would be to have more activities."

During the inspection we saw very few activities took place. On all three days, the TV was on and people were not consulted regarding their choice of viewing. On day three, some people sat in the garden for a short time, two staff members had a chat with some people and one briefly played a ball game with them. During the inspection the hairdresser visited the home and a number of people were supported to see them to have their hair washed and styled. We noticed that everyone who had been to the hairdresser had the same colour eye makeup and the same colour lipstick when they returned to the communal lounge. When we asked one person if they could choose their own make up, they told us, "Oh no, before you know it it's slapped on you and you are out of the chair." For the rest of the time during our inspection, people were left for long periods of time with no interaction and nothing to do or look at.

We looked at the record of people's activities for June and July 2016. These showed that one person took part in 11 activities. These included one physiotherapy session, two religious services, one chiropody session, two appointments with the visiting hairdresser, two gentle movement sessions and two garden visits. When we asked staff which garden the person had visited they explained this meant sitting in the service's garden. A second person took part in 10 activities in June and July, including a music session, three religious services, three film club sessions, chiropody, an appointment with the visiting hairdresser and one visit to the service's garden. A third person took part in seven activities in June and July. These included three religious services, one film club session, an appointment with the visiting hairdresser, one music session and a visit from the chiropodist. We saw no evidence of activities outside the home, although one relative told us they were part of a group of relatives (Friends of Threen House) who met three times a year and organised regular events, including some outings.

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

This evidence shows that the provider failed to respond to the issues raised in our last report in relation to a lack of provision of meaningful activities and also failed to complete a key action specified in their action plan of appointing an activities co-ordinator. This meant that people spent long periods with no meaningful activities for them to be engaged in or with.

When we asked people if their cultural or spiritual needs were met in the service, they told us, "We have the church service on the TV or radio," "I haven't been to church since I have been here. I was a church warden for 15 years but nobody will get me there because no one drives," "Two people died here and [the provider] drove us to the funeral, those who wanted to go" and "we had mass yesterday."

Three people told us they had never needed to make a complaint. Their comments included, "I would go to the top of [the local authority]," "There is a sheet you can fill in if you are not happy" and "I've never needed to complain." Some staff were aware of the provider's complaints procedure and said they would report any concerns to the provider. They were confident the provider would listen to them and act on their concerns. One care worker told us they were not aware of the complaints procedure, but would speak to someone first and complete an incident form. They also told us they would speak with a senior colleague if a person using the service wished to raise a complaint.

Inadequate

Is the service well-led?

Our findings

On the first day of our last inspection in January 2016, we saw that the provider had not displayed the service's Inadequate quality rating from our previous inspection in July 2015. At this inspection we saw the provider had displayed the quality rating on the notice board in the hallway of the service where people using the service and visitors could read it.

At our inspection in January 2016 we also found that, although the provider carried out some checks to monitor the quality of the service provided, these were not always effective. For example, people's care plans were not always regularly reviewed, staff training was not evaluated, there was no supervision or appraisals for staff and we found evidence of poor medicines management practises. The provider identified none of these issues as part of their monitoring of the service. The provider sent us an action plan on 6 April 2016. They told us they had already taken action to address issues raised in the report and these would all be completed by 30 June 2016.

At this inspection, we found that the provider had improved the management of medicines, but there were still concerns about the standard of care planning and risk management, staff training, staff recruitment and the provision of activities that the provider had not identified through their monitoring of the service. The provider was unable to show us any evidence of audits of care plans, risk assessments or medicines. In their action plan, the provider told us, "Reports made by the Quality and Systems auditor will identify any shortfalls and include an action plan with timescales." However, at this inspection the provider was unable to show us any quality monitoring reports they, or the independent quality assessor, had completed.

This evidence shows that the provider again failed to act as specified in the action plan they sent us. In addition, and as shown elsewhere in this report, the provider had also failed to complete several actions as specified in their action plan. Effective quality monitoring processes would have identified these, as well as other, shortfalls and ensured appropriate action was taken. The absence of effective quality monitoring systems therefore placed people who used the service at multiple risks of receiving inappropriate and unsafe care which was also not person-centred as we have clearly shown elsewhere in this report.

This was a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The provider is registered with the Care Quality Commission (CQC) as an individual and does not require a registered manager. However, the service had always had a registered manager as the provider did not have the qualifications to manage a care home providing accommodation for people who require nursing or personal care. The service did not have a registered manager. The previous registered manager left the service following the last inspection in January 2016 and another manager appointed by the provider in May 2016 left in July 2016, shortly before this inspection. Two weeks after this inspection the provider told us they had appointed a new manager who would apply for registration with the Care Quality Commission (CQC).

Staff were complimentary about the provider and told us they felt supported by him. Their comments

included, "[Provider] is always here, 24/7," "[Provider] is nice. We ask for help, he gives us help," "He doesn't look like a manager. He's nice and works with us. He is patient and answers all my questions. For him, the most important thing is the residents. I told him, 'you are very nice and kind with people. I like your way'. It's about trust. People like him" and "I love the fact that the manager is involved with people. I find that fantastic." A relative we spoke with told us, "There have been some changes since the last inspection. We got together with other relatives to discuss the report. At times, there was a bad atmosphere. This has improved considerably. Communication could still be improved further."

The provider had completed some health and safety audits and they were able to show us reports that analysed responses to questionnaires sent to people using the service, their relatives and professionals involved in their care. Comments from professionals in June 2015 were positive, including, "Staff and management is excellent and exceeds the standards I would expect." Responses from people using the service and their relatives in April 2016 were also largely positive. Where people made comments on improvements they wished to see, the provider recorded their response. For example, one person said they wanted to see "More single accommodation" and the provider responded "This is available at a premium." Another person said they would like more activities and the provider responded, "New and improved activities have been actioned. Examples include live entertainers, panto, saxophonist, mini concert, trips to the park and days out to the local shopping centre." However, we saw no evidence of this range of activities being available for people using the service during the inspection or in the care records we reviewed. We have shown elsewhere in this report how a clear lack of meaningful activities was having a negative impact for people who used the service.

As this service has again been rated as overall Inadequate and hence remains in special measures, we have judged the correct rating for this domain to also be Inadequate. This is because, despite our two previous inspections very clearly setting out the required improvements needed to ensure people who have used this service received safe and good quality care, the provider had clearly failed to respond and make such improvements sufficiently. In addition, the provider had clearly failed to carry out the actions specified in the action plan they sent us following our last inspection.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person did not design care and treatment with a view to achieving service users' preferences and ensuring their needs are met. Regulation 9 (3) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment of service users was not always provided with their consent. Regulation 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. Regulation 17 (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered person did not operate effective

recruitment procedures

Regulation 19 (2)

The registered person did not ensure staff had the qualifications, competence, skills and experience that are necessary.

Regulation 19 (1) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Persons employed by the service provider did not receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (2) (a)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not assess the risks to the health and safety of service users Regulation 12 (2) (a) The registered person did not do all that is reasonably practicable to mitigate any such risks. Regulation 12 (2) (b)

The enforcement action we took:

We issued a Warning Notice and required the provider to become compliant with Regulation 12, section 2 (a and b), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014