Broadoak Group of Care Homes

Broadoak Lodge

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 3 and 4 December 2015. The first day of the inspection was unannounced. We told the provider that we would be returning for a second day. We started the second day of the inspection at 5.30am as we had identified some concerns about people being woken up early.

At our last inspection of the service, 27 and 28 August 2015 the provider was failing to meet two regulations. These related to governance and safe care and treatment. We issued the provider with a warning notice in relation to governance at the service and told them that they needed to improve. We also issued them with a requirement notice relating to providing safe care and treatment at the service. At this inspection we found that the provider had failed to address all of the concerns and we identified further concerns about the health, safety and wellbeing of people at the service.

Broadoak Lodge provides accommodation, care and support for up to 27 people who require personal care. On the day of our inspection 25 people were using the service. There should be a registered manager at the service. 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. The service did not have registered manager in post although a registered manager from another of the provider's services was working at the service.

People were not consistently protected from risks relating to their health and safety. Risks had not always been assessed. Where there was guidance in place for staff to follow to reduce risks associated with people's care this was not consistently followed.

People were not protected from abuse. People were made to get up early, sometimes up to four hours before their preferred time to rise, without any choice and this was abusive. Allegations of abuse and safeguarding incidents had not been reported or investigated appropriately and so people had been denied the oversight and protection of the council and the Care Quality Commission.

People told us that the staff were kind and caring. However, we found that people had to wait for their needs to be met as there were not sufficient staff at the service. Staff did not have the time to get to know people and respond appropriately to meet their needs. People did not always receive choices or communication from staff about how and where they spent their time.

People were at risk of not receiving their medicines as prescribed. This included medicines prescribed for severe heart, eye and metal health conditions. There was not always clear guidance for staff to follow to ensure that people received their medicines when and how they needed them. Some staff who were expected to administer important medicines had not received training on how to do so and did not have ready access to them. Recordings of the administration of medicines were inconsistent.

People received care from staff that had undergone the appropriate pre-employment checks. Staff had not all received appropriate training and support to enable them to fulfil their roles. Night staff on duty for example had not received any training from the provider in relation to their roles, including their responsibilities to administer important medicines and to use necessary moving and handling equipment.

The service was working within the principles of the Mental Capacity Act 2005 (MCA). Where there was a reasonable doubt that a person lacked capacity to make decisions the service had a mental capacity care plan in place. However, the information relating to the people's mental capacity was not decision specific and therefore did not fully meet the requirements of the MCA legislation. The service had taken appropriate steps where they had identified that people were being deprived of their liberty in any way and they had made referrals to the local authority as is required.

People enjoyed the meals they were offered. Drinks and snacks were available throughout the day. People were not always however supported to maintain a balanced diet when they needed assistance or supervision.

People were supported to access healthcare services but the provider did not always ensure that advice given by health professionals was carried out.

People's needs had been assessed and care plans were in place with the intention of people's needs being met. On a day to day basis people were not supported to take part in social activities. Activities did not reflect people's individual hobbies and interests.

The provider had taken some action to improve the systems and processes in place to assess and monitor the quality of service. However the action they had taken had not been closely monitored for its effectiveness and we continued to identify a number of areas where improvements had not been made.

We identified that the provider was in breach of four of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) and one breach of the Care Quality Commission (Registration) Regulations 2009. You can see at the end of this report the action we have asked them to take.

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.

Risk was not continually assessed and consequently peoples' safety was not consistently maintained. People were not protected from abuse and incidents of abuse had not been followed up and reported appropriately. There were not sufficient staff on duty. Arrangements for supporting people with their medicines were unreliable.

Is the service effective?

Inadequate

The service was not effective.

Staff had not received adequate training and support to enable them to meet people's needs. Staff did not respond effectively to people needs. Information relating to people's mental capacity was not decision specific and therefore did not fully meet the requirements of the Mental Capacity Act legislation. Where people were being deprived of their liberty in any way the service had made appropriate referrals. People were not always supported to maintain a balanced diet. People were supported to access healthcare services as required.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People told us that the staff were kind and caring. Staff had a good understanding of how to respect people's privacy and dignity. However, staff did not always get the time to know people or support people's well being by responding appropriately to their needs because they did not have the time.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans contained details of people's preferences and needs. Information recorded within them was not always an accurate reflection of people's preferences. Activities did not reflect people's individual hobbies and interests. Complaints had not

always been recorded. Information relating to complaints needed updating.

Is the service well-led?

Inadequate

The service was not well led.

Statutory notifications of injuries and alleged or actual abuse had not been submitted. The provider had failed to take notice and act on feedback to evaluate and improve the service. Systems and processes in place were failing to identify and mitigate risks relating to people's health, safety and welfare.

Broadoak Lodge

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 3 and 4 December 2015 and was unannounced.

The inspection was carried out by three inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert had experience of caring for someone who used dementia care services.

We reviewed notifications that we had received from the provider. A notification is information about important events which the service is required to send us by law. We contacted the local authority who had the responsibility to investigate safeguarding concerns at the service and funded some peoples care. We spoke with a community nurse who visited the service on the day of our inspection and a district nurse following our visit.

We spoke with 11 people who used the service and seven relatives. The majority of people who used the service were elderly and had limited mobility and dementia. We observed the care they received and the interactions of staff. We spoke with the manager of the service, two senior carers and five carers, two of whom worked the night time shift.

We examined in detail at the care of four people and we looked at the care records of five people relating to their specific needs. We looked at the incident and accident forms that had been completed for the past three months. We looked at documentation about how the service was managed. This included policies and procedures, four staff records and records associated with quality assurance processes. We also used the Short Observational Framework Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

At our last inspection we had found that there were still some concerns about how the provider was ensuring that risks associated with people's care were being continually assessed, monitored and managed. This had originally been identified at our inspection on 25 September 2014.

People were not consistently protected through the effective assessment, identification and management of risks to their health and safety when they received care and support. One person displayed behaviours that challenged others and regularly walked around the service entering other people's rooms. People had experienced harm as a result of this person's behaviours. There had been no assessment of why the person did this and no assessment of the risks this posed to themselves and others as a result of their behaviour. There was no guidance in place for staff to follow to reduce any of the associated risks and ensure that the person was receiving consistent and appropriate responses from staff.

Three people had been identified as displaying behaviours that challenged other people. Assessments and guidance were in place for staff to follow to reduce the risks to them and to others associated with their behaviours. However, throughout our inspection we saw instances when these people became agitated and staff did not respond in line with the guidance in place. On one occasion we saw how this almost caused another person harm.

We saw that staff were not consistently following risk management plans that were in place. For example, one person was identified at high risk of falls. Their risk assessment stated that staff should be with the person when they walked around the home. We saw a number of occasions when this person was left to walk independently and three occasions when staff moved their walking frame away from them out of reach to discourage them from walking. We saw that this person continued to get up without their frame and attempted to walk without it for support. Staff actions on these occasions did not follow the person's risk management plan and were dangerous. They increased the risk of harm to this person by their actions.

We also found that risk assessments were not being consistently updated to reflect people's changing needs. For example, one person's continued to be assessed as being at low risk of falls despite having actually fallen and as a result required medical attention. Another person's malnutrition risk assessment continued to state that they were at low risk of malnutrition although they had recently lost 13.9kg within a period of 34 days. This was 17% of their original body weight.

These matters were a breach of Regulation 12, (1) (2) (a & b): Safe care and treatment. Health and Social Care Act 2008 (regulated activities) Regulations 2014 (Part 3)

Most people at the service told us that they felt safe. However one person told us that they didn't feel safe at night time as they'd been told they had to leave their bedroom door open. They told us they were frightened that somebody would come in so they were not having a good night's sleep. Another person told us that somebody had been in their room and tried to get into their bed. They went on to tell us how they had tried to stop the person and they had then been slapped by them across the face. This person went on to tell us

that they now had a key to their room but they were worried about other people's safety.

We found that people were not always protected from abuse. There had been an increase in the number of safeguarding concerns in relation to the quality and safety of care within the home and in relation to the conduct of some staff members where staff had failed to carry out checks as required, moved a person who had experienced a fall and delayed seeking medical attention for them. These concerns had been substantiated by the local authority. However we found that the systems in place to protect people in the home had not strengthened in light of the outcome of the local authority's investigations. During our inspection we found that the service was failing to identify safeguarding concerns and report them appropriately. The service had failed to report them to the local safeguarding authority and the Care Quality Commission. This denied people the protection and oversight of two important external agencies and put people and staff at the service at unnecessary risk .

For example we saw two records of unexplained bruising where no further investigation had been carried out into how these bruises had occurred. These injuries had not been recognised as potential signs of rough handling or inappropriate care.

We found incidents had been recorded within the staff communication book and on behaviour recording charts. Records said that people had been subjected to abuse from another person that used the service. However, the service had not reported any of these concerns to the local safeguarding authority or the Care Quality Commission. The local authority have the lead responsibility to investigate safeguarding concerns and it is a requirement of the Care Quality Commission (Registration) Regulations 2009 to report any abuse or allegation of abuse in relation to a service user to CQC. We referred all of these incidents to the local safeguarding authority, who have the legal responsibility to investigate safeguarding concerns.

We carried out a visit at 5.30am and we found that people were being made to get up from 4am. Night staff confirmed that it was an expectation that they started to wake people up from 4am. They told us that they were instructed to have 11 people up by the time the day staff started their shift at 7.30am. Night staff provided us with a list of names of people they were expected to wake at 4am. One person who night staff confirmed they had woken up at 4am that morning told us, "4am is far too early. I like to get up at 8am." They went on to tell us, "They just pull the covers off of you." Once people were up they were assisted into the lounge and had to wait for day staff to start their duty before they offered anything to drink. For one person this meant that they had been left for four hours before being offered anything to drink. We referred these concerns through to the local safeguarding authority who have opened an investigation into institutional abuse.

Staff members were able to tell us about the various types of abuse and they told us that they were aware of how to report any concerns. They knew who to report concerns to both internally and externally. Some staff had reported concerns of abuse to the manager but these had not been further investigated or referred on in any way. We saw that there was a whistleblowing policy in place but staff had not used this to report concerns. We looked at the providers safeguarding policy which provided details about abuse and how staff should report it. The policy needed to be updated to reflect current legislation and did not include any contact details for external agencies.

These matters were a breach of Regulation 13: Safeguarding service users from abuse and improper treatment. Health and Social Care Act 2008 (regulated activities) Regulations 2014 (Part 3)

Three people using the service told us that the staffing levels were not sufficient to meet people's needs. One person told us, "They're short staffed, they just can't manage." Another person told us, "There is a

shortage of staff mainly in the afternoon and evening times." When talking about how long it took staff to respond to people's call bells and requests for staff to assist them with personal care including assisting them to the toilet, one person told us, "It varies between five minutes and an hour." Another person also told us they had to wait for up to an hour for staff to respond.

Staff told us that there were not sufficient staff to meet people's needs. One staff member told us, "[the staffing levels are] atrocious and diabolical and I'm losing the ambition to come to work." Another staff member told us "There are not enough staff to meet people's needs. People are vulnerable when you are rushing around." They told us that they and people using the service were particularly vulnerable during the afternoon shift. In relation to the staffing levels one staff member told us "I just don't feel safe." Other staff members also raised concerns about the safety of people that used the service with the staffing levels that were in place.

We observed people waiting for their needs to be met. On one occasion a person who required one to one supervision and support to ensure that they ate and drank sufficiently was sitting at the dining table for two hours. Staff attempted to interact with them while passing by. However, throughout this period they had nothing to eat or drink. We also observed that staff supporting people were being continuously interrupted to attend to other people's needs. This resulted in people receiving disjointed support that fell short of the support they required to meet their needs.

We discussed staffing levels with the manager. The manager did not have a system to determine staffing levels within the service. We identified that since our last inspection people's level of needs had increased and the staffing levels had decreased.

We found that two night staff members on duty during our inspection had not received sufficient training to enable them to meet people's needs. The provider had failed to ensure that there were sufficient numbers of staff deployed at the service to keep people safe or to meet their needs properly.

These matters were a breach of Regulation 18: Staffing Health and Social Care Act 2008 (regulated activities) Regulations 2014 (Part 3)

There was a policy in place to support the safe administration of medicines however this was not being followed. People were at high risk of not receiving their medicines as prescribed. We found that two people had been prescribed medicines and were not given those medicines for two days because they were not in stock at the service. This happened because the manager had waited until they had completely run out of those medicines before taking any action to get more in stock. Another person was prescribed eye drops for one affected eye to reduce the pressure in the eye to help to prevent serious loss of vision. Nowhere was it detailed which eye they should be administered in. We spoke with the manager and a senior member of staff about which eye these should be administered in and they provided different answers. The person was unable to tell staff which eye they should be administered to so there was a risk that this person was not receiving their eye drops as prescribed and in the longer term this could have had a serious detrimental effect on their sight.

There were not always PRN and variable dose protocols in place. PRN medication is medication that is prescribed on an as required basis. This was particularly concerning where a person was prescribed a medicine for maximum pain relief, because there was no guidance in place for staff to follow about when and how to give the person the medicine. Another person was prescribed a medicine to be administered when they experienced breathing difficulties. However, there was no protocol in place for this and not all staff who were responsible for administering it were aware of where it was stored.

Recordings of medicines were inconsistent and unreliable. Medication administration records (MAR) did not always accurately reflect the prescription. This meant that the provider could not assure themselves that people were receiving their medicines as prescribed. For example, we found that where people had been on a short course of tablets there were more signatures of administration of the medicine than the actual amount that had been delivered. We found that for another person the amount of tablets that should have been administered differed to the details on the prescription on the packet.

We found one tablet on the floor in the lounge area on the first day of our inspection. The manager cold not account for how this may have happened.

We also had concerns about the location of the controlled drugs cabinet. Although it was secured to the wall the door to the room was regularly left open and it was not in a secure location.

These matters constituted a breach of Regulation 12, (1) (2) (f & g): Safe care and treatment. Health and Social Care Act 2008 (regulated activities) Regulations 2014 (Part 3)

People received care from staff that had undergone the appropriate employment checks. We looked at the staff records for four staff members that were working at the service. We saw that the service had undertaken relevant pre-employment checks prior to the staff commencing work. Staff had completed an application form which for three staff members provided full details of their working history. They had two written references and had a disclosure and barring service check carried out. Intentions of these checks were to ensure that staff were suitable for the roles for which they had been employed.

Inadequate

Is the service effective?

Our findings

Staff had not all received an appropriate induction and training to enable them to meet people's needs. One staff member told us that there had been an additional staff member on their first shift but they had not completed an induction checklist or workbook. Neither of the night staff on duty had received any training from the service. One had worked at the service for one month and the other was working their second shift. These staff had not had received training and support to enable them to meet people's needs. The staff training matrix confirmed this. Neither of these staff had detailed knowledge of people's preferences and needs and they were the only staff on duty from 9.30pm until 7.30am.

Other staff members told us that they had received an induction and some training to enable them to meet people's needs. However, they felt that they had not been supported recently to enable them to meet a person's behavioural needs. Staff told us that they had reported their concerns to the manager but they had not received any training or guidance about how to meet their needs. Staff felt that they did not have the knowledge and skills to meet this person's needs. No support had been put in place to address this.

Staff responses about supervision varied. Some staff told us that they had supervisions on a monthly basis and others could not recall how frequently they happened. One staff member who had been at the service for over six months told us that they had not received a supervision at all. There were no notes available for us to confirm if these had taken place or the frequency of them. The manager told us that all staff had received a supervision session in July or August 2015 but the notes of these had not been made available to staff as the quality group manager who had carried them out had left the organisation. They showed us the record of a supervision meeting they had had with the quality group manager in July 2015. The manager advised us that they had not carried out any further supervision sessions with staff members since this time and they did not have access to any previous notes. This meant that staff had not received effective supervision.

Staff did not effectively respond to people who were living with dementia. Throughout our inspection we observed staff members responses to people's needs were not consistent with their care plans or basic good practice. For example a person was repeatedly calling a name of a person. Another person shouted at them and told them to stop. A staff member then told the person to stop shouting as they were upsetting other people. We looked at this persons care records and we identified that they had a daughter by the name they were calling. Staff did not attempt to distract this person at all or follow the guidance in their care plan. Staff did not have the time or skills to respond appropriately to people's needs.

This was a breach of Regulation 18 (1) (2) (a): Staffing Health and Social Care Act 2008 (regulated activities) Regulations 2014 (Part 3)

One person told us, "I ask for a drink if I need one otherwise drinks are available all of the time." Another person told us, "The food is good." We saw that drinks and snacks were served throughout the day and there were jugs of juice available within the lounge area. People told us that enjoyed the food and that they were offered choices. The menu was displayed on a chalk board in the dining room but was difficult to read. No

other formats were available to support people with communication needs. We saw that where concerns had been identified with people's swallowing the speech and language therapy (SALT) team had been involved and people were being supported with diets that had been advised by them. However, we saw that follow up appointments with the SALT team had not always been made. For example, one person's nutritional advice given on 13 January 2015 should have been followed up by the service with the SALT team in four weeks, but this was still outstanding at the time of our inspection. This failure placed this person at unnecessary risk.

Where a concern had been identified with a person's dietary intake the service had put food charts in place to enable them monitor the person's diet. However, these did not accurately record what people had to eat as they did not record the quantities that people were given. For example, one person's records stated `cornflakes and tea - ate most of this' but did not say of what sized portion. The provider was not monitoring people's dietary intake in any other way and this also placed people at unnecessary risk.

We spoke with staff we saw serving drinks particularly about people who required thickeners in their drinks to help avoid known risks of choking or taking fluids into their lungs. Thickened drinks are safer because they move around the mouth more slowly and allow better control of swallowing. Staff we spoke with were not clear who required thickeners in their drinks and the people who required thickeners were unable to communicate what their needs were in this area. This meant that there was a risk to those people's health and welfare.

We saw that where one person had experienced a substantial weight loss in the period of just over a month. However, staff were not monitoring their nutritional intake. We observed this person was sleepy during the second day of our inspection and throughout a period of one and a half hours of being sat at the table they only ate eight spoonful's of porridge. This was not recorded or monitored in any way. We observed other people not being supported appropriately throughout mealtimes with their food and drink. For example, one person was served with their food and then 10 minutes later the staff member returned to cut it for them as they were unable to do this for themselves. Another person declined anything to eat but looked into their cup several times, this was not identified by staff as a request for drink. An inspector asked the kitchen staff for a drink for this person which they then drank.

These matters also constituted a breach of Regulation 12 (1) (2) (a & b): Safe care and treatment. Health and Social Care Act 2008 (regulated activities) Regulations 2014 (Part 3)

The environment also was not 'dementia friendly'. For example the carpet was very heavily patterned and there were two televisions within the same lounge area on different channels. We also saw one person who had a diagnosis of dementia was seated in an armchair underneath a television screen that was secured to the wall. This person became agitated shouting "shut up, shut up" at people looking towards them. These people were watching the television but the fact that they were looking towards the person was agitating them. The layout and use of this lounge was not sensitive to the needs of people living with dementia and was causing unnecessary confusion and distress. The lounge environment was noisy and busy and did not meet the needs of all of the people at the service.

People told us that staff provided them with choices. One person told us, "Oh yes, they always ask what I prefer." Staff members told us how they offered people choices in their day to day care. They told us that this was important and gave us examples of how they were able to offer people choices relating to their day to day care such what they wanted to wear, what they wanted to eat and if they wanted music on. We observed people being offered choices at breakfast time. However we found that people were not offered choices about the times they wanted to get up. We observed a staff member enter a person's bedroom, turn the light

on and say "Morning time to get up." This was not the persons preferred time to get up and the staff member did not offer the person any choice.

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

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

We checked whether the service was working within the principles of the MCA. We saw that people had mental capacity plans in place that referred to them being able to make simple decisions about daily living and provided details of who needed to be involved in more complex decisions, such as their family members. Care plans detailed that a mental capacity assessment had been carried out but these had not been recorded in any way and there was no evidence of any best interest decisions that had been made. The information relating to the people's mental capacity was not decision specific and therefore did not fully meet the requirements of the MCA legislation.

We saw that the service had three people with standard DoLS authorisations in place and had made a further 17 referrals to the local authority which they were awaiting decisions on. This demonstrated that the service had taken appropriate steps where they had identified that people were being deprived of their liberty in any way.

People were supported to access healthcare services. We saw evidence of healthcare professional visits in people's files. We found that where advice for staff to follow relating to people's care had been provided we saw that staff were following this. We spoke with a healthcare professional who also confirmed this. We saw that where a person had lost a substantial amount of weight, the service had contacted their GP to advise them of the weight loss.

We received feedback from two healthcare professionals who told us that the service was more reactive than proactive. One also told us that they had concerns about the service completing required paperwork. They gave us an example of how three or four people from the service had been referred for continence assessments. The service had been left with the relevant paperwork but it had still not been completed.

Requires Improvement

Is the service caring?

Our findings

At our focused inspection on 27 and 28 August 2015 we found that people were using other people's en suite facilities to enable them to have a shower as not all rooms at the service had showering facilities. The communal bathroom was not being used and was not suitable to meet people's needs. During this inspection we found the same situation. People were continuing to use other people's en suites to enable them to shower and the hairdresser was also based within a person's room. We spoke with the provider about this situation and they advised us that they were converting the communal bathroom into a wet room and that this work was due to be completed by the end of February 2016 to be responsive to people's bathing needs .

People told us that the staff were kind and caring. One person told us, "They [the staff] are genuinely caring." Another person told us, "They [the staff] are the best," while a third person told us, "They [the staff] are lovely." A relative told us, "The staff are kind and caring. I've always got on well with everyone." Another relative told us that the staff provided, "Very good quality care."

Staff that had worked at the service for a period of time appeared to know people that used the service well. For example, one staff member told us, "[person that used the service] is quite proud, smart and doesn't always want you to help, but they need a bit more help than they think. You just have to approach them in the right way." Some staff members were concerned that they didn't get the time to get know people that used the service. One staff member told us, "We don't get time to know people and we are always on catch up." Another staff member told us, "It would be nice to get to know people more but there doesn't seem to be enough time."

We saw that staff regularly spoke with people in passing in a kind manner. We also saw that when staff noticed that people needed assistance they supported them as soon as they were able to. Although this at times meant that they were interrupted from supporting another person. We also saw that staff did not have the time to use the distraction techniques that had been identified in people's care plans for when they became anxious. This led to staff not supporting people's wellbeing or responding appropriately to their needs.
We saw that when a person became distressed in the communal lounge area a relative of another person raised their voice at them, swore at them and told them to shut up. A senior staff member was in the lounge during this time but they offered no support or engagement with the person during this time. Staff failed to respond appropriately to this person's distress.

We also saw examples where staff did not treat people with kindness. When talking about getting up in the morning, one person told us, "They just pull the covers off of you." We saw that when a person was woken up in the morning this was not done in a kind and caring way. The person was not offered any choice and the main light in the room was immediately turned on. We discussed this with the provider and manager who advised us that they would address the situation.

People told us that they were involved in decisions about their care and support and that staff listened to

them. We saw that people and their relatives had been involved in decisions and discussions about their care. However, we saw that where people needed assistance from staff to support them to move they were not involved in decisions about where they spent their time. For example two people who were sleepy throughout the morning were left sitting at the dining table for over two hours in their wheelchairs without any choices being offered to them about where else they might like to spend their time. We also saw that when staff assisted people in their wheelchairs they did not always talk to them to offer them choices or explain what they were doing or where they were taking them.

People told us that staff respected their privacy and dignity. One person told us, "[the staff member] always covers me up and shuts the bathroom door." Staff members had a good understanding of how they were able to support people's privacy and dignity through their daily work. Examples of things they told us they could do included taking people to their own rooms to use the toilet, ensuring the door was closed and speaking to people subtly and quietly about their needs if they were in a communal area. However, we saw that not all staff practised dignity in care. We found that people's privacy and dignity was not always respected. We saw that service users who shared rooms were not provided with any privacy when staff were assisting them with personal care and the door to the room was also left open. People told us they were able to be as independent as they wanted to be. One person told us, "They [the staff] know what I like and let me do what I can do." We found that people were able to be as independent as they wanted to be. For example one person was able to self-medicate and carried out their own personal care.

Requires Improvement

Is the service responsive?

Our findings

One person told us, "There's not a lot to do." A relative told us, "They have some activities of sorts, not that many people engage, some choose not to participate but [my relative] would not be able to." People told us that a volunteer came into the service to carry out activities. A staff member confirmed this and told us, "We have an activities volunteer twice a week." We saw a volunteer playing a throwing game involving bean bags in a communal area of the service. We looked at the activities records which confirmed that activities took place approximately twice a week and included things such as a bean bag game and bingo. When asked about activities one person told us, "I don't always join in but I thought I would today."

Activities that were carried out at the service were group activities and did not reflect people's individual hobbies and interests. Staff told us that a person came into the service and carried out reminiscence therapy twice a month. On a day to day basis people were not supported to take part in social activities and people who received all of their care in bed received no stimulation apart from when people were assisting them with their care.

We found that people's needs had been assessed and care plans were in place with the intention of meeting their needs. We found that people's care plans contained details about their life history, employment and family. We found that for some people there was information available relating to their preferences such as methods of bathing and the times they liked to get up or go to bed. However, we found these records were not always correct and the service was not providing care in line with these preferences. For example, one person who staff had woken up at 4am told us it was their preference to get up at 8am and their care plan detailed that they liked to get up at 6.30am. Out of the 12 people that night staff confirmed they assisted to get up before 7.30am, there were no preferred times for getting up recorded in five of the people's files. This meant that the service was not providing care and treatment to reflect people's preferences.

A relative of a person told us how they had raised the issue of staffing with the provider's son as their relative had been upset about it one evening. They said they had been provided with reassurances and felt that this had been addressed. We were told that no formal complaints had been received within the past 12 months. However, not all complaints had been recorded because people and their relatives told us about complaints they had made since this time. This meant there was a risk that complaints would not be investigated or responded to appropriately and this was also a missed opportunity for learning and improvement.

A relative told us, "I haven't needed to make a complaint, but I'd go to [the manager]." Staff were familiar with the complaints policy and told us that they would refer any complaints to the manager. We saw that information that was provided to people prior to them moving into the service included information about how they could make a complaint. However this was very dated and included information about referring complaints to the Commission for Social Care Inspection which transferred to CQC in 2009. Therefore there details of where people could refer their complaints to if there were not satisfied with the provider's response needed updating. The complaints procedure was not provided in an accessible format to make it easier to read for people that used the service.

Inadequate

Is the service well-led?

Our findings

At our inspection in August 2015 we found that the provider was in breach of Regulation 17 (2) (a) (b) & (c): Good Governance. This was because systems and processes in place were failing to assess, monitor and improve the quality of the service. Systems and processes in place were failing to mitigate risks relating to people's health, safety and welfare. An accurate, complete and contemporaneous record for each service was not being kept.

During this inspection we found that the provider had taken some action to improve the systems and processes in place. However, the action they had taken had not been closely monitored for its effectiveness and we continued to identify a number of areas where improvements had not been made.

Daily audits that had been introduced at the service to ensure that people were receiving care to meet their needs and that relevant documentation was being completed were failing to identify concerns. These audits were introduced to be completed at the end of each shift to ensure that people had received the care that they required throughout that particular shift. These audits had been completed by staff members that were not working on that particular shift. We also found that one person's fluid charts had not been completed as required for a period of 10 days. Audits had failed to identify this. Therefore the system was failing to improve the quality of the service and was not an accurate record of the shift. Records had not been completed to ensure that there was a complete and accurate record of people's care.

We identified a number of concerns relating to medicines at the service. The manager confirmed that these issues had not been identified by medication audits by the service. Therefore there was no system in place to ensure compliance with the safe management of medicines at the service.

Relatives and staff members had provided feedback about the staffing levels at the service. The provider had failed to take notice and act on this feedback to evaluate and improve the service. Staff levels remained a concern. Rotas were not effectively planned to ensure enough suitably skilled and experienced staff were deployed.

People and staff members told us that safeguarding incidents had occurred. Staff had reported and documented incidents that had occurred and the provider had failed to take action to mitigate the risks.

Concerns about how the provider was ensuring that risks associated with people's care were being continually assessed, monitored and managed had originally been identified at our inspection on 25 September 2014. These issues continued to be concern during the inspection.

These issues constituted a breach of Regulation 17, (1) (2) (a) (b) (c) (e): Good Governance. Health and Social Care Act 2008 (regulated activities) Regulations 2014 (Part 3)

The manager regularly provided care and was responsible for the administration of medicines. They were aware of staffing issues at the service but this had not been addressed. Staff told us that they had discussed

safeguarding concerns with the manager but no action had been taken in relation to these.

We discussed the safeguarding concerns with the manager who was aware of a number of the incidents that had occurred. They had not felt the need to report any of the concerns through to the local safeguarding authority or make anybody else aware of the incidents. There was not an open and transparent culture at the service. Staff members told us that they had raised concerns about the staffing levels at the service with the manager and provider but no action had been taken to address this. Staff members also told us that they had raised concerns about a person's behaviours that challenged others with the manager and no action had been taken in response to this. Staff felt that their concerns were dismissed.

The provider was not notifying the Care Quality Commission of incidents they were required to report. For example there had been a recent safeguarding investigation that had been substantiated that the manager had not reported. There were six incidents recorded on behaviour monitoring forms that referred to other people at the service being either physically or verbally abused by another person. These had not been reported. These notifications are an important safeguard for people using services and failure to notify the Commission denies people and important level of oversight and protection. These notifications are also a requirement of the Care Quality Commission (Registration) Regulations 2009: Regulation 18: Notification of other incidents that any abuse or allegation of abuse in relation to a service user is reported to CQC. The provider had failed to act in accordance with this legislation.

This was a breach of the Care Quality Commission (Registration) Regulations 2009: Regulation 18: Notification of other incidents.

There was no registered manager in place at the service and this had been the case for over six months. During this time a registered manager from another service had been covering the post. Some people spoke very positively about the manager, their comments included, "Yes they always find out if we are happy with the service," another person told us, "They listen to your suggestion." Staff members also spoke positively about the manager. Words they used to describe them included, `lovely, approachable and caring'. However some relatives of people at the service were not sure who the manager was. One relative told us, "I don't know the manager." Another relative told us, "I have never spoken to the manager."

The manager at the service had previously been provided with support from a Group Quality Manager to assist them to address issues at the service. However since the Group Quality Manager was no longer working for the provider they received little ongoing support, guidance and dedicated time to undertake work related to their managerial role. This meant limited time was available to make improvements that were required. The manager was included in the rota staffing numbers for the shift and throughout our inspection we saw that they were involved in providing day to day care at the service. This included being responsible for the administration of medicines when they were on shift.

The manager had been asked to support the service in March 2015 but they were unsure how long they would be working at the service for. They had been made aware of concerns that had been identified throughout inspections but they had not been supported with appropriate guidance and support to address the issues.