ADR Care Homes Limited

St Nicholas Nursing Home

Inspection report

1-3 St Nicholas Place
Sheringham
Norfolk
NR26 8LE

Tel: 01263823764
Website: www.adrcare.co.uk

Date of inspection visit:
30 January 2017
01 February 2017

Date of publication:
20 March 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 30 January and 1 February 2017 and was unannounced. It was carried out in response to concerns we had received about the service.

St Nicholas Nursing Home is not a nursing home and does not provide nursing care to people. The provider has not amended the name of their service on their registration since they ceased to provide nursing care. St Nicholas' provides accommodation and care for up to 39 people, some of whom may be living with dementia. At the time of our inspection visit 21 people were living in the home, with two people in hospital.

A registered manager was in post. They were in the process of handing over the management of the service to a new manager who was in post as the acting manager. Both were present during the inspection. The registered manager told us that they are at the service most days in the week. They had been promoted to the role of operations manager for the provider who has five services in total. An acting manager was in post and was being trained with a view to applying for registration as the manager.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

This inspection found breaches of nine regulations. We found serious and widespread concerns at this service. There were significant shortfalls in the care and service provided to people.

Risks to people's welfare had not always been identified. Risk assessments were sometimes generic and not specific to individuals. There was not always clear guidance provided to staff about how to mitigate risks to people.

We observed poor practice that put people's safety and wellbeing at risk. Whilst records showed that staff had received training it was either not being put into practice or the training was not of a suitable standard.

On occasions people were not always referred to healthcare professionals when necessary and staff had failed to implement guidance they had received from healthcare professionals.

There were not enough care staff on duty to keep people safe or to meet their needs in a timely way. There was not enough housekeeping time allocated to ensure the home was kept clean at all times. There was not enough laundry time allocated to ensure that people's clothing was effectively laundered.

People were positive about the food they received. However, we were concerned that some people, who required higher levels of support with their meals, did not receive this. Relatives and health professionals

had also raised concerns about people not being supported with eating and drinking.

In their direct dealings with people we saw that most staff were kind and caring. However, some staff didn't engage appropriately with people. We found practices in the home which showed a lack of respect and compassion for the people who lived there. People were not receiving person centred care which met their needs or preferences.

We found there was a lack of effective management and leadership. This coupled with ineffective quality assurance systems meant that the issues we found had not been identified or resolved.

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 provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to the health, safety and wellbeing of people who used the service had not always been identified, assessed or planned for. There was insufficient guidance for staff about how to support people in a safe manner.

We observed unsafe practice in relation to moving people and supporting people with meals who were cared for in bed.

There were not enough staff available to meet people's needs. Recruitment processes were not robust.

Is the service effective?

Requires Improvement

The service was not always effective.

Training records were in place for staff, however not all staff training was effective in ensuring they were competent in their roles.

People did not receive adequate support with eating and drinking.

Mental capacity assessments had not been carried out for specific decisions. People's consent to care was not always determined.

Is the service caring?

Inadequate

The service was not caring.

People were not supported to maintain their dignity, privacy or independence.

People did not always receive care that was compassionate, from caring staff.

Is the service responsive?

Inadequate

The service was not responsive.

People's needs were not met in a person-centred way. People's health, emotional and social needs were not always planned for and people did not receive individualised care.

A complaints system was in place. However not all complaints were responded to adequately or to the satisfaction of the complainant.

Is the service well-led?

Inadequate

The service was not well-led.

Systems in place for auditing and monitoring the service were not effective as they did not identify concerns or lead to actions.

The service did not promote an open culture and concerns were not always investigated and responded to appropriately.

The registered manager and the provider had not always told the relevant authorities of events that they were required to notify.

St Nicholas Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 30 January 2017 and 1 February 2017 and was unannounced. The inspection team comprised of two inspectors.

Prior to this inspection we reviewed statutory notifications we had received from the service. Providers are required to notify us about events and incidents that occur in the home including deaths, serious injuries sustained and safeguarding matters. We also liaised with social care professionals from the local authority's safeguarding and quality monitoring team.

During the inspection we spoke with seven people living in the home, relatives of five people and three visiting health professionals. We made general observations of the care and support people received at the service throughout both days of our inspection. We also spoke with the registered manager, the acting manager, the deputy manager, three care staff and the cook.

We reviewed nine people's care records and the medication records of five people. We viewed records relating to staff recruitment as well as training records. We also reviewed a range of maintenance records and documentation monitoring the quality of the service.

Inadequate

Is the service safe?

Our findings

We found that there was inadequate guidance in place to support staff to move people safely. We saw that one person was unable to get themselves up out of their chair. There was no information in their care plan which detailed their ability to transfer from their chair to their walking frame. On the first day of our inspection we saw one member of staff lift them up under their arm. This posed a risk of injury to the person as they were very frail, and did not reflect safe manual handling practice. On the second day of our inspection we observed a staff member asking the person how they wished to get up. The person was unable to answer because they could not hear as they were not wearing their hearing aid. Staff members took five attempts before the person was upright. Staff had not given effective prompting to guide the person to stand up safely, but they eventually managed to stand themselves up. However, when they were standing we could see that the person was unable to stand fully upright and hold their own weight safely, using their walking frame. They were stooped over and looked very wobbly. We saw from the care plan that there was no consistent method instructed to staff on how to assist the person to move around. We referred these concerns to the local authority's safeguarding team.

Risk assessments in relation to individuals were incomplete. They did not contain adequate consideration of risks or guidance for staff on how to mitigate risks to people. For example, we found that where people required equipment or support to move around, this had not been detailed in care plans. Falls risk assessments were generic and did not contain information about people's conditions that may affect their risk. Previous falls history was not recorded in these risk assessments, or sufficient guidance to staff on how to mitigate any risks other than pre-printed generic information. Risk assessments had not been carried out in relation to people administering their own medicines.

Risk assessments with regard to specific health conditions were not always detailed. For example, there was a risk assessment in place for one person in relation to their diabetes. The risk assessment did specify signs of concerns, such as trembling, blurred vision and palpitations. However, it did not say whether these were attributable to high or low blood glucose levels and what actions staff should take in the event of any concerns. There was no associated care plan to guide staff to manage the person's diabetes. We were concerned that there was not always guidance in place for staff to support people effectively with their health conditions. This meant that in the event of signs of problems, staff may not always react consistently and effectively in determining what course of action they should take.

We saw that for people who walked around the home a lot, there were no risk assessments in place with regards to them entering other people's rooms. Where people may have had substances in their rooms which could be used inappropriately by someone living with dementia, there were no risk assessments in place with regards to this.

We observed a staff member about to assist someone to eat who was cared for in bed. The person had not been supported to sit up at a safe angle for eating to reduce the risk of choking or aspiration. Their back was flat on the bed with only their head inclined. We asked the staff member to find assistance from another staff member so that the person could be appropriately positioned, which they did. This was also reflected by a

visiting health professional who told us that they had observed staff assisting someone to eat who was lying down. This demonstrated to us that staff did not always have awareness of safe eating positions, therefore putting people at risk of choking.

Whilst the results of sample testing of the water system for the legionella bacteria were negative, the provider had not determined what the risks were in the home's water system. Maintenance records showed that the water outlet and boiler temperatures were not being recorded and outlets not in use were not flushed through regularly. The provider had failed to ensure that risks had been identified and suitable maintenance of the water system had taken place.

These concerns meant that the provider was in breach of Regulation 12 (1) (2) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that people's equipment was not always properly maintained and in good working order. Two healthcare professionals we spoke with also raised concerns about equipment not being put in place as promised by staff. For example, one healthcare professional told us they had suggested a pressure mat be put in place for one person who was at risk of falls, and this was not put in place. We also saw that one person's door was wedged open with a walking frame, and another person's fire door mechanism was faulty. There was increased fire risk as these doors must be free of obstacles and in full working order to enable them to close in the event of a fire.

We also had concerns relating to people's pressure care. For example, a healthcare professional had assessed one person on 9 January 2017 and recommended a barrier cream to prevent pressure areas. We found that no care plan had been written in relation to this and no barrier creams had been made available. These concerns meant that some people continued to be at risk of developing pressure areas the appropriate action had not always been taken.

Two healthcare professionals we spoke with expressed concerns about staff not always using equipment appropriately in relation to pressure area care. For one person, we saw that they were advised to wear pressure relieving boots at all times. However, the person often refused having become distressed. There was no care plan in place which detailed how staff should approach this, and the healthcare professional had concerns that the person's needs were not met. The impact on the person of not wearing the boots resulted in increased risk of worsening pressure areas, as the person had already sustained a pressure ulcer. Furthermore we found that one person's pressure mattress was not working and staff had not identified this. We raised this with the acting manager who contacted the engineer and this was fixed the same day.

Where people had received additional input from healthcare professionals, staff had not always followed their recommendations. Therefore we were concerned about people's safety in relation to their health conditions. For example, for one person we saw that the GP had advised that they needed to be weighed weekly because due to a change in their medicines they were at risk of increased fluid retention which could be detrimental to their health because of underlying health conditions. This had only been done once since this advice had been given in December 2016. The person had gained 1kg in a week. No further action was taken to ensure the person continued to be weighed weekly.

These concerns meant that the provider was in breach of Regulation 12 (1) (2) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that one senior staff member had their medicines administration competency check on 13 October 2016. It had identified that the staff member required more training in respect of PRN (as required)

medicines as well as booking medicines in and out. However, the next record on 16 October said that they were working well administering medicines, without mention of further training having been completed. This staff member's training file referred to their medicines training. This was that they had taken a knowledge test in the operation of the supplying pharmacy's monitored dosage system (MDS). However, staff were also required to administer medicines from original boxes, bottles and cream tubes which required other knowledge and skills. The registered manager told us they were unsure if the MDS training included additional training for other medicines. Therefore we could not be assured that this staff member had the skills, training or experience to be in charge of administering people's medicines. The staff member was senior at weekends responsible for administering all medicines, and we could not be assured that they had received all the identified training they required.

Risks related to the management of medicines were not always mitigated. On the first day of our inspection visit we found that the medicines administration records (MARs) front sheets were not all up to date with people's photographs for identification purposes. This was particularly important when new staff were employed. We also found that up to date protocols and recording sheets were not all in place for 'as required' (PRN) medicines. These protocols help staff ensure that clear guidance is followed for determining when it is appropriate to administer these medicines. We alerted the deputy manager to this who put these protocols and updated front sheets in place the next day. One relative told us that some staff gave people tablets using their fingers, rather than decanted tablets into a medicines pot. This presented a risk of contamination caused by handling medicines.

We received mixed feedback about whether people had access to 'as required' (PRN) medicines when they needed them. One person told us that they often experienced pain at night and were told by night staff that no-one was on shift who was able to administer 'as required' pain relief. The registered manager told us that they lived on site seven nights a week and that they were always available overnight.
Medicines were not stored at a safe temperature. The temperatures in both of the medication rooms exceeded 25 degrees, which exceeded the recommended storage temperature for most of the medicines we looked at. We saw that high temperatures had been recorded for several months, which meant that there was a risk to the effectiveness of the medicines given. We also saw that in several rooms there were prescribed creams left out. This posed a risk that people living with dementia could use these items in an unsafe manner.

We looked at the (MARs) and found that staff had signed for medicines given. However, we found that not all medicines which had been signed for had been given. We found that prescribed dietary supplements had been signed for when they had not been consumed, and staff had signed for administering an inhaler which they had not administered. We found a bottle of a prescribed dietary supplement by one person's bed which had been opened but not consumed, and saw that staff had signed for this. We discussed this with a member of staff who confirmed that staff always signed for these drinks regardless of whether the person had consumed the whole drink or not. This meant that it had not been identified by any staff carrying out audits that the person was not receiving their prescribed items as instructed, and that the person continued to be at risk of losing weight. We found that the inhaler staff had signed for was often kept by the person themselves and self-administered. There was no risk assessment in place for this, or any assessment to show whether or not the person could safely take this responsibility. We also found a tablet on the floor in an empty room which had not been secured.

We found that where there were higher risk medicines such as those used to thin the blood, these had been given as prescribed. We sampled quantities of medicines available for administration and compared them to records held and found that medicine stock levels were in order.

These concerns meant that the provider was in breach of Regulation 12 (1) (2)(a) (b) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As part of our inspection visit, we looked around the home to see if areas were kept clean. We found faeces on one bathroom floor in the morning that was not cleaned up until two hours later. One person's bedroom floor had a lot of loose debris, a used glove for personal care and a commode that smelled strongly of urine. In the main upstairs communal bathroom a pair of dirty underwear had been hung over a metal frame, the bin was overflowing and the toilet seat was smeared with faeces. Another person's bed controls had faeces on them.

These concerns meant that the provider was in breach of Regulation 12 (1) (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had received concerns that people had to wait for assistance. One person we spoke with told us, "They're a long time coming sometimes. Sometimes they say that they will come back and they don't." Another person said, "There's never enough staff here." All of the relatives we spoke with felt that there were not enough staff to meet people's needs. One relative told us that they rarely found that staff were available in the lounge when they came to visit their family member. They told us, "Last week two people were shouting at others and one person was wandering around looking for something. There was no-one about." Another relative told us, "Sometimes I sit up there with [family member] for hours in that lounge and nobody comes to check on anyone. At Christmas the acting manager had organised to do the food with their family, but I'm sure there was only one or two other staff as well. In the end the relatives ended up helping out." A healthcare professional we spoke with said they felt there was not enough staff. However, staff we spoke with told us that there were enough of them on duty to ensure that people's needs could be met.

The dependency tool used to calculate how many staffing hours were needed was out of date and inaccurate. Several people who had been included in the latest assessment of staffing were no longer in the home. Other people who had been admitted and who were living with dementia and physical disabilities, had not been accounted for. Where people were assessed using the dependency tool, we found that incorrect information was used and every person was assessed as having 'low' dependency needs. However, several people in this home had considerable needs and required assistance and/or equipment to mobilise, reposition themselves or to eat and drink

There was little staff presence in the lounge to support people who required assistance. For example, on one morning we went into the lounge to find eight people there and no staff. One person had become distressed as they required support to go to the toilet but there were no staff there to assist them. We had to find a staff member to assist them. On another occasion one person was walking around asking for assistance to use the toilet, and we alerted staff to support the person. The one call bell was attached to an external door. Most people were unable to mobilise unassisted to be able to reach this. Some people's walking frames were in the centre of the large lounge with their chairs around the edge so they were not able to reach their frames if they needed to get to the call bell.

We looked at the dependency tool they used and asked them about the way in which they assessed people for it. We gave an example of how this had been done incorrectly for one person, and they were unable to explain this. We asked the registered manager how care was delivered at night with two members of staff, as many people living in the home required two members of staff for any personal care. They were unable to explain this to us.

There were four care staff members on duty during the day and two at night, including the senior. The senior

care staff member on duty in the day spent a lot of their time administering people's medicines and updating people's care records. This meant that throughout much of the day they were not able to assist with people's immediate needs. At the time of our inspection 21 people were living in the home.

There were only dedicated staff to carry out cleaning and laundry for five days a week for between five and six hours a day. There were no domestic staff engaged at weekends and care staff were required to carry out any urgent tasks.
Consequently, the provider was in breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed the recruitment records of three staff members. The application form for a senior member of staff stated that the staff member's last two employers could be approached for a reference. Their references had been received, however, one reference was from the most recent employer, for whom the staff member had only worked for one month. The second reference was from the acting manager at the home who had provided a character reference. This was a conflict of interest due to the acting manager already working for the organisation considering employing the person. Furthermore these references did not cover a sufficient time period of employment to provide assurance of the person's capabilities.

Some staff we spoke with were knowledgeable about safeguarding people from harm and understood about different types of abuse that could occur and what action they would need to take if they had any concerns.

Requires Improvement

Is the service effective?

Our findings

The registered manager provided us with a schedule that showed when staff supervisions had been carried out for the year of 2016. Supervisions provide an opportunity for staff to meet with a senior member of staff to discuss any concerns or ongoing training needs, as well as their role in general. This timetable indicated that staff were receiving supervisions on a regular basis. There was also a deputy manager in post, who told us that they had received supervision and competency checking with relation to administering medicines.

We had asked to see the supervision records for the acting manager and deputy manager as well as one senior carer. The registered manager told us that the deputy manager had not received any supervisions since the registered manager had been managing this home in October 2016. The deputy manager had been in post since October 2016. The registered manager also told us that the acting manager, who had also been in this role since October 2016, had not received any supervisions in this role. The registered manager declined us access to see any staff supervision records when we requested to see them for three staff.We had said that we were happy for them to seek staff member's consent. Consequently, we could not be assured that the senior staff, and the acting manager, who were new to responsible roles in the service were receiving suitable support from the registered manager.

The staff training matrix we were supplied with showed that staff training was up to date for all staff. Staff training included health and safety, moving and handling, first aid and food hygiene. However our observations of staff practice throughout our two day inspection showed that staff lacked skills in positioning people to eat safely whilst in bed and safe moving and handling. Staff training was not equipping staff with the skills they needed to provide effective and safe care to people. There was no evidence that the registered manager had checked these competencies in order to identify any gaps in staff knowledge and ability.

A staff member who had worked in the care sector for a total of six and a half months was in charge of the home during the day at weekends. We observed this staff member about to assist someone to eat in an unsafe way. A health professional told us that the same staff member had attempted to give someone in an unresponsive state a drink, which put them at risk of choking. This staff member did not have the skills, training or experience to be in charge of the service. There was no evidence that the registered manager had effectively checked their competencies in delivering care. We were concerned that as a senior this staff member was in charge of advising other staff during some shifts, and organising care for people. This demonstrated a risk to the safety and welfare of people living in the home.

We were concerned about poor practice with regards to supporting people to move safely. One person told us that one staff member didn't know how to move people. "They pull you rather than lift you." We observed one staff member perform an underarm lift on one person, which demonstrated poor practice and posed a risk of hurting the person. The staff member later told us that they had not received any practical training on how to manoeuvre specific people. They had only watched videoed information on general techniques.

We found that there was not a comprehensive and effective system in place for checking staff competency

and conduct. We found concerns with staff manual handling and lack of competency in this area. We observed many task-led interactions with people and noted many missed opportunities for staff to meaningfully interact with people. This had not been picked up by the provider or the registered manager. These concerns demonstrated to us that staff competency was not always assessed and monitored.

Staff did not have necessary knowledge to be able to estimate a person's body mass index (BMI) when they were cared for in bed and unable to be weighed or have their height measured. A BMI score can be used to identify whether someone is at risk of malnutrition. Staff had recorded the length of one person's ulna on a monthly basis. This measurement is used to estimate a person's height. However, in order to estimate a person's likely BMI they would have needed to measure the person's mid upper arm circumference. This was not being done and therefore meant they could not assure themselves of whether the person was losing significant amounts of weight or not. This demonstrated to us that there was a lack of specific support, training and guidance to enable staff to carry this out effectively.

These concerns constituted a breach of Regulation 18 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. Mental capacity assessments were in place for day to day tasks, and showed where staff could support people by making decisions in their best interests if necessary. However, there were no assessments in relation to any specific decisions that needed to be made that could restrict people's freedoms or were needed to ensure their welfare. For example, some people living with dementia were being given their medicines covertly, had bed rails fitted to their bed or needed to wear pressure relieving boots. However, no assessment had been made of their capacity to agree to this. Some people had varying capacity as the mental capacity assessments had detailed that they could make some decisions, however it did not guide staff about how to empower people to make decisions, for example, regarding their communication needs. This meant that the provider could not be assured that they were making decisions in the best interests of people or giving the opportunity to make them themselves. There were no records in place if best interests decisions were made with family members where people were not able to make a decision themselves.

Where there had not been a recorded assessment of people's capacity to use the call bells, there was inconsistent information. For example one person's care plan said that they should have access to a call bell at all times to ask staff for assistance. However, when we asked the registered manager about this, they told us the person would not have capacity to use it, despite what their care plan said. This posed a risk that staff did not always have systems in place to know whether people had capacity or not, and where they did not, a system for checking on their welfare. Likewise, it posed a risk that staff expected people to call for help when they required it, not knowing if they were capable of doing so.

People's care records showed that they had signed to consent to receiving assistance with their personal

care, nail care and hairdressing. There was also a consent form for photographs. It is good practice to have a photograph of people for identification purposes, for example if new or agency staff were employed. However, the consent form also contained permission for the service to use their photograph in relation to activities people participate in. We were concerned that some people who signed these consent records may not have been meaningfully able to consent due to living with advanced dementia. This demonstrated some lack of understanding of the MCA.

The care record of one person who was living with advanced dementia showed that a named person held 'power of attorney' for them. However, the records did not stipulate whether this was in relation to their property and finances, care and welfare or both.

Staff understood that that they needed to obtain people's consent, but there were occasions where people's consent was not obtained. One person was being assisted into the lounge and was clearly making towards a specific chair when they were redirected without their permission being asked to another chair. A relative told us about another incident where staff took their relative's equipment out of their room for communal use without asking for permission.

These concerns constituted a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us that they had submitted DoLS applications to the local authority in relation to some people living in the home. These applications had yet to be determined by the local authority. Where people were deprived of their liberty, the least restrictive methods had been used.

People told us that the food was good and had been improving in recent weeks. The lunchtime meals we saw on both days of our inspection visit looked and smelled appetising. One person asked the cook for the skin of the rice pudding that they particularly enjoyed and this was provided. However, meal times were poorly organised and people didn't always get the support they needed from staff. People were seated in the dining room for over 30 minutes on both days of our inspection visit before their food was served. One person commented on the long wait.

We saw that two people who required the assistance of staff to help them eat or encourage them to eat their meals did not receive this. They were asleep in the lounge with their hot meals in front of them, uncovered, for at least 10 minutes before any assistance arrived. We observed another person in their room asleep in their chair with their meal going cold. A staff member attempted to encourage them to eat by offering them a spoonful of their lunch. However, their lunch had been there for at least 30 minutes and they declined it when offered. A visiting health professional also confirmed to us that they had observed that people's food had been allowed to go cold before they had been supported to eat it.

One person told us that they had very poor vision and that staff didn't tell them what was on their plate or offer to cut up larger pieces of food for them. They said, "They just put it down and off they go." One relative told us, "You get some people who don't eat very well. Their tables are not always near enough to them. People are trying to eat their food but they are two feet away from the table." These comments reflected that people did not always receive the support with eating they needed according to their own individual requirements.

Another person was prescribed three nutritional supplements a day in the form of a milkshake because they were of a very low weight. We saw on the first day of our inspection visit that there was a bottle of this which had not been drunk, opened on their table. The deputy manager told us that the person often didn't drink

them. The person told us that they didn't like the banana flavour milkshake. Staff had not identified this person's preferences about the milkshake flavours and consequently were not supporting them effectively with their nutrition.

Whilst people were offered choices for lunch two people told us that there was no choice about what to have for tea. One of them said, "I'm a bit fed up with the sandwiches. I'd love to see some choice, cheese on toast or a nice bowl of soup."

Several relatives told us that people did not always have drinks available or that they were not within reach. One relative said, "They don't bring drinks around for hours." Another told us, "Unless I'm here or someone else gives [family member] a drink they can't get it. I always get them a drink when I arrive and they love it." A third relative told us, "Every time you go in their room their water jug is empty." One healthcare professional also told us they had concerns that people did not always have enough to drink. We spoke with one person in their room who did not have a drink available. They told us, "Yes, it's horrible. I'm thirsty." Another person asked us to refill their water jug. A third person asked us to put a straw in their water so that they could have a drink.

We reviewed the fluid charts for three days of one person who was cared for in bed and required staff support to eat and drink. On one day they were recorded as having had a drink three times only. There was no indication that that they had been offered a drink at other times in the day and had declined. On another day records showed that they had drunk 400mls in one go. We had concerns that people were drinking a considerable amount when offered fluids because they were thirsty. There were no fluid targets that guided staff on how much people should have to drink per day, and no analysis of how much people were drinking.

People were not always supported with their nutrition. For example, one person had been losing weight steadily and was significantly underweight. However, no referrals had been made to health professionals. This person did not receive the support they needed to eat to maintain a safe weight. We referred this concern to the local authority's safeguarding team. Another person had lost 3.4kg in three months and their records showed that they should be weighed fortnightly. This had not been done. Their dietary care plan had last been reviewed in October 2016 and stated that they needed to be 'prompted with meals'. We saw during both of our visits that they did not always receive this in a timely way. We also saw that one person's care plan said they required encouragement with their meals. We saw on one day that this person remained in their room alone at lunch time and was asleep for 30 minutes with their food in front of them with their lunch going cold, before staff interacted with them. At this stage we saw that a staff member asked the person once if they wanted to eat, to which the person declined so the staff member removed the tray. This meant that those people who were deemed to be at risk of not eating enough and required support with eating did not always receive this, which meant they continued to be at risk.

The nutritional and hydration needs of people were not being met. These concerns constituted a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One relative told us they felt staff did not always communicate in a timely way regarding getting equipment in place for people. This was also reflected by two healthcare professionals we spoke with. People had access to a variety of health professionals. These included the GP who visited on a weekly basis but would come out if necessary between the weekly calls. Other people received interventions from the community nursing team to support them with health issues such as pressure relief or diabetes. However, staff had not raised concerns in relation to one person's low weight with the GP. They did not always respond to requests made from health professionals to help ensure people's wellbeing. The service had not responded to requests for a barrier cream for one person and weekly weights for another person.

Inadequate

Is the service caring?

Our findings

The service did not take sufficient steps to ensure people's dignity or promote their independence. We observed one person in their room sitting on a commode in front of their door, which had been left fully open. Another person had removed some of their clothing in the main lounge, used by several other people, who were able to see the person. There were no staff available to supervise or to prevent the situation from occurring. We saw that a similar incident had occurred on the previous day of our inspection visit; when staff intervened they did not attempt to address the reasons why the person was doing this, simply assisted them to do their clothes up again and then asked them to sit back down. On the second day of our visit, the person had been left without staff support for a longer time and had fully removed their lower half clothing and put a soiled pad on the floor in the lounge, again with others present. Staff had not been around to offer the person assistance with personal care in a timely manner, and the person who was living with dementia had not had any supervision to prevent this from happening. This did not uphold or protect the person's dignity.

We saw that when staff were not supervising communal areas, some people who were living with dementia were walking around looking for the toilet, and staff were not always available to help. This was confirmed to us by a relative who told us, "In communal areas we've seen people saying that they need the toilet and carers just ignoring them. It's soul destroying." Another relative told us that when they had requested assistance for their family member to be supported to the toilet they were told that, "[The person] has just been and they have a pad on anyway." This did not support people to maintain their dignity and independence.

A visiting health professional told us that they had arrived to see one person and had found them naked on the floor in their room. Staff had been unable to tell them how long they might have been there. They were aware that another visiting health professional had found the person in a similar state two weeks previously. They told us that another person they visited was frequently found to be in a wet bed. Another relative told us that they had found someone else's false teeth in their family member's room. These concerns demonstrated to us further that people's dignity was not upheld, and that staff did not always show respect for people.

Two people and one relative had told us that clothes were not cleaned or ironed properly. The relative told us that they sometimes took their family member's clothes home to wash themselves as they were, "...fed up with things getting shrunk." We observed that one person was dressed in stained clothing. Their relative told us that the person had always been very particular about their clothing. This demonstrated to us that staff did not always respect people's belongings.

The concerns meant that the provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not always develop positive, caring relationships with people. We observed two staff members hoisting one person. They were not talking to the person or providing any assurance to them and were

talking generally between themselves. The person was largely being ignored. During lunch periods we saw that staff were not engaging with people they were assisting to eat their meals. There was little, if any, conversation or interaction.

We received mixed views about the staff. People told us that some staff were more caring than others. One person said, "I am being looked after very well." A relative told us about one staff member whom they felt was very good. They added, "They just haven't got the time to interact and talk with people." Another relative told us that their family member got on with all staff apart from one. Apart from this person their family member said that they were spoken to nicely. A third relative told us that their first impressions were good and that staff were welcoming and pleasant. However, one person told us that they felt a bit intimidated when one staff member asked them why their family member didn't take them to a health appointment.

We had observed that staff practice was inconsistent. We saw examples of good and poor practice. Some staff were caring and considerate towards people, getting down to a person's level, maintaining eye contact and giving them time to say what they wished. However, others didn't engage so well with people and did not adapt their communication effectively.

People were not always consulted about planning care appropriate to their needs. One person told us that they now preferred to eat alone in their room as they were embarrassed because they often ended up with food over the floor. Staff had failed to support the person appropriately. Aids such as plate guards were available that might help to relieve the person's concerns and could mean that they could enjoy meals in a more sociable environment. However, staff had not discussed such options with the person. One relative had written in to tell us that staff had not advised them when their family member had been admitted to hospital. The first they heard about this was when the hospital telephoned them.

One relative did tell us that staff had consulted them about their relative's preferences with regards to what they liked to eat, but this had not included what times they liked to get up and go to bed, or what their hobbies had been. They told us that staff had kept them informed of their relative's involvement with the GP. Their family member was living with dementia and was unable to discuss their care in detail themselves. We saw that for one person, there was a missed opportunity to involved a family member in their care planning. Staff had not completed the social and emotional care plan and documented that the person did not understand it so they were unable to complete it. However, we spoke with the person's relative who confirmed that they visited the home daily. There was no evidence that staff had attempted to ask the relative about the person's social and emotional needs prior to living with dementia.

The service did not take sufficient steps to ensure people's dignity or promote their independence. We observed one person in their room sitting on a commode in front of their door, which had been left fully open. Another person had removed some of their clothing in the main lounge, used by several other people, who were able to see the person. There were no staff available to supervise or to prevent the situation from occurring. We saw that a similar incident had occurred on the previous day of our inspection visit; when staff intervened they did not attempt to address the reasons why the person was doing this, simply assisted them to do their clothes up again and then asked them to sit back down. On the second day of our visit, the person had been left without staff support for a longer time and had fully removed their lower half clothing and put a soiled pad on the floor in the lounge, again with others present. Staff had not been around to offer the person assistance with personal care in a timely manner, and the person who was living with dementia had not had any supervision to prevent this from happening. This did not uphold or protect the person's dignity.

We saw that when staff were not supervising communal areas, some people who were living with dementia were walking around looking for the toilet, and staff were not always available to help. This was confirmed to us by a relative who told us, "In communal areas we've seen people saying that they need the toilet and carers just ignoring them. It's soul destroying." Another relative told us that when they had requested assistance for their family member to be supported to the toilet they were told that, "[The person] has just been and they have a pad on anyway." This did not support people to maintain their dignity and independence.

A visiting health professional told us that they had arrived to see one person and had found them naked on the floor in their room. Staff had been unable to tell them how long they might have been there. They were aware that another visiting health professional had found the person in a similar state two weeks previously. They told us that another person they visited was frequently found to be in a wet bed. Another relative told us that they had found someone else's false teeth in their family member's room. These concerns demonstrated to us further that people's dignity was not upheld, and that staff did not always show respect for people.

Two people and one relative had told us that clothes were not cleaned or ironed properly. The relative told us that they sometimes took their family member's clothes home to wash themselves as they were, "...fed up with things getting shrunk." We observed that one person was dressed in stained clothing. Their relative told us that the person had always been very particular about their clothing. This demonstrated to us that staff did not always respect people's belongings.

The concerns meant that the provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not always develop positive, caring relationships with people. We observed two staff members hoisting one person. They were not talking to the person or providing any assurance to them and were talking generally between themselves. The person was largely being ignored. During lunch periods we saw that staff were not engaging with people they were assisting to eat their meals. There was little, if any, conversation or interaction.

We received mixed views about the staff. People told us that some staff were more caring than others. One person said, "I am being looked after very well." A relative told us about one staff member whom they felt was very good. They added, "They just haven't got the time to interact and talk with people." Another relative told us that their family member got on with all staff apart from one. Apart from this person their family member said that they were spoken to nicely. A third relative told us that their first impressions were good and that staff were welcoming and pleasant. However, one person told us that they felt a bit intimidated when one staff member asked them why their family member didn't take them to a health appointment.

We had observed that staff practice was inconsistent. We saw examples of good and poor practice. Some staff were caring and considerate towards people, getting down to a person's level, maintaining eye contact and giving them time to say what they wished. However, others didn't engage so well with people and did not adapt their communication effectively.

People were not always consulted about planning care appropriate to their needs. One person told us that they now preferred to eat alone in their room as they were embarrassed because they often ended up with food over the floor. Staff had failed to support the person appropriately. Aids such as plate guards were available that might help to relieve the person's concerns and could mean that they could enjoy meals in a

more sociable environment. However, staff had not discussed such options with the person. One relative had written in to tell us that staff had not advised them when their family member had been admitted to hospital. The first they heard about this was when the hospital telephoned them.

One relative did tell us that staff had consulted them about their relative's preferences with regards to what they liked to eat, but this had not included what times they liked to get up and go to bed, or what their hobbies had been. They told us that staff had kept them informed of their relative's involvement with the GP. Their family member was living with dementia and was unable to discuss their care in detail themselves. We saw that for one person, there was a missed opportunity to involved a family member in their care planning. Staff had not completed the social and emotional care plan and documented that the person did not understand it so they were unable to complete it. However, we spoke with the person's relative who confirmed that they visited the home daily. There was no evidence that staff had attempted to ask the relative about the person's social and emotional needs prior to living with dementia.

Inadequate

Is the service responsive?

Our findings

People's social needs were not met. All of the healthcare professionals we spoke with told us they did not feel that the home fully met people's healthcare needs. The registered manager and the acting manager did not keep up to date with the needs of people or the home.

People did not have access to meaningful activities. There was no activities co-ordinator employed and there was a lack of appropriate activities to keep people occupied and engaged. The registered manager told us that the last post holder for activities had left the service about a month ago and they were in the process of recruiting. They added that when staff had time they supported people to engage socially but that people's personal care was their priority. One staff member told us that they tried to give people choices of what they wanted to do as much as possible and when they had time they did activities in the afternoons.

We observed that people sat in the lounge for long periods of time with no stimulation other than the television. The lounge was large and people were sat some distance away from each other and from the television, so they could not always watch the television actively or interact with others effectively. Some people were supported with their interests and spiritual activities. One person told us that they were assisted to go to church on a Sunday but staff were not available to take them to the shops. They were reliant upon their visitors if they needed anything, such as toiletries.

We saw that some people who would have been able to use them did not have their call bells within reach. One person told us, "I have to call out." A relative and a healthcare professional we spoke with expressed that people did not always have a call bell within reach.

A relative told us that their family member had been continent prior to moving in to the home. Since then they had been wearing continence aids, and the relative felt that staff had not promoted their independence with regards to this . They also said that the person was often unclean and did not always have their personal care attended to properly. They also told us that their family member had been able to mobilise prior to moving into the home and now had difficulty weight bearing. They felt that the staff at the home were not responsive to requests for support to use the toilet and that their relative was left in a chair all day and therefore their mobility had deteriorated. We saw that this person sat in a chair all day on both days of our inspection visit, trying to get up at times. Another relative told us that they sometimes visited their family member on two consecutive days. On the second day they found that their family member had not been washed or dressed from the day before.

Staff were not always responsive to people's needs and the care people received did not always meet their needs, or reflect their preferences. We observed that one person had received their breakfast of toast in their room. However, they told us they were having trouble putting their dentures in following recent surgery on their face, and were waiting for staff to assist them. They were unable to call for assistance as they could not reach their call bell. Their toast was cold by the time staff had arrived to attend to them. Relatives we spoke with felt that people did not received personal care in a timely manner when they needed it.

Another relative told us that their family member had always dressed smartly and wore scarves, perfume and lipstick prior to moving in to the home. However, the service had not supported their family member to present themselves in a way that that the person would have wished. Two people complained to us that their clothes were not ironed One relative told us how their family member was dressed in someone else's clothes when they had visited a few days ago.

One person's care plan stated that they used a hearing aid. However, they were not wearing it. The impact of this was that we were unable to converse with them. The acting manager told us that the person had visited their family the previous day for Sunday lunch and had left it there. A family member was going to bring it in later on in the day. However, following our inspection we spoke with a relative of the person who told us that this was not the case. They confirmed that the person was returned to the home on Sunday afternoon with their hearing aid. When the relatives visited on the following Wednesday evening the person was not wearing their hearing aid, but it had been found before they left the home that evening.

As a result of what we saw and what people told us, we concluded that staff did not always pay attention to details in order to provide the care that people required to enhance their well-being and maximise their quality of life.

Each person had a care plan but these did not always record their individual needs, which meant people were at risk of receiving inappropriate care. There were no care plans to support people with their specific needs resulting from physical or mental health conditions. Not all people living with diabetes had a specific care plan for this. There was no care plan or risk assessments to support one person living with chronic obstructive pulmonary disease and who used inhalers to relieve their symptoms. There were no care plans to guide staff how to support people with their mental health and no assessments to identify what might trigger behaviours that challenged so that staff could act to reduce people's concerns or anxieties. When people's care needs changed their care plans were not always updated. For example one person had recently undergone a procedure which meant that their dietary needs had temporarily changed. Their care plan had not been changed to reflect this.

These concerns constituted a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A relative told us that they had been asking for some information since September 2016 regarding their family member's care and medicines arrangements. The person had consented to this, but no information had been forthcoming despite the relative sending in a letter from their solicitor. The registered manager told us they did not feel this constituted a complaint but assured us they were dealing with it.

The service had a complaints process in place and we found that written complaints had been responded to. However, people told us that they had little confidence that action would be taken if they raised any concerns. One person said, "I've raised all sorts of things, nothing gets done." One relative told us, "I've given up now. I don't want to have a massive row with them." Two relatives were worried that raising concerns with the management team could result in their family member receiving a lesser standard of care.

The registered manager did not always respond in a timely manner if health professionals raised concerns about the standard of service people received. The local authority's safeguarding team were waiting for a response in relation to a matter they had raised with the registered manager several months ago. Following a complaint we received we contacted the service on 9 December 2016. A response was received on 30 December which did not address any of the issues raised. A response to the complaint addressing the specific concerns was finally received on 13 January 2017.

When concerns about the home had been received in the months prior to the inspection, we found we did not always get a timely response from the registered manager. When we did obtain responses, they were not always satisfactory and this demonstrated to us that the registered manager did not always investigate concerns appropriately and act on them. Therefore there was limited learning from errors or proactive approach to improving the service.

Inadequate

Is the service well-led?

Our findings

The service was not well-led. We looked at various audits which had been carried out in respect of care plans, weights and other areas such as medicines and found that none of the concerns we picked up, were identified. We saw that there were infection control audits in place, however they had not identified concerns we found and did not cover individual's rooms in respect of their cleanliness. We found that checks on the environment were not effective and this meant that the service was not always made safe for people. A monthly bedroom check covered various aspects of rooms such as window and lighting fittings, however the concerns we found about people's fire doors had not been picked up. There was no system in place for checking that each person had the equipment they required.

The audits for care plans were not effective. The registered manager had not identified gaps in people's care plans, concerns about records not being up to date and risk assessments not being in place. We found that the registered manager had not checked whether people were receiving the care they required, or that staff were following recommendations for people's health and welfare.

The care plan audit had not picked up where there were inconsistencies or inaccurate information within people's care plans.. The care plan audits were a tick list of the pages that were in the care plan. They did not include checks on the accuracy of the information or whether sections of care plans were complete or not. For example, for one person, the care plan audit had ticked that the pre-admission assessment was in place, however these documents had been left blank within the care plan. Additionally the social and emotional care plan had not been completed either, for one person, who could become distressed according to one section of their care plan. No actions were documented from the audit to complete the records or to provide knowledge and guidance about the person's needs.

We saw that the provider's representative carried out a monthly audit, which had identified in November 2016 that some supervisions needed to be completed. However the latest provider's audit was in December 2016 and this had not identified any actions needed to improve the service. Therefore it had not identified any of the issues we found during our inspection.

The most recent medicines audit was carried out the week prior to our visits and had stated that 'all medicine was locked in cabinets'. However during our visits we saw that medicated creams had been left out in several rooms in the home. The medicines audit also stated that there were clear directions in place for PRN medicines. We found that this was not the case, and the deputy manager put these in place during the week of our inspection following our discussions about this. The registered manager and the provider had not identified other medicines concerns that we found within the audit. For example around staff signing for medicines they had not given, or that one tablet was missing, which we found during our second visit to the home. As audits had not identified these concerns no action had been taken to make medicines administration safe and effective.

Where we found serious concerns regarding people's nutrition, we found that there were no effective systems in place to monitor this. There was no auditing of fluid and food charts and no action taken when

people were found to be losing weight. There was a 'weights audit' in place, however this had not identified any of the problems we identified or led to referrals or actions for people who had lost weight.

It is the provider's responsibility to adequately assess staffing requirements according to people's needs, as well as keep up to date with best practice and knowledge. There was not a system in place which had identified that staffing presented a concern and they did not carry out any audits in relation to staffing.

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

The registered manager had not always notified us of events which they were legally required to do so. This included notification of a DoLS application granted in August 2016 and a grade three pressure ulcer in January 2017. These should have been notified to CQC as per the regulation.

These concerns constituted a brach of breach of Regulation 18 of CQC (Registration) Regulations 2009.

The service had poor leadership. We found that there was not an open culture within the home. The service was not developed and improved with people's input. When relatives told us they had raised concerns, they said they were not always rectified by the registered manager. Furthermore, other healthcare professionals who raised concerns did not always get a proactive and professional response from the registered manager. The registered manager was not always transparent in their cooperation with us. We asked them about staff supervisions and they refused to request staff consent for us to see the records.

Safeguarding matters were not dealt with in an open, transparent and objective way. We also found in the incidents records that where there had been a safeguarding concern, the registered manager had not referred this to the local authority safeguarding team. This showed a lack of transparency and knowledge of protecting people from possible avoidable harm.

We also spoke with relatives who felt that concerns or requests for information were not dealt with professionally and openly. We discussed this with the registered manager and they said this was not the case.

Two healthcare professionals and several of the relatives we spoke with felt that concerns raised with the manager had not been taken seriously and acted upon. The manager did not actively seek the views of people using the service or their relatives. Where people had made comments regarding the service we did not see any evidence that this has resulted in positive change. As a result many people felt that their comments were not listened to. The service held meetings for people living in the home, however when we looked at the last meeting minutes from this the majority of the comments were from the staff. We were not assured that the staff proactively gathered feedback from individuals and their relatives about the service they received.

The concerns we found demonstrated a lack of understanding of good quality assurance systems and how they can contribute to, and sustain, improvement. We found that there was not a drive for improvement as we found additional breaches to those that we had found in previous inspections.

The registered manager told us they felt supported by the directors of the company, who visited the home regularly. However, we found that this had not been effective in identifying and preventing problems and sustaining improvements to the service. The staff we spoke with said they felt that the registered manager was supportive and helpful to them if they had any problems or concerns.

We have found during past inspections that the service has been unable to sustain improvement. We found several breaches of regulations when we inspected twice in 2013, again in two inspections in 2014, and after a third inspection in 2014 it was rated 'inadequate' in all areas. In 2015 the service was rated as 'requires improvement' with some breaches of regulations, before being rated 'good' following our inspection in June 2015. Given the history of this service we are not confident that there is good leadership which is able to make and sustain the improvements required to consistently deliver a good standard of care to people.