HC-One Limited

Wymeswold Court

Inspection report

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Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Requires Improvement**

Overall summary

An unannounced inspection took place on 5 February 2015 and we returned on 6 and 9 February 2015 in order to complete our inspection. Our previous inspection of 24 September 2014 found the provider was not meeting two regulations at that time. These were in relation to care and welfare of people who use services and assessing and monitoring the quality of service provision. Following that inspection the provider sent us an action plan to tell us about the improvements they were going to make. At this inspection we found that the necessary action had not been completed and there were continued breaches of these regulations. We also identified two additional breaches in relation to staff support and management of medicines.

Wymeswold Court provides care and support for up to 40 older adults with a variety of needs including people with dementia. The home has two floors with a number of communal areas and gardens available for people to use. There were 23 people using the service at the time of our inspection.

Summary of findings

The previous registered manager had left in October 2014. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. A new manager had been recruited and had been in post for weeks at the time of our inspection. We were considering their application to become a registered manager at the time of our inspection. The provider had also given responsibility for oversight of the home to a new area manager.

People using the service had mixed views about the home and the care and support they received. Some people were satisfied with their care and support and told us they were treated with kindness and respect. Other people told us they would have liked more activities or events and some described inadequacies in their care. Some people's relatives were also happy with the home and the staff team. We were told that staff were considerate and helpful and had a good understanding of their family member's needs. However, other relatives were not so confident in the care being provided and were concerned about their family member.

People's likes, dislikes, preferences and individual needs had been recorded by the service but we found examples when people's wishes had not been followed. There was limited evidence that people had been involved in making decisions about their care. People had the opportunity to express their views about the service being provided in residents meetings but it was not clear how their suggestions were put into practice by the provider.

On many occasions we observed care being provided to people appropriately by staff who were kind, patient and friendly. These staff offered people choices and were helpful and appropriate in their approaches and engagement. However, we also observed occasions where staff treated people with a lack of respect and consideration. Most staff promoted people's dignity and communicated effectively but this was not consistent and there were occasions where people's dignity was not respected. Most staff we spoke with had a good understanding of people's needs and were committed to providing the best care they could.

Staff recruitment procedures were robust and ensured that appropriate checks were carried out before staff started work. Staff had received training and support to assist them in their roles, however this was ineffective. We observed occasions where staff did not put their training into practice. For example, we observed the unsafe administration of medicines and unsafe moving and handling procedures. Health professionals we spoke with both before and during our inspection raised concerns about the competency of the staff team. We were told that staff did not put their learning into practice which had caused shortfalls in people's care.

There were significant shortfalls in the planning and delivery of people's care and people had been placed at risk as a result. People's needs in relation to their behaviour had not always been responded to appropriately by staff at the service and there was confusion and inconsistency about this area of practice. People's health needs had been responded to and monitored but advice from health professionals had not always been incorporated and acted on by the staff team.

People's nutritional and dietary requirements had been assessed and a nutritionally balanced diet was provided. People received the support they required in relation to eating and drinking but this was not always carried out in a dignified manner.

There were enough staff available to meet the needs of people who used the service but people were not always able to call for help when they required it because call bells were out of place or not available.

People's care needs, particularly in relation to their personal care had not always been met adequately. Many people's bedrooms were dirty and unhygienic and their bed linen was soiled, stained and worn. Procedures for the appropriate disposal of clinical waste were not being followed. The new management team took immediate action to address these issues and we noted an improvement on the subsequent days of our inspection.

Medicines were safely stored and but people had not always received their medicines as prescribed because the systems for re-ordering of medicines were inadequate. This meant that the service had run out of people's medicines on a number of occasions. We also observed medicines being administered in a way that did not protect people from the associated risks.

Summary of findings

Staff were aware of how to protect people from avoidable harm and were aware of safeguarding procedures to ensure that any allegations of abuse were reported and referred to the appropriate authority. The requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2008 were known and understood by the new management team but there was inconsistency in how they had been applied by previous managers.

Incidents, accidents and complaints had been reported but they had not always been robustly investigated and responded to appropriately. Learning from these issues was not evident.

There were systems in place to assess and monitor the quality of the service but these were ineffective as they had not identified the widespread and significant shortfalls in service provision. This had placed people at risk of receiving inappropriate or unsafe care. The new management team were committed to making the necessary improvements and have an action plan in place to help them achieve this.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which correspond to three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we took at the back of this report.

Summary of findings

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 had not received their medicines as prescribed. Risk assessments were in place but staff were not always providing care in the safest way. Accidents and incidents had been reported but not always responded to appropriately.

People's bedrooms had not been maintained or cleaned to an acceptable standard. Action was taken to address this during our inspection.

Managers were aware of local safeguarding procedures. Staff had been properly recruited and there were sufficient numbers available to meet the needs of people who lived there.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People had not always been supported to maintain good health. Staff did not always have the skills or knowledge to deliver effective care to people.

Principles of the Mental Capacity Act 2005 had not always been adhered to.

People had received support in relation to eating and drinking but this was not always delivered in a dignified way.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Some people told us staff were caring in their approaches and we observed some positive interactions. We also observed occasions where staff did not promote people's dignity and acted in a disrespectful manner.

People were not always involved in decisions being made about their care and support.

Is the service responsive?

Inadequate

The service was not responsive.

People's care and support had not been planned and delivered in an effective way and people's care needs were not always met. There was limited evidence of people's involvement and engagement in the planning and delivery of their care but most staff were aware of people's individual needs.

There was a complaints procedure in place but learning and responding to complaints was not always evident.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Summary of findings

There were significant failings in management systems and people had been placed at risk of inappropriate or unsafe care as a result. The home had been without a registered manager since October 2014. A new manager and area manager had been recently appointed but due to the short timescales they had been unable to bring about the required changes. The new management team have sent an action detailing the improvements they are making.

Wymeswold Court

Detailed findings

Background to this inspection

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

Before the inspection the provider completed 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 reviewed the PIR, other information we held about the service along with notifications that we had received from the provider. A notification is information about important events which the service is required to send us by law. Prior to our inspection we received information of concern from health professionals, the local authority and others. These concerns related to standards of cleanliness, staff competency and the standard of care people were receiving. We took this into account during the inspection.

This inspection took place on 5 February 2015 and was unannounced. We returned on the 6 and 9 February 2015 in order to complete our inspection. The inspection was carried out by three inspectors.

We spoke with nine people who used the service. We also spoke with 4 visiting relatives about their views of the service, a visiting health professional and a visiting social worker. We spoke with the area manager, manager, deputy manager and seven staff members including care workers and kitchen assistants.

We reviewed a range of records about people's care and how the home was managed. This included six people's plans of care, six staff records, medication records and records in relation to the management of the service such as audits, checks, policies and procedures.

Inadequate

Is the service safe?

Our findings

People did not always receive the medicines they needed. These included medicines prescribed for serious medical conditions. People's medicines were not being handled safely by staff at the home. Although they were being stored correctly, systems for the reordering of peoples medicines were not effective which meant that some people had not been given their medicines as they were prescribed. Five people's medicines had run out of stock within the last two months. Two people had been without two of their medicines for four and five days respectively. Another person had been without one of their medicines for eight days and a fourth person had been without one of their medicines for 13 days. This persons' medicine records had been signed by a staff member to state that this medicine had been administered, though it had not. The fifth person had run out of their medication used to control their pain the day before our last visit. Other medicines that had not been administered correctly included medicines used to treat high blood pressure, allergies and the symptoms of dementia. There were clear risks therefore to people's health and welfare when they did not receive the medicines that they needed as prescribed by their doctor. Although staff had noted medicines were out of stock they had failed to seek medical attention for people when they had not been able to administer their medicines.

Monthly medication audits and daily spot checks carried out by the management team had not picked up these shortfalls. There were not systems in place to ensure the safe management of people's medicines.

We observed the senior on duty during one of the lunchtime medication rounds and found that safe administration procedures were not always followed. We found two people's medication in separate pots stacked on top of each other on top of the drugs trolley. These medicines had been left unattended until the senior returned from assisting another person. There was no record of who these tablets belonged. The door to the room where medicines being stored was unlocked. This meant there was a risk of people receiving the wrong medication and the service was not protecting people from the risks associated with medicines.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the management team about these issues as soon as we identified them. The matter was also referred to the local authority safeguarding team. The provider sought assistance from the pharmacist immediately following this to carry out a full audit of people's medicines and ensure that stock levels were all in place to prevent future occurrences and thorough medicine audits were put in place.

Our previous inspection found people's care and treatment had not been planned and delivered in a way that was intended to ensure people's safety and welfare. This was a breach of Regulation 9 of the Health and Social Care Act 2008 and we asked the provider to take action to rectify this. Following this inspection the provider sent us an action plan detailing the changes they would make.

We looked at people's care records and found they included individual risk assessments which identified potential risks to people's health or welfare. Risk assessments recorded these risks and any action that should be taken to minimise the risk. For example, we found that risk assessments were in place where people were at risk of falls or developing pressure sores and these detailed action staff should take. However, our observations showed staff were not always following these risk assessments and providing care in the safest way. For example, on the first day of our inspection we found one person had not been seated on a pressure cushion to prevent the known risk of them developing pressure sores. This was addressed by the management team and the person was seated appropriately during our subsequent visits.

We also saw three instances of unsafe moving and handling procedures being carried out. One staff member became distracted whilst supporting a person to walk with their walking frame and took their attention away from what they were doing. The staff member did not gauge the distance between the chair and the walking frame and did not ensure the area was hazard free which placed this person at risk. We also saw staff become distracted whilst hoisting people and begin talking across the room rather than concentrating on ensuring the transfer was being

Inadequate

Is the service safe?

carried out safely. On two occasions we saw a staff member knocking people's legs with equipment during moving and handling procedures. We did however see some examples of good moving and handling practices by other staff working at the home.

Any accidents or incidents that had had occurred, such as falls or behavioural challenges had been recorded and logged onto a computer system so the provider could review and analyse. However we found appropriate action had not always been taken to investigate and respond to these issues. For example, there were two body maps completed for one person which showed unexplained bruising and skin tears but no investigation had taken place, despite this being drawn to the attention of the manager who was in post at the time.

We found a record of an incident where a staff member had reported a situation where they had been attacked whilst attempting to carry out personal care. However, the responses they recorded to the incident were highly inappropriate and placed this person at risk of harm. This incident had been reviewed by a senior manager at the time and had not been investigated.

People and their relatives gave us mixed responses when we asked whether the home was safe. One person's relative told us, "It's a good home, the staff are lovely" and other people said, "The staff are very nice" and "What more do I want, it is a good home and I feel safe here".

Another person's relative told us, "I don't think she [family member] is safe in her bedroom because of where her chair is; she can't reach the bell". Another person's call bell was trapped behind their headboard. A further persons' call bell had been removed for their safety but no alternative had been put in place so they could call staff if they required assistance. We asked how they would call someone and were told, "I would shout, they reckon they check but I don't believe them". This persons' care plan stated staff should carry out hourly checks to ensure this persons' safety but these were not being carried out. We spoke with the managers of the service about these issues on the first day of our inspection and they took immediate action to ensure people's call bells were located in an appropriate place and alternative systems were sought when call bells were inappropriate.

This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although the communal areas of the home were well maintained and safe for the people living there, we found that some people's bedrooms had not been maintained to an appropriate standard. Due to our concerns about the standards of people's bedrooms we carried out a full check of all bedrooms, (where it was appropriate to do so) on the first day of our inspection. Some of the carpets were stained and soiled, wallpaper was ripped and there was evidence of black mould on windowsills. Some people's curtains were frayed and the blackout lining had deteriorated on the backs of the curtains. Most people's bedding was old and worn and some was soiled, ripped or stained.

Some people's bedrooms had not been cleaned to an appropriate standard. Many people had stained and soiled chairs and their toiletries and personal items were dusty and on occasion unhygienic. Some people's bedrooms were malodorous and we found that clinical waste was being disposed of in people's bins rather than in appropriate bins suitable for clinical waste. This meant that people were being placed at risk of cross-infection due to poor standards of hygiene and cleanliness.

We drew our findings to the immediate attention of the manager and area manager. The area manager had already recognised some of these issues and the upstairs carpet was in the process of being replaced. Some of the bedrooms had also been listed on a schedule for re-decoration. However, the area manager agreed this was unacceptable and took immediate action to rectify these issues. Bedrooms were deep cleaned during our inspection and an order was placed for new bedding for all people living at the home. During the subsequent days of our inspection we noted that improvements had been made to the cleanliness of people's bedrooms and the proper facilities for the disposal of clinical waste were being used. The old bedding was disposed of immediately and new bedding placed on people's beds. New chairs, curtains and other items had been ordered to replace old ones.

People we spoke with were confident there were enough staff available to meet their needs and told us staff responded promptly when they requested help or

Inadequate

Is the service safe?

assistance. Staff we spoke with gave mixed responses about whether there were enough staff on duty although most told us they had enough time to meet people's needs. During all three days of our inspection we found call bells were responded to promptly and people did not have to wait to have their care or support needs met.

Staff were aware of the proper procedures to report any safeguarding concerns and told us they had received training about how to protect people from the risk of abuse. Records we looked at showed that most staff had received training in this area. The new management team were aware of local procedures for reporting concerns about people's welfare and any allegations of abuse. We saw evidence that the provider was working collaboratively with the local authority to investigate safeguarding issues within the home.

We looked at staff records and found that appropriate checks were undertaken before staff began working at the home. This meant people using the service could be confident that staff had been screened as to their suitability to care for the people who lived there. However, one record we looked at showed the staff member had a conviction on their police record. The deputy manager was aware of this and did not consider the conviction to have any impact on the safety of people living at the home. However, there was no formal risk assessment in place to document this which would have recorded how the information had been considered and conclusions reached.

Requires Improvement

Is the service effective?

Our findings

People using the service were confident their health needs were being met and they told us they had been supported to see relevant health professionals when it was appropriate. One person told us about the GP being called when they had a bad cough and people's relatives also told us of other occasions when health professionals had been involved in their family members' care.

Prior to our inspection we had been contacted by two health professionals raising concerns about the support people received to maintain good health at the home. There were concerns that professional advice had not always been understood and incorporated into practice and that people's well-being had not been promoted. We were also aware of an on-going safeguarding investigation where it was alleged that staff had not recognised and responded to the deterioration in one persons' health which had caused them harm.

Records we looked at provided information about people's health conditions and showed that referrals to relevant health professionals had been made. In most cases, advice from health professionals had been incorporated into people's care plans but we found some instances where it had not. We also found some instances where guidance and advice was not being followed by the staff team in the delivery of people's care. For example, one persons' care plan made reference to guidance from the dietician but did not include all the information that had been given. Another persons' guidance from their speech and language therapist gave specific guidance for staff to follow with regard to communication with this person. This had not been incorporated into their care plan and staff were unaware of this. We also found guidance from an occupational therapist about carrying out daily exercises with one person. Although most staff were aware of this they were not all clear about who was responsible for carrying out these exercises and when they should take place.

We spoke with a visiting health professional who told us that some staff were not proactive about seeking advice from health professionals and questioned the competency of some of the staff. We were told training had been provided but staff had failed to out this into practice. They described how community nurses were increasingly concerned that the basics were being missed. We spoke with the manager about these issues and found they had already had a meeting with the community nursing team to develop communication and resolve these issues.

We looked at how staff had been supported to deliver effective care to people. Staff we spoke with told us that they had received a period of induction when they first started working at the service and appropriate training courses such as moving and handling and safeguarding awareness had also been provided. One staff member told us, "I think the training is excellent, I am waiting to do palliative care and end of life training next." Records we looked at confirmed this. All staff we spoke with said they had been provided with enough training to enable them to carry out their roles effectively. Staff felt supported by the management team, meetings had been held and staff told us that supervision sessions had been provided. Records checked however showed us that only four members of the staff team had been provided with one of these sessions so far this year.

Staff told us that they could go to the management team at any time. One staff member told us, "I have noticed when I have had any concerns, I've spoken with [the acting manager] and she has dealt with it, there is definitely support there."

A healthcare professional visiting at the time of our inspection and other healthcare professionals we spoke with prior to our inspection told us that they felt that the staff sometimes struggled to retain the information included in training they had provided. We were told, "I have given training in catheter care but they still don't follow through".

During our inspection we observed occasions when staff did not put their training into practice. For example, we observed unsafe moving and handling procedures and unsafe administration of medicines despite staff having received training in these areas. We also found shortfalls in staffs' understanding of how to respond and manage inappropriate behaviour. This meant that staff training was ineffective and their competency to deliver care and support was not being checked. As a result people were placed at risk.

The management team were aware of the need to update staff's understanding in specific areas of care and were confident that's these shortfalls could be addressed. We

Requires Improvement

Is the service effective?

drew our concerns regarding staff training to their attention during our inspection and further training for staff in moving and handling procedures and dementia awareness has been arranged.

There were policies and procedures in place in relation to the Mental Capacity Act (MCA). The MCA is a law providing a system of assessment and decision making to protect people who do not have capacity to give consent themselves. Staff we spoke with were aware of the MCA and the management team had a good understanding of their responsibilities with regard to the MCA. Some records we looked at showed that where people lacked capacity to make a decision about their care or support, the proper procedures had been followed. This included carrying out a mental capacity assessment in consultation with relevant individuals and professionals. However, the application of this was inconsistent as other people's records showed the MCA had not been followed when staff considered people lacked capacity to make decisions about their care and treatment.

The Deprivation of Liberty Safeguards (DoLS) had been used appropriately by the provider. The DoLS are a law that requires assessment and authorisation if a person lacks mental capacity and needs to have their freedom restricted to keep them safe. The management team had a good understanding of the circumstances which may require them to make an application to deprive a person of their liberty and had recognised the need to make an application for a person who had been newly admitted to the home. However, again the application of this was inconsistent as we found DoLS had not been considered when people were displaying signs of being resistant to their care or restrictive practices were in place. We discussed this with the manager and the area manager told us that several DoLS applications had subsequently been made.

Most people we spoke with told us the food provided at the home was good and they enjoyed their meals. People told us they had enough to eat but one person told us they had not been offered any breakfast. We spoke with a care worker about this and were told they had not been offered any breakfast because they had got up late. We spoke with area manager about this and they told us this was unacceptable and people should always be offered breakfast. All other people using the service had been offered breakfast on this day. People told us they had a choice of meal and we observed this to be the case. Relatives told us that staff were aware of people's food preferences and provided meals accordingly.

We look at the food and drink people were offered during our inspection and observed the lunchtime meal. We saw the meal was freshly prepared, nutritious and nicely presented. People had been supported to make a choice of food and drink and were provided with a choice of both hot and cold drinks throughout our visit. Records we looked at identified whether people were at nutritional risk and detailed action staff should take to mitigate these risks. People were given food and drink in a way that met their needs, for example soft diets were catered for and people had thickeners in their drinks when appropriate. We observed occasions where people were assisted to eat and drink appropriately. However, on some occasions they were not supported in a dignified way. We observed one care worker supporting two people to eat their meal at the same time. This did not promote either person's dignity.

Requires Improvement

Is the service caring?

Our findings

Some people we spoke with told us the staff were caring. One person told us, "They're all very nice" and another said, "They do their best". Relatives we spoke with told us staff were friendly and helpful.

However some people raised concerns with us about the staff team. One person said, "The carer can be all lovey dovey with you and next time [the carer will] come and see me and then go off and say that [they haven't] got time. [They] can be horrible, but some of them are very caring." Another person told us, "It's 'schoolish', some have no flexibility, you have to do as they say. I haven't had any breakfast, I'm starving. Some of them are extremely kind though". A third person said, "The staff are hectic, one or two are alright though". We passed these comments onto the management team who agreed to look into the concerns.

During our visit we observed many interactions and exchanges between people living at the home and the staff team. The majority of staff were kind and attentive in their approaches to people and took the time to explain to people what was happening and gave them the opportunity to make choices about how they would like their care and support to be provided. Some staff demonstrated a genuine rapport with the people living at the home and took the time to ensure people were comfortable and had everything they needed. Some staff were skilled at speaking with people who had limited communication or needs in relation to their dementia and we observed people benefitted from these interactions with staff as they were smiling and enjoying the exchanges.

However, not all staff approaches were as positive. Some staff provided care and support with limited interaction with people. For example, we saw staff moving people in their wheelchairs without first taking the time to tell people where they were going. We saw another person ask the staff member what was happening whilst they were being hoisted because the staff member had not communicated that they were being moved to their chair. We observed some staff interacting inappropriately with people which was not in accordance with their care plan. This gave the person mixed messages and they became confused about staff reactions to them.

Staff we spoke with gave us appropriate examples of how they maintained people's privacy and dignity. One staff member explained, "I make sure the curtains are closed and the door is shut. I explain what I am going to do…I keep them covered up and ask them how they want things to be done". We found that staff had received training in these areas and some of the staff team were 'dignity champions'. However, we found that this training and initiatives had not always been put into practice as we observed some practices at the home where staff had not promoted people's dignity and acted in a respectful manner. For example, we observed one staff member providing support at meal times to two people at the same time. This was undignified as the staff member did not focus on each person's individual needs .This staff member also used inappropriate and undignified language to describe this by referring to people as 'the feeders'.

Staff did not always treat people in a respectful manner or consider their needs. We found a toilet in the bathroom was heavily soiled and blocked. A staff member attempted to take a person into this bathroom and we drew it to their attention that the bathroom was in an unpleasant state. The staff member told us they were aware of the blocked toilet and proceeded to take the person into this bathroom regardless. There were other clean bathroom facilities available at the home. This demonstrated an uncaring attitude and lack of respect for the person.

Most people we spoke with told us they were able to make decisions about their care and support. For example, they said they could get up and go to bed when they wished. However, other people felt at times they were not always involved in the decisions being made about their care. Records showed that people's individual needs, wishes and preferences had been sought and recorded but it was not always clear how these were acted on. People had regular reviews of their care but records did not always record the persons' view or those of their relatives.

Inadequate

Is the service responsive?

Our findings

Our previous inspection found people's care and treatment had not been planned and delivered in a way that was intended to ensure people's safety and welfare. This was a breach of Regulation 9 of the Health and Social Care Act 2008 and we asked the provider to take action to rectify this. Following this inspection the provider sent us an action plan detailing the changes they would make. During this inspection we looked to see if improvements had been made. Although people's care records had been regularly reviewed and updated, the planning and delivery of people's care was inconsistent and at times ineffective. We also found that people's care needs had not always been met and advice from health professionals had not always been incorporated in people's care.

Some care plans provided insufficient guidance to staff about how people's needs should be met. This was particularly apparent with regard to people's needs in relation to their behaviour. From looking at incident charts we identified that some people were having incidents of challenging or inappropriate behaviour but there were no corresponding care plans in place which detailed how staff should respond to such incidents. Where there was mention of people experiencing behavioural difficulties, there was insufficient guidance for staff to follow. This placed people at risk of receiving inappropriate or unsafe care and support from the staff team. We found evidence on one incident form where a staff member had responded inappropriately to a behavioural challenge and placed the person at risk.

We spoke with the staff team about incidents of challenging behaviour and how they approached them. We found their responses to be inconsistent and at times confusing. Staff described different ways of dealing with people's behaviours and other staff did not consider people to display any challenges at all. For example, a staff member described a recent incident to us where a person had become anxious and aggressive towards them. They said this incident had been reported to the deputy manager at the time and as a result an additional staff member had been introduced at night. However, the deputy manager had told us that this person did not experience any behavioural difficulties that they were aware of.

Where care plans did have clear guidance in place for staff to follow, we found they were not always being followed. For example, we found one person seated without the pressure relieving cushion they required and observed a staff member responding to a person in a way that was inconsistent with their care plan which gave the person mixed and confusing messages.

On the first day of our inspection we found that people's care needs had not always been met, particularly in relation to their personal care needs. This meant that staff were not delivering effective care to people. For example, we noted that many people's toothbrushes were bone dry and caked in toothpaste and so we concluded that people had not been adequately supported with cleaning their teeth which staff were required to do. We showed this to the area manager and they agreed with out conclusions. One person did not have any toothpaste and told us they could clean their own teeth but had been requesting toothpaste for some while. We also found that people's soap and personal toiletries were unused or dusty which we concluded meant they had not been supported to use these. One person's records showed that the dentist was unhappy with the plaque build-up on the persons' teeth and requested staff support them more thoroughly. People's individual needs were not being met.

We observed that some people at the home appeared unkempt and had dirty fingernails, despite individual charts recording that staff had supported them with these tasks. One persons' care plan recorded they would like a daily bath and should be shaved and have their hair washed on a daily basis. However, records showed they had only had their hair washed on three occasions, been shaved on 12 occasions and bathed on three occasions throughout January 2015. There was no nail care at all recorded during this period. Another person had not been bathed at all throughout January 2015 but a daily 'wash' was recorded.

This meant there was a continued breach of Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the area manager and manager about these concerns on the first day of our inspection and they agreed our findings were unacceptable and took action to rectify this. The area manager ensured the purchase of new

Inadequate

Is the service responsive?

toothbrushes, toothpaste and toiletry bags for all people living at the home and ensured nail care was carried out for all who required it. The managers also agreed to review the delivery of personal care so as to ensure this was being carried out effectively by the staff team. We saw a marked improvement in people's appearance on subsequent days of our inspection.

Most people we spoke with were satisfied their care needs were being met and were confident that staff supported them in the right way. One person's relative also told us that staff had a good understanding of their family members' requirements and ensured they had the right care and support. One person said, "It's a lovely home and I'm well cared for".

However, one persons' relative said, "We were told that she [their relative] could have a shower daily but she's only had one bath". Another persons' relative told us, "I worry a lot…she could do with a bath and we would like more doing".

We looked at people's care plans during our inspection and found that care plans did contain some detail in relation to people's personal histories and preferences and that these had been recorded where possible. However, we saw little evidence of people being involved in the care planning process and this was not being documented at the home. People had not always consented to their plan of care and people were not involved in the on-going reviews of their care plans.

People were able to express their views about the service during meetings held for people using the service, however, these were held three times in 2014 and it was not possible to determine any other systems in place to enable people to express their views about their care on a regular basis. People using the service were positive about the home and said they were well cared for, however, care plans did not provide evidence of people being enabled to contribute to how their care was delivered to them.

Several people told us there were limited activities at the home. On the first day of our visit people had very little to do, although this improved on subsequent visits when people were encouraged to listen to music, take part in games and go for a walk. One person said to us, "It's monotonous here", another told us, "We just sit around normally" and a third said, "I hardly ever go out. I have been out on the bus but not very often". They went on to tell us about places they would like to go and family they would like to visit. Another person told us they would really like to do some baking. We spoke with staff who told us about visits to the garden centre and a tea dance that people had taken part in and some told us they had arranged trips but people did not want to go. Other staff told us that people did not have much to do in the winter but there was more going on in the summer. It was not clear how people had contributed to the activity schedule and how people's likes and dislikes, hobbies and interests had been considered.

People using the service told us they would be happy to raise a complaint or concern with the new manager and relatives we spoke with felt the manager was approachable and friendly. They told us they were able to speak with the manager whenever they wanted. There was a complaints policy in place at the service and a system in place for dealing with complaints received. We looked at the complaints that had been received by the home, most of which had been dealt with by the previous management team. We found they had been responded to promptly and action taken to resolve matters on some occasions. However, there were complaints about people's personal hygiene, cleanliness of the home and staff not following moving and handling procedures. In these cases the previous management team had responded with the action they were going to take to investigate and make improvements. We could not see that this had happened as we found evidence that these areas were still a cause for concern during our inspection.

Requires Improvement

Is the service well-led?

Our findings

Our previous inspection found there was an ineffective system in place to monitor and assess the quality of service being provided. We found that audits were not effective and there was a lack of learning from incidents. This was a breach of Regulation 10 of the Health and Social Care Act 2008 and we asked the provider to make improvements. During this inspection we looked to see if improvements had been made and found significant shortfalls in a number of areas.

We identified numerous concerns in a number of areas throughout all areas of service provision. These included the management of people's medicines, the delivery of people's care, staff training and competency, cleanliness and maintenance of bedrooms, the management of incidents, accidents and complaints at the home and quality assurance. There was a system in place to assess and monitor the quality of service provision at the home but this was inadequate as it had failed to identify and respond to a number of concerns that we identified during our inspection. This meant that people had not been protected from the risk of inappropriate or unsafe care because of the failure in the management systems. **This meant there was a continued breach of Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

We discussed our findings with the manager and area manager. The home had been without a registered manager since October 2014 and had been managed by different managers from a number of the providers other homes in the interim. The provider had appointed a new manager for the service who had applied for CQC registration at the time of our inspection. This manager was new in post and new to the organisation and had only been responsible for the running of the home for a matter of weeks at the time of our inspection. The area manager was also newly responsible for the oversight of the service and we saw evidence that they had identified some issues at the home, but due to the timescales involved had not been able to bring the necessary improvements at the time of our inspection. During our inspection the area manager took immediate action to rectify some of the issues we identified and has provided us with an action plan to address the other failings. We considered that the manager and area manger had the potential to provide strong leadership to the home but due to the prior inconsistencies and gaps in management oversight there were still widespread and significant shortfalls in the way the service had been led. This had impacted on the care and support people living at the home had received and many had been placed at risk as a result.

Staff we spoke with told us about the difficulties they had had with management changes and inconsistent direction and oversight. However, they were all confident in the new management team and hoped this would provide consistency and direction to them. All staff we spoke with told us they were committed to providing the best care they could and most welcomed the changes that were being introduced. Health professionals told us they had met with the new management team and hoped to develop better working relationships with the home in the future.

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 did not take formal enforcement action at this stage. 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 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services** **How the regulation was not being met:** **People's care and treatment had not been planned and delivered in a way that ensured people's safety and welfare and meet their individual needs. Regulation 9 –(1)(b)(i)(ii)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of Medicines** **How the regulation was not being met:** **People were not being protected against the risks associated with unsafe use of medicines because the provider did not have appropriate arrangements in place to manage medicines. Regulation 13**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision.** **How the regulation was not being met:**

This section is primarily information for the provider

Action we have told the provider to take

Systems designed to protect people from inappropriate or unsafe care were ineffective and poorly managed. Regulation 10-(1)(a)(b)