Bostan Care Homes Ltd

Woodford Care 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?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Woodford Care Home is situated on a main road in Hull and consists of three combined terraced houses. It is registered to provide accommodation and personal care for up to 18 people. The home has a mixture of single and shared bedrooms over two floors. Communal rooms consist of a main lounge, an additional smaller lounge and a dining room. There is also a third room, used as a thoroughfare that has two easy chairs. There are several bathrooms, although only one has an assisted bath. At the time of the inspection, there were 13 people using the service.

This unannounced comprehensive inspection took place on 20, 22 and 29 September 2016. The inspection was carried out by one adult social care inspector. At the last inspection of the service in August 2015, the registered provider had achieved compliance with the regulations we had found to be non-complaint during inspections carried out in February and May 2015.

There was no registered manager in post at the time of this inspection. 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.

A registered manager left the service in April 2016. A manager was recruited who began the application process to become the registered manager but they left the service in August 2016. A senior carer was then promoted and is referred to as the 'acting manager' throughout this report.

During this inspection, we found that the registered provider had failed to sustain the improvements we found at the last inspection of the service in August 2015.
We found multiple breaches of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special Measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the registered provider's registration of the service, will be inspected again within six months. The expectation is that registered providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of Inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the registered provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where

necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of Inadequate for any key question or overall, we will take action to prevent the registered provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

The infection control practices within the service increased the risk of people contracting a healthcare related infection. Staff carried soiled laundry through the home and we saw used incontinent pads left on the shelving in people's rooms. The extractor fan in the main bathroom/toilet, which is situated off the main lounge and adjacent to the kitchen; was not working at the start of our inspection this increased the risk of air borne spoors contaminating the lounge and the kitchen.

The environment was not maintained effectively to ensure the safety and welfare of the people who used the service. Vulnerable people had access to water temperatures that could have burnt or scalded them because the registered provider had failed to ensure safe water temperatures were maintained.

Safe recruitment practices were not followed. The registered provider had failed to assure themselves that prospective staff were suitable to work with vulnerable adults because they failed to undertake Disclosure and Barring Service (DBS) checks or acquire suitable references before staff commenced working with vulnerable people autonomously.

Staff with relevant training, skills and abilities were not always deployed. We cross-referenced the staffing rotas and staff training records and saw that on numerous occasions during July, August and September 2016 staff working the night shift had not completed important training. This included dementia, infection control, health and safety, fire, first aid, food hygiene, the Mental Capacity Act 2005 (MCA) or Deprivation of Liberty Safeguards (DoLS) or medication training. This exposed people to the risk of not receiving the care and support they were assessed as requiring.

Staff were not supported effectively and had not received regular supervision, appraisal or professional development.

The CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of adults by ensuring if there are restrictions on their freedom and liberty, these are assessed by appropriately trained professionals. The registered provider had not fulfilled their responsibilities in relation to DoLS; they had failed to identify who met the criteria for DoLS and to submit applications to the supervisory body as required. This meant that people who used the service may be unlawfully restricted.

People were supported to eat and drink sufficiently to meet their needs but we found choices of meals were limited and people were not always offered alternatives if they did not want to eat the main meal options.

During the inspection, we observed a range of care and support and witnessed staff supporting people and meeting their needs in a caring way. However, we also witnessed staff not responding to people's questions or requests in a caring way and noted that, on more than one occasion staff actions failed to maintain people's dignity.

People's care plans did not reflect their current level of needs and we found two people had not had a care plan created by the service. This meant staff may not be fully aware of people's needs or the care and support they required.

The registered provider had a complaints policy that included acknowledgement, investigation and response times. The policy was made available to people who used the service.

There was no evidence that any form of auditing or quality assurance had taken place within the service between April and September 2016. The acting manager had completed tests of the emergency call bell systems in three random rooms and undertaken infection prevention and control audits on three occasions in September 2016. However, the audits failed to highlight the concerns found during our inspection and their findings were not sufficient to drive improvement within the service.

The registered provider had failed to adhere to advice and guidance provided by relevant persons such as the local fire authority and the environmental health team.

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 who used the service had access to water that exceeded recommended temperatures which could have burnt or scalded them.

Staffs actions increased the risk of healthcare related infections spreading throughout the home. Areas of the service could no longer be cleaned effectively.

Appropriate action was not taken to mitigate known risks to people's health, safety and welfare.

People were not always supported by adequate numbers of suitably trained staff.

People received their medicines as prescribed.

Staff were not recruited safely; appropriate checks were not completed to ensure staff were suitable to work with vulnerable adults.

Is the service effective?

Inadequate

The service was not effective. Staff had not completed training to ensure they had the skills and abilities to meet people's needs.

People were not supported in line with current legislation including the Mental Capacity Act 2005 or the Deprivation of Liberty Safeguards.

People were supported to have sufficient to eat and drink to meet their needs. Meal choices were limited and appropriate action had not been taken to enable people living with dementia to choose what they wanted to eat.

People were supported by a range of healthcare professionals as required.

Is the service caring?

Requires Improvement

The service was not always caring. People were not always treated with dignity and respect by staff.

Staff did not always respond to people's requests in a caring or supportive way.

The limited facilities within the service impacted on people receiving care and support in a private and dignified way.

Is the service responsive?

Inadequate

The service was not responsive. Care plans had not been developed for two people who used the service.

As people's needs changed, care plans were not updated to ensure staff had guidance in how to meet them.

The registered provider had a complaints policy in place which was made available to the people who used the service.

Is the service well-led?

Inadequate

The service was not well-led. There had been no registered manager at the service for over five months which is a condition on the registered provider's registration.

Auditing of the service had not taken place for several months. Quality assurance systems were not utilised effectively and subsequently failed to highlight shortfalls and drive improvement.

Woodford Care 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 registered 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.

This unannounced inspection took place on 20, 22 and 29 September 2016 and was completed by one adult social care inspector.

Before the inspection, we contacted the local authority commissioning, safeguarding and environmental health teams to gain their views on the service. We reviewed all of the information we held regarding the service, including notifications and previous inspection reports.

During the inspection, we spoke with six people who used the service and five visiting relatives.

We also spoke with the nominated individual, the acting manager and nine members of staff, including care and domestic staff and the cook.

We looked at seven people's care plans along with the associated risk assessments and medication administration records (MARs). We also looked at how the service used the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) to ensure that when people were assessed as lacking capacity to make informed decisions themselves or when they were deprived of their liberty, actions were taken in their best interest.

We looked at a selection of documentation pertaining to the management and running of the service. This included quality assurance information, recruitment documentation for six members of staff, the staff training records as well as a number the registered provider's policies and procedures.

Inadequate

Is the service safe?

Our findings

People who used the service were not protected from the risk of scalding or burns. This was because of excessive hot water temperatures at 16 outlets/taps including 13 bedrooms, a communal toilet, a staff toilet and the sluice room. Water temperatures exceeded recommended guidance which stipulated, 'temperatures over 44°C can create a scalding risk to vulnerable people who use care services' and 'Engineering controls should be provided to ensure that water hotter than 44°C is not discharged from outlets that may be accessible to vulnerable people'. Water temperatures at five outlets/taps exceeded 60°C, a further four exceed 65°C and one exceeded 70°C.

The nominated individual told us, "I'm not sure how this has happened; we do water temperature checks every few months." After the second day of the inspection, the nominated individual sent us confirmation that necessary works had been completed to ensure people were no longer exposed to this risk. However, when we returned for the third day of the inspection, we found the outlets/taps in three people's rooms had been decommissioned [hot water was no longer available] and in another person's bedroom the water was still in excess of 44°C.

We also found outlets/taps that did not provide hot water. A hot water tap was run for over five minutes in a communal toilet and did not provide hot water; hot water was also not delivered to a person's bedroom and an unused bedroom even when the water was run for an extended period. The cook told us, "Some days there isn't hot water [in the kitchen] and some days there is but it takes forever to come; other times it's really hot."

The above information demonstrated a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, premises and equipment. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

The issues with the water temperature contributed to the poor infection control practices within the service. A member of staff told us, "The water has been a joke for ages; we have to take hot water into some people's rooms in buckets or bowls because there is no hot water. How do we give personal care using cold water?" Another member of staff said, "The hot water in the rooms [bedrooms] isn't too bad; we can run the cold as well so the water in the sink is at an acceptable temperature."

When we asked staff how they washed their hands after using the toilet we were told, "I just use the hand sanitizer; the water is either really cold or red hot", "I have a technique were I put my hands under the hot then cold then the hot again" and "I just do it [wash their hands] as quickly as I can." Failing to follow recommended hand hygiene techniques before providing care and support to vulnerable people who may have diminished immune systems increased the risk of people contracting healthcare related infections.

During a tour of the building, we went into the service's only bathroom which is an internal room without windows. It is situated directly off the main lounge, opposite the kitchen serving hatch. The extractor fan was not working which meant when the toilet was used air borne spoors would disperse from the bathroom and

into the home. We have raised this issue with the registered provider during a previous inspection [9, 10 and 26 February 2015] and advice and guidance was provided to them to ensure the safety and wellbeing of people who used the service.

The acting manager said, "Oh, I didn't realise that it [the extractor fan] wasn't working, it's usually on all the time." The nominated individual told us, "We do have problems with it, we have to have it on all the time so it burns the motor out and stops working."

The laundry room is located in an external building and we saw that clean and dirty laundry was stored within five feet of each other. A used red bag [used to transport soiled laundry and designed to dissolve in the washing machine to reduce the spread of healthcare related infections] was stored against the door of the washing machine. Due to the soiled and wet laundry, the bag could have started to disintegrate allowing the laundry to leak out and contaminate the floor and disrupt the dirty to clean flow in the laundry room. The washing machine's metal base had rusted to the extent that only rust was visible which meant it could no longer be cleaned effectively. The linoleum floor had lifted in a number of areas which required addressing.

Of the 24 staff employed at the service, only eight had completed infection prevention and control training. This meant staff's understanding of effective infection control techniques was limited. During the inspection, we observed staff completing a range of daily tasks and saw that their actions increased the possibility of healthcare related infections spreading through the home. One member of staff carried soiled underwear through the small lounge into the main lounge; they wore disposable gloves but failed to use appropriate equipment, such as a red bag. The member of staff continued through the lounge and opened an external door that lead to the laundry area. They opened the door with their gloved hand and contaminated the door handle. Another member of staff wore disposable gloves throughout a medication round; they touched numerous surfaces, carried keys and wrote in the medication books, then applied cream/gel to a service user's legs whilst wearing the contaminated gloves. A third member of staff carried urine soaked bed sheets into the lounge and then asked another member of staff to bring them a bag to put them in.

A person's bed had been made when a dried urine stain was clearly visible on the sheets. The sheets smelt of urine and the person was known to regularly be incontinent during the night. A second person's bed had been made with faeces stains on the sheets. A used incontinence pad was left on the shelf in a third person's bedroom. On the third day of the inspection, we noted which people were in the lounge on our arrival; three hours after we arrived, a member of domestic staff was seen carrying a mop and bucket upstairs. We asked where they were going and they said they had been told by a member of staff that a particular room needed cleaning as there was faeces on the floor. When we checked the room number it became apparent it was the room of one of the people who was in the lounge when we arrived. This meant the faeces had been left on the floor for at least three hours before it was cleaned.

A person who used the service told us, "It [the service] could do with a bit of decoration but they try and keep it nice and it's usually clean." Another person said, "The girls clean my room every week."

The above information demonstrated a breach of Regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

During the tour of the premises, we noted that an upstairs bedroom contained an external door that led onto a fire escape/walkway. The fire escape/walkway led to another bedroom on the other side of the home. Both doors were locked but could be opened internally without a key. The nominated individual explained

that both doors were fire exits and in the event of a fire or emergency evacuation, staff were expected to unlock the door on the adjacent side to the fire to enable people gain access back into the building. If staff failed to unlock the door people would then be stuck on the fire escape/walkway.

We spoke with 10 members of staff and none of them were aware of the action's the registered provider required them to take in the event of a fire or emergency evacuation. In the event of a fire people were exposed to an unacceptable level of risk because staff were not aware of the fire evacuation plans.

Training records showed that only nine members of staff had completed fire training. We found that in July, August and September 2016, there were nine nights when the members of staff on duty were not trained in fire safety and evacuation procedures. This exposed people to the risk of not receiving the support they required in the event of a fire or emergency evacuation.

The doors that led onto the fire escape/walkway were located in bedrooms. At the time of the inspection, one room was occupied and the second was empty. The fact that the doors were merely locked with twist locks posed a risk to the people who used the service. Some people who may be living with dementia could have easily gained access onto the fire escape/walkway. The registered provider had failed to ensure the safety of the people who used the service because they had not taken appropriate action to mitigate this risk.

Personal emergency evacuations plans (PEEPs) had been created for the majority of people who used the service. However, when we reviewed the care plan for a person who stayed for respite care there was no PEEP available. We asked the acting manager and nominated individual to supply the PEEP but one could not be found. Another person's PEEP had not been completed fully. Failing to ensure a PEEP is in place containing detailed guidance to enable staff to safely and efficiently support people in the event of a fire or an emergency evacuation, increased the risk that they would not receive they support they required.

The above information demonstrated a breach of Regulation 12 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

We checked the recruitment information in relation to two new members of staff and saw that appropriate checks had not been completed. Both staff had only one reference and a disclosure and barring service (DBS) check had not been completed by the registered provider. We found DBS certificates for both staff which had been undertaken by their previous employer; one was dated December 2012 and the other was completed in November 2013. The nominated individual explained, "I told the last manager that we could use DBS checks from people's last place of employment if it was in the last two years, obviously these are older than that." This meant the registered provider had failed to assure themselves that both members of staff were suitable to work with vulnerable people and in turn exposed people who used the service to the risk of receiving care and support from unfit staff.

The above information demonstrated a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, fit and proper persons employed. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

Medicines were stored in a suitably secure trolley which was kept in a room that staff and people who used the service had to use to gain access to certain parts of the service. Appropriate arrangements were in place for the storage of controlled drugs and medicines that required storing at cooler temperatures. We looked at the medication administration records (MARs) for seven people and saw they were completed accurately

and without omission.

We found issues with some areas of recording, for example, the room and fridge temperatures were not completed daily and staff had recorded unrealistic temperatures and not followed this up. We reviewed the controlled drugs record and saw that on two occasions in September 2016, controlled drugs were administered without a witness as best practice guidance requires. We spoke with the nominated individual regarding our concerns who provided assurance recording would improve.

A person who used the service told us, "I get my tablets every day." A relative we spoke with said, "They look after Mum's medication, she wouldn't be able to do it herself."

Inadequate

Is the service effective?

Our findings

People were not supported by suitably skilled and experienced staff because the registered provider failed to ensure staff had completed relevant training to enable them to carry out their roles effectively. Of the 24 staff employed by the registered provider; eight had completed safeguarding vulnerable adults training, four had completed dementia care training, 13 had completed moving and handling people training, 10 had completed infection prevention and control training, eight had completed health and safety training, nine had completed fire training, 12 had completed food hygiene training, 12 had completed first aid training and nine had completed medication training.

We cross-referenced the staff rotas with the staff training records and saw that on numerous occasions, appropriate numbers of suitably trained staff were not deployed to meet the needs of the people who used the service. The registered provider had determined that two members of staff were required to meet the needs of the people who used the service throughout the night which went from 10pm to 7am. On various dates in July, August and September 2016, night shifts were carried out by staff who had not completed relevant training and therefore did not have the skills and competence to meet the needs of the people who used the service. For example, on 29 July 2016 neither member of staff had completed dementia, infection control, health and safety, fire, food hygiene, the Mental Capacity Act 2005 (MCA) or Deprivation of Liberty Safeguards (DoLS) first aid or medication training. On 30 August 2016, neither member of staff had completed safeguarding vulnerable adults, dementia, infection prevention and control, health and safety, first aid or medication training. On 10 September 2016, neither member of staff had completed safeguarding vulnerable adults, dementia, infection prevention and control, health and safety, fire, first aid or medication training.

A member of staff told us, "I've hardly done any training since I started; I was asked about what training I'd done in my last job and if I could bring in the certificates." A second member of staff said, "The training is rubbish, you do it on a computer. It's all multiple choice and if you get the wrong answer you just go back and do it again; you don't learn anything."

This meant people were exposed to the risk of not receiving safe and effective care in a timely way. If someone woke in the night and required pain relief, there was no member of staff available to administer this. If a person required emergency first aid, there was no staff available to provide this. In the event of a fire, no trained staff were available to support people during an emergency situation.

We saw records of staff supervision but this was based around the competencies to deliver care only and was not used to discuss with staff their general strengths and area's for improvement or what skills they would like to develop. A member of staff told us, "We have had quite a few managers recently and they all do things differently, the one to one's have been a bit hit and miss." Another member of staff told us, "I'm quite new but have already had a couple [of supervision meetings]."

The above information demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, staffing. We are currently considering our regulatory response to this

breach and will report on any action once it is completed.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires, 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. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the service did not always work within the principles of the MCA because people were being deprived of their liberty without appropriate authorisation being sought.

The nominated individual and acting manager told us they would not allow any of the 13 people who used the service to leave unattended. The nominated individual said, "I would want a carer or a family member with them, to protect them and keep them safe. Our priority is to keep people safe." The acting manager commented, "We would not let anyone leave by themselves." If the registered provider believed people needed to be under 24 hour supervision and control, they were legally required to ensure a DoLS authorisation was applied for. A member of staff told us, "We have had issues with not letting people out. One lady was stood at the door and was trying to get out. Staff tried to get her to come back into the lounge and she became really aggressive; she told staff to go away and she hit out."

We asked how many people were subject to a DoLS and were told by the nominated individual and acting manager that they were unsure and would need to check. Information was not held within the service and the Supervisory Authority (the local authority safeguarding team) was contacted to ascertain this information. DoLS applications had been submitted for six people in September 2015.

On the third day of our inspection we were informed by the acting manager that DoLS applications had been submitted for the other seven people the nominated individual stated met the criteria. However, we were informed by the Supervising Body that the applications for these people had not been completed appropriately and failed to include required information such as capacity assessments and least restrictive care plans, which meant they needed to be updated and re-submitted. We were also told that there were similar issues with the applications submitted in September 2015 and those would also need updating and re-submitting.

We reviewed the care plans for six people and could not find any evidence that consent to care and support had been gained by the registered provider. The acting manager told us, "The care plans are done on the computer so we can't get people to sign [to show that consent has been agreed]." On the second day of the inspection, we saw a number of consent forms had been completed. One person had signed the form with a different name to their own, another stated a discussion had taken place with a family member (granddaughter) and a third had been signed by a family member. When we asked if the service held evidence that either family member had been granted power of attorney, to act on behalf of the two people, the acting manager informed us they were unaware that such information was required. This showed us the registered provider and acting manager did not have sufficient knowledge about MCA, DoLS and consent issues and had not acted within best practice principles regarding MCA.

The above information demonstrated a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, need for consent. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

People were supported to have sufficient amounts to eat and drink to meet their needs. However, we found choices were limited. For example, lunch on the first day of our inspection was sausage, vegetables and mash or pork vegetables and mash. We overheard one person saying that they did not want either of the main meal options and instead of offering an alternative, staff tried to encourage the person to pick one of the two main meal options. We spoke with the acting manager about what we had heard and they ensured the person could choose something else.

People were asked to choose their main meal in the morning; staff went to each person, told them what the choices were and recorded their chosen option. There were no pictorial aids used during the inspection, which would have aided people who may be living with dementia to make and remember their choices.

We spoke to the cook who confirmed they were aware of people's dietary requirements and those who needed their food preparing to a particular consistency following advice from the speech and language therapy team. We watched staff supporting people to eat their meals when required and saw this was done at an appropriate pace and in a way which did not impede on people's independence.

The last Food Hygiene Rating Scheme (FHRS) inspection was carried out by a local environmental health officer in February 2016. The service was awarded a '0' rating, the lowest possible score and an 'A' rating which means further inspections will be completed on a 6 monthly basis. The food hygiene rating or inspection result given to a business reflects the standards of food hygiene found on the date of inspection or visit by the local authority. The inspection found, amongst other things; mould growth and condensation to the walls in the rear food store room, the dishwasher was not working, cutlery and dinner plates that had been cleaned were still dirty, the probe thermometer used to record temperatures of cooked food was in a filthy condition, the kitchen was dirty throughout, paper towels supplied for hand drying were in fact toilet paper, staff were unable to dry their hands effectively and the door to the bathroom off the lounge was open, which increased the risk of airborne contamination.

People were supported by a range of healthcare professionals including G.Ps, community nurses, speech and language therapists and emergency care practitioners. A community nurse was visiting at the time of our inspection and they told us, "I think there have been quite a few changes recently but all the staff seem to know the residents well and they do follow any instructions we give them."

People who used the service told us they were supported by staff that had the skills and abilities to deliver care and support effectively. One person said, "They [the staff] do a good job of looking after me." Another person said, "I think the staff do a good job."

Requires Improvement

Is the service caring?

Our findings

People who used the service were not always treated with dignity and respect. Due to the lack of facilities at the service, there is only one toilet accessible to people who require support from staff. This toilet is situated in the only bathroom, which is accessed through the main lounge. During the inspection, we heard numerous people on multiple occasions being told they had to wait to use the toilet as the bathroom was currently occupied.

We saw a basket of clean underwear stored in the laundry room which had a note placed in it. The note read, 'Days, would it be possible if you could see who these belong to as there are no names'. If people's personal garments are not labelled in any way and are then mixed together, it creates the risk that people may wear other people's underwear. As a number of people who used the service experienced continence issues, this posed an infection control risk and showed a lack of respect regarding people's dignity and management of their personal items such as clothes.

Staff did not always meet people's needs or speak to them in a respectful way. We heard one person telling a member of staff that their room was cold and damp and they did not want to sleep there. The member of staff informed the person that they had to stay in their room because no other rooms were available. They did not offer any reassurance or offer to provide anything that would keep the person warm such as a second duvet. At the time of the inspection, there were five available bedrooms which the person could have been offered.

The above information demonstrated a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, dignity and respect. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

Staff's ability to deliver person-centred care was impacted by the lack of information held within the service. Some people's care plans contained 'personal history' pages that stated where people grew up, where they went to school, their work history and family lives. However, this information had not been documented for other people with affected staff's ability to engage with them and talk about things that were important to them. During this inspection, we witnessed very few activities taking place and saw people spent the majority of their time in communal areas with televisions or radios on, but without meaningful engagement.

We witnessed several positive interactions between staff and the people who used the service. Staff showed compassion and had developed ways to support people that were not documented in their care plans. A member of staff said, "We know most of the people really well so don't need a care plan for them. It's hard with the new people because we have practically no information and we can only get that through talking to people or their families; it's hard when they have dementia."

People's needs were not always met in a caring way. Records showed one person who used the service regularly refused to go to bed and slept in a chair in the main lounge. No action had been taken by the service to provide additional support to the person and ensure their comfort, such as a pressure relieving

cushion. Sleeping in a static position in a chair increased the risk of the person suffering from pressure related sores.

The nominated individual confirmed that visiting hours were not restricted. They said, "We don't have any written rules, generally visitors can come and go as they please. I think maybe 8 or 9 o'clock would be the limit because other people are going to bed at that time."

Some people who used the service praised the staff, one person commented, "All the staff are lovely, all of them are." However, another person said, "I have my favourites, some are really nice, some are just ok."

Private and confidential information was stored securely. Care plans were held electronically which staff could access using personal log-in details and passwords. Paper copies of care plans were kept in a locked filing cabinet to ensure that if there were any issues with the service's computer system staff could still gain access to vital information. However, the care plans we saw in a paper format had not been updated for over six months and were no longer reflective of people's needs. The nominated individual told us, "I have access to the system so if there are any issues I can bring my computer to the service."

We saw that staff had signed the registered provider's data protection and confidentiality policy to confirm they had read and understood the information and were aware of their responsibilities to not disclose any private or sensitive information regarding people who used the service.

Inadequate

Is the service responsive?

Our findings

People did not receive responsive and personalised care because the registered provider failed to ensure care plans had been created for every person who used the service. A person moved into the service on 28 August 2016 for respite care. We found that at the time of their admission, a care plan was not created to ensure their needs were met or that care and support was delivered in line with their preferences. The person complained of a headache and dizziness on 4 September 2016 and after being seen by an emergency care practitioner was taken to hospital. They were found to have low blood pressure and an irregular heartbeat and stayed in hospital for 10 days before returning to the service. On their return, a care plan was still not created. On the last day of the inspection, we saw that a care plan had been created but still failed to include relevant information to enable staff to support them effectively. The care plan contained no information about the person's recent hospital admission, what signs to look out for or what action to take if they complained of a headache or dizziness.

Another person who stayed at the service from 4 to 14 September 2016 for respite care also had no care plan created. The registered provider could in no way be assured that either person's care and support needs were met in line with their needs and preferences because they failed to ensure a care plan was created which gave guidance to staff regarding their needs and preferences. This exposed people to the risk of harm and unsafe care and treatment. When we raised our concerns with the nominated individual, we received a contradictory response. We were told, "We have always used the 'my life, my way' care plans [created by the local authority commissioners] for respite clients" and "Obviously the manager should have created a care plan, I understand we need to have one in place for everyone."

Although care plans had been created for the other people who used the service, we found evidence to confirm they did not always reflect their current needs. One person's care plan stated they could choose when to go to bed and would do so with minimal assistance from staff. However, when we checked the daily records, the person had refused to go to bed and slept in a chair in the lounge on nine occasions in August 2016. Staff told us, "[Name of the person] doesn't like to go to bed if anyone is up; you can't get him to go to bed if the lights are on."

The daily records also showed that the person had been both verbally and physically aggressive towards staff when they had tried to encourage them to go to bed. The behavioural support strategies section of the person's care plan was left blank, which indicated they did not present with behaviours that challenged the service and others. This meant that no guidance had been created to enable staff to support the person safely or effectively when required.

A member of staff told us, "If someone has been here for quite a while and their needs haven't really changed then their care plan will be accurate. If they moved in recently or if their needs have changed then it won't be." Another member of staff said, "The care plans aren't very good, if I'm honest they are a bit out of date as well."

We saw that people's care plans contained computer generated, non-specific statements. For example,

'[Name of the person] is at high risk of falls due to the following factors; difficulties on executing a task or action, physical weakness, previous falls or has performed poorly on the timed up and go test.' There was no personalised information regarding how the person required supporting, if equipment was used to mitigate the risk or how many times they had fallen in a particular time frame. Another person's care plan stated, '[Name of the person] presents behaviour that can be predicted and managed by trained staff who are able to maintain a level of conduct that does not pose a risk to herself or other.' No information was provided to staff regarding how to manage the person's behaviours or how to recognise the person was becoming agitated so action could be taken before it escalated. The acting manager said, "When you do a care plan on the computer, you answer one question and depending on your answer it asks for more information or moves to another area" and went on to say, "You can't personalise anything, I really don't like it."

The above information demonstrated a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, person-centred care. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

The registered provider failed to ensure that care plans were created for each person who used the service and care plans were updated as people needs changed and developed. Subsequently risks assessments were not created or updated to mitigate known risks. For example, we saw that one person's care plan stated they weighed 73kg in June, 70kg in July, 67kg at the beginning of August, 61kg in the middle of August, 60kg at the beginning of September, 61kg in the middle of September and 72kg in late September. The records indicated the person had been consistently losing weight and then gained 11kg in 16 days. There was no evidence to show that action had been taken by the service such as contacting the community dietician or other relevant professionals to gain their advice following weight loss or the dramatic recording of weight increase. There was no evidence to indicate the weighing scales had been checked to ensure the readings were accurate.

The above information demonstrated a breach of Regulation 12 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment – assessing and mitigating risk. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

The registered provider had a complaints policy in place and we saw that information regarding how to raise concerns was provided to people at the commencement of the service. We reviewed the complaints log and saw that a recent complaint that led to a person moving out of the service was not recorded. The nominated individual commented, "It wasn't an official complaint, we didn't ever receive anything in writing." Failing to accurately records complaints and concerns could lead to opportunities for improving the service being missed.

Inadequate

Is the service well-led?

Our findings

On 6 and 7 May 2015 we completed a focused inspection at the service to see if the registered provider had taken action to rectify the non-compliance identified at our comprehensive inspection on 9, 10 and 26 February 2015. We found that improvements had been made in some areas but insufficient improvements had been made in relation to infection prevention and control and quality monitoring. On 2 July 2015 the Care Quality Commission (CQC) issued a notice of proposal to cancel the registered provider's registration. The registered provider appealed this decision so a comprehensive inspection was carried out on 3, 8 and 9 October 2015. At that inspection, we found the registered provider had achieved compliance with all of the regulations and the decision was made to withdraw the notice of proposal to cancel their registration.

During this comprehensive inspection carried out on 4, 20 and 22 September 2016, we have found the registered provider had failed to sustain the improvements that were made and were in breach of nine regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider failed to ensure effective systems were established and operated to maintain compliance with regulations pertaining to delivering person-centred care, treating people with dignity and respect, obtaining appropriate consent to provide care and support, delivering safe care and treatment, infection prevention and control, maintaining safe premises, good governance, ensuring appropriate number of suitable trained staff are deployed at all times and employing fit and proper persons.

The service was being operated without a registered manager; the last registered manager left the service in April 2016. One of the conditions on the registered provider's registration states, "The registered provider must ensure that the regulated activity, accommodation for persons who require nursing or personal care, is managed by an individual who is registered as a manager in respect of that activity at or from all locations." This meant the registered provider has been in breach of a condition for over five months by failing to have a registered manager.

The registered provider failed to ensure systems were in place to assess, monitor and improve the quality of service provision. There was no evidence to show that auditing had occurred within the service between April and September 2016. We saw that the previous registered manager had conducted a manager's daily audit until they left the service in April 2016; however, the audits were visual checks and lacked the depth to drive improvement.

The acting manager had completed tests of the emergency call bell systems in September 2016 in three random rooms. The tests showed the call bell system was working adequately but failed to highlight that call bells were not available in every person's room which meant that people who occupied those rooms had no way to alert the staff they required support.

The acting manager had undertaken infection prevention and control audits on three occasions in September 2016. The audits had highlighted that the tumble dryer was not working, the sluice machine was not working and areas of the service contained odours and required cleaning. The audits failed to highlight

numerous concerns found during our inspection including the poor practices of staff, the unclean kitchen, the compromised dirty to clean flow in the laundry room and the extractor fan not working in the downstairs bathroom/toilet.

The above information demonstrated a breach of Regulation 17 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance – assessing, monitoring and mitigating risk to improve quality. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

The registered provider had failed to act on advice and guidance from relevant persons, namely the fire service and environmental health team. The service was visited in February 2013 by the fire service and management were informed that the balcony/walkway joining two sides of the service was not required as a route of escape. Despite this the registered provider had created a fire risk assessment in September 2016 stating that the balcony/walkway should be used in the event of a fire.

After our inspection in February 2015, the service was visited by the local authority's environmental health team. Instructions were provided regarding the bathroom/toilet extractor fan which amongst other things, had to remain in good working order. On the first day of this inspection, we noted that the extractor fan was not working. We asked the acting manager when the extractor fan had stopped working and they said they had not noticed. This meant people were exposed to the risk of healthcare related infections because the registered provider had failed to ensure they followed the advice and guidance of relevant professionals.

The above information demonstrated a breach of Regulation 17 (2) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance – seek and acting on feedback from relevant agencies. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

The registered provider failed to maintain accurate, complete and contemporaneous records in respect of each person who used the service. Two people who received respite care and support had no care plans in place. Subsequently no guidance was available to staff to enable them to meet people's needs and no risk assessments had been created to ensure known risks were mitigated and people were supported safely.

The above information demonstrated a breach of Regulation 17 (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance – maintaining records. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

People who used the service had been partially involved in developing the service. For example, we saw that questionnaires had been completed by some people who used the service but there was no evidence to show their feedback had been assessed or used to improve the service.

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 8 HSCA RA Regulations 2014 General The registered provider failed to comply with regulations 9, 10, 11, 12, 15, 17, 18, and 19 of the Health and Social Care Act 2008. Regulation 8 (1)

The enforcement action we took:

We followed our enforcement policy and issued a notice of proposal to vary the conditions of the registered provider's registration as a service provider and remove this location. The registered provider decided to close this location following the receipt of our proposal.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care people who used the service did not receive person centred care because the registered provider failed to ensure care plans were created and care plans reflected people current needs and preferences. Regulation 9 (1)(a)(b)(c)

The enforcement action we took:

We followed our enforcement policy and issued a notice of proposal to vary the conditions of the registered provider's registration as a service provider and remove this location. The registered provider decided to close this location following the receipt of our proposal.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People who used the service were not always treated with dignity and respect. Regulation 10 (1)(a)(b)(c)

The enforcement action we took:

We followed our enforcement policy and issued a notice of proposal to vary the conditions of the registered provider's registration as a service provider and remove this location. The registered provider decided to close this location following the receipt of our proposal.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 11 HSCA RA Regulations 2014 Need for

personal care	consent The registered provider failed to ensure people who used the service received care and support that had been appropriately consented to and authorised. Regulation 11(1)(2)

The enforcement action we took:

We followed our enforcement policy and issued a notice of proposal to vary the conditions of the registered provider's registration as a service provider and remove this location. The registered provider decided to close this location following the receipt of our proposal.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider failed to ensure people who used the service received safe care and treatment. Regulation 12 (1) (a)(b)(c)(d)(h)

The enforcement action we took:

We followed our enforcement policy and issued a notice of proposal to vary the conditions of the registered provider's registration as a service provider and remove this location. The registered provider decided to close this location following the receipt of our proposal.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment the registered provider failed to maintain premises and equipment. Regulation 15 (1)(e)

The enforcement action we took:

We followed our enforcement policy and issued a notice of proposal to vary the conditions of the registered provider's registration as a service provider and remove this location. The registered provider decided to close this location following the receipt of our proposal.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not established and operated effectively to ensure compliance. Regulation 17 (1)(a)(b)(c)(e)

The enforcement action we took:

We followed our enforcement policy and issued a notice of proposal to vary the conditions of the registered provider's registration as a service provider and remove this location. The registered provider decided to close this location following the receipt of our proposal.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 19 HSCA RA Regulations 2014 Fit and

personal care	proper persons employed Recruitment practices were not established and operated effectively. Regulation 19 (1)(2)(3)

The enforcement action we took:

We followed our enforcement policy and issued a notice of proposal to vary the conditions of the registered provider's registration as a service provider and remove this location. The registered provider decided to close this location following the receipt of our proposal.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed at all times. Regulation 18 (1)(a)

The enforcement action we took:

We followed our enforcement policy and issued a notice of proposal to vary the conditions of the registered provider's registration as a service provider and remove this location. The registered provider decided to close this location following the receipt of our proposal.