Mr A Y Chudary

Woolton Manor Care Home

Inspection report

Allerton Road
Liverpool
Merseyside
L25 7TB

Tel: 01514210801

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

Summary of findings

Overall summary

Woolton Manor provides accommodation for people who require nursing or personal care. The home can accommodate up to 66 people. The home is split into two units. A residential unit for people who require support with their personal care and a nursing unit for people who have needs that require nursing care. At the time of our inspection, there were 24 people who lived in the residential unit and 14 people who lived in the nursing unit.

There was no registered manager in post at the time of our inspection. 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.' At the last inspection of this service in November and December 2016, a manager was in post who was not registered with CQC. They have since left the employment of the provider and were not in post on the day of this visit. At this inspection, an acting manager was in post but they had only been at the service at short while. The acting manager was supported to manage the home by a consultant. The consultant had been brought in by the provider after our last inspection to drive up improvements.

At our last inspection, we identified multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service was rated inadequate and placed in special measures. During this visit we followed up the breaches we identified at our previous visit and found that the provider had not taken appropriate action to address our concerns and make the improvements. This meant people who lived at the home continued to be placed at serious risk. The rating for the service at this inspection has therefore not changed, the service remains inadequate and in special measures.

During this inspection, we found breaches of Regulations 9,10,11,12,13,17,18 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at 11 care plans and found some improvements to the way people's care was assessed and delivered had been made but these improvements were insufficient and inconsistent. There was little evidence that people's preferences and wishes in relation to their care had been discussed with them so person centred care could be delivered. Some of the risks in relation to people's care had not been risk assessed and some of the risk management information was contradictory and confusing for staff to follow. This placed people at risk of receiving inappropriate or unsafe care. Records relating to the provision of care showed that improvements to people's catheter care and wound care had been made but we found that other aspects of people's care required improvement.

For example, records showed that people did not receive the support they required with their personal care to preserve their dignity and skin integrity. People's ability to make decisions about their care had not been assessed in accordance with the Mental Capacity Act 2005 and the correct legal processes to deprive people of their liberty had not been followed. We found that people had no access to any social or recreational

activities in support of their emotional well-being and observed that the majority of people sat all day watching the TV.

People and the relatives we spoke with told us that there were not enough staff on duty to meet their needs at all times. Some people said that they had to wait long periods of time to be assisted the toilet or for staff assistance when they rang their call bell. They told us that the care staff worked hard but that there wasn't enough of them on duty to always meet their needs in a timely manner. Our observations of care confirmed this.

Records showed staff were recruited safely but we found that one staff member had been promoted to a senior post without any evidence that a robust recruitment process had taken place. One staff member was also disciplined for poor conduct without adequate disciplinary procedures being followed. We also found that staff had not received the training or support to do their job role effectively.

Care staff spoken with had a good knowledge of safeguarding and the action to take should abuse be suspected but the provider had not always followed the required processes to protect people from the risk of abuse. For example where potential abuse was suspected, there was no evidence that the provider's own safeguarding policy or the Local Authority's safeguarding procedures had been followed. This meant there was no evidence that incidents of abuse were investigated, reported and responded to appropriately.

Staff were observed to support people in a kind, caring and patient manner. We found however their ability to spend any meaningful time with people was hindered by the fact they were too busy trying to meet everyone needs. We observed that staff were unable to spend any meaningful time with people unless they were directly supporting them with their personal care. People told us that the majority of staff treated them well. We found however that the service did not always protect people's right to privacy, dignity and confidentiality.

For instance, some people had not received a bath or shower for significant periods of time; some people's bathrooms did not have any window blinds or coverings to protect their dignity and people's visits to the hairdresser were undignified and de-personalised. In addition, people's personal information was not stored confidentially and was accessible to unauthorised people.

The provider had audits in place to check the quality of the service but these were ineffective. For instance inconsistencies in people's care planning information had not been picked up, premises issues had not been addressed and the provider's medication audits had identified that the management of medication was unsafe.

People views about the quality of the service had not been sought and some of the people we spoke with did not know who managed the service.

This service was not well-led. At the end of our inspection, we discussed the concerns we identified during the inspection with the acting manager and the consultant. The acknowledged and accepted the concerns we had raised with regards to the service.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

-□Ensure that providers found to be providing inadequate care significantly improve.
-□Provide a framework within which we use our enforcement powers in response to inadequate care and

work with, or signpost to, other organisations in the system to ensure improvements are made.
-□Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.
-□
Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The management of people's risks had improved in some areas but required further significant improvement.

Safeguarding allegations were not properly documented, investigated, reported or responded to by the provider.

Staff recruitment was satisfactory but employment procedures relating to the staff promotion and disciplinary action were not followed.

Staffing levels were insufficient to ensure meet people needs in a timely manner.

Medication was not stored safely and the administration of some medicines could not be accounted for.

Parts of the premises were unsafe and unclean.

Is the service effective?

Inadequate

The service was not effective.

People's ability to make decisions was not assessed in accordance with the Mental Capacity Act and decisions to deprive people of their liberty did not comply with DoLS legislation.

Staff were not adequately trained and supervised and their competency to do their job role effectively had not been reviewed.

People told us the food was satisfactory and they got enough to eat and drink. The kitchen area was unsecure and accessible to unauthorised persons.

Is the service caring?

Inadequate

The service was not consistently caring

The majority of people said the staff were kind and treated them well. Our observations of care confirmed this.

People did not receive the support they needed to maintain their personal care as access to a bath or shower was very limited.

Parts of the premises did not protect people's right to privacy when personal care was delivered.

The way in which people were supported to have their hair done by the visiting hairdresser was undignified.

People's wishes in relation to their end of life care were poorly documented. Staff were not trained in end of life care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People received support for their medical and physical health needs from a range of health and social care professionals.

People's preferences and wishes in relation to their care were not documented so person centred care could be delivered.

People had no access to any social or meaningful activities in support of their emotional well-being.

Provider's complaints policy required improvement but records showed that when people raised concerns they were dealt with adequately.

Is the service well-led?

Inadequate

The service was not well led.

The service was rated inadequate at our last inspection. Despite this, the provider had not taken effective or prompt action to ensure improvements were made to mitigate the risk of harm.

The quality assurance systems in place did not effectively identify and address the risks to people's health, safety and welfare.

People's satisfaction with the service had not been sought. Some people told us they were unsure who managed the service.

Woolton Manor Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the 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 10 July 2017 and was unannounced. The inspection was carried out by two adult social care inspectors, a specialist nurse advisor and an expert by experience. An expert by experience is person who has personal experience of using or caring for someone who uses this type of service.

Prior to our visit we looked at any information we had received about the home and any information sent to us by the provider since the home's last inspection.

At this inspection we spoke with eleven people who lived at the home, four relatives, the acting manager, the deputy manager, five care staff, two nurses, a domestic member of staff and a visiting community matron.

We examined a range of documentation including the care files belonging to 11 people who lived at the home, six staff files, the provider's staff training information, a sample of medication administration records and records relating to the management of the service. We also looked at the communal areas that people shared in the home and visited some of their bedrooms.

Inadequate

Is the service safe?

Our findings

At our last visit to the home in November and December 2016, we identified serious concerns with the safety of the service. Risks to people's health, safety and welfare were not adequately mitigated. Medication management was poor, premises safety and cleanliness were inadequate, incidents of a safeguarding nature had not been properly responded to and there were not enough staff on duty at all times to meet people's needs. This domain was rated inadequate. At this inspection, we looked at the progress made by the provider in addressing the concerns we identified at the previous inspection and found that the concerns had not been adequately addressed.

Care staff spoken with demonstrated that they knew what action to taken to protect people from the risk of abuse and all of the people we spoke with told us they felt safe. People's comments included "I'm in a safe home"; "Everything's normal, nobody fights" and "I've got no problems".

We found concerns however with the way the provider had identified and responded to incidents of potential abuse, staffing levels within the home to meet people's needs, staff management, the planning and delivery of care, premises safety and the management of medication. The concerns we identified during our visit showed that people continued to be placed at serious risk of receiving inappropriate and unsafe care.

The provider had a policy in place for identifying and reporting potential safeguarding incidents but we found that where incidents of potential abuse had been identified, the policy had not always been followed. We found safeguarding incidents to be poorly documented, investigated and responded to with little evidence that appropriate action had been taken to protect people from the risk of harm.

For instance, a relative we spoke with told us that the person who lived at the home had previously been subject to potential abuse. They said that the previous manager had been slow to respond and investigate the person's concerns. The relative told us that they had to force the issue with the manager and insist that the incident was reported to and investigated by the Local Authority. We contacted the local authority who confirmed that it has been reported to them but when checked the provider's safeguarding records, no documentation had been kept by the manager with regards to the allegation made, the investigation or the outcome.

When we checked staff files we saw that another person had made an allegation of potential abuse but when we checked the provider's safeguarding records, there was no documentation to show what the allegations were or the action taken. There was no evidence that the allegation had been reported to and investigated by the Local Authority and there was no evidence that it had been reported to the Care Quality Commission in accordance with the provider's legal requirements.

This evidence demonstrates a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 the provider did not have robust procedures and processes in place to protect people from potential abuse and to take appropriate action should abuse be suspected.

We saw that some improvements had been made to the way people's care was assessed and planned. We looked at 11 people's care files and saw that they contained some evidence that the risks in relation to their health and welfare were assessed and reviewed. For example, moving and handling, nutrition, pressure sores and people's risks of falls. We found however that not all of the risks in relation to people's care and safety were assessed and in some cases the risk management advice provided to staff to follow to mitigate these risks was insufficient or not adequately followed.

For example, one person had bed rails in place that had not been properly risk assessed. There was a risk assessment in place but this focused primarily on whether the physical installation of the bed rail was safe as opposed to whether the person needed to, or was safe to have bed rails installed in the first place. Other documentation in the person's file also indicated they may have been at greater risk of harm with bed rails in situ, than not having them at all.

One person had complex mental health needs that were not properly risk assessed and staff lacked clear guidance on how to support this person on a day to day basis to prevent a further mental health decline. Another person had complex medical conditions with specific risks but staff had little information on what these conditions were, the signs to spot in the event of ill-health and the action to taken.

People's skin integrity, nutritional and falls risk assessments identified risks but the guidance in place was either very limited or inconsistent. For example, one person's diet and fluid care plan stated they were to have a normal diet whereas their diet notification sheet stated they were to have a soft diet due to the risk of choking and potential aspiration. There was no risk assessment in place to determine the likelihood or severity of a choking or aspiration incident should it occur or the action to take.

These incidences were a breach of Regulations 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not ensured the risks to people's health, safety and welfare were appropriately assessed and managed.

People's feedback on the number of staff on duty was mixed but most people, relatives and staff thought there were not enough staff on duty to meet people's needs at all times. One person said "It's not fair to them, you have to wait, it can be up to 45 minutes. Quite often I've had an accident (waiting to be helped to the toilet). Its nearly every day and I'm upset by it". Another person said "They (the staff) always seem to be wanted and I have to wait sometimes" and a third person said the home needed to "Get some more experienced staff".

A relative said "I think there should be a few more (staff). When a buzzer goes off, it goes on forever to be answered. Sometimes (name of the person) waits 2 to 3 hours for milk. A second relative told us "The only problem we have got is if (name of person) askes to go to the toilet and if there is a queue, they have to wait".

A staff member working on the residential unit told us "There used to be five of us (staff on duty during the day), then it went down to four and now it's down to three. Another staff member said that they were not always able to give people a bath or a shower as much as they would like as they did not have time. They said that the ability to meet people's needs depended on "How the day goes and who is on duty". Staff said it was not always possible to answer people's call bells promptly as they are sometimes too busy.

During our visit, we saw that a staff presence in communal areas was sporadic. People were often left for long periods of time alone in communal areas with no access to a call bell to ring for staff assistance if they needed help. On day one of our inspection, the expert by experience had to personally intervene in a

potentially volatile situation between two people who lived at the home as there were no staff in the vicinity to assist.

We discussed our concerns about the number of staff on duty with the acting manager. We asked them how they had ensured staffing levels were safe and sufficient to meet people's needs. They were unsure. We asked them if they undertook any formal analysis of people's dependency needs when determining how many staff should be on duty. They told us the provider did not have any system in place to do this. This meant there were no adequate systems in place to ensure that the number of staff on duty was sufficient to meet people's needs.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not ensured that there were sufficient staff on duty at all times to ensure people's needs were met

We looked at the arrangements in place for the safe storage of medication. We found that some medications were not stored securely or at a safe temperature. Prescribed creams were stored in people's bedroom with no evidence that it was safe to do so and on the second day of the inspection the temperature in the medication room exceeded safe temperature ranges. Records showed that on 13 days during June and the beginning of July 2017, the temperature in the medication room exceeded safe temperature ranges with no evidence that any effective remedial action was taken. Medication can become ineffective or unsafe to use when stored at too high a temperature.

We saw that people's medication was mostly dispensed via monitored dosage blister packs. There were some 'as and when' required medications for example, painkillers that were dispensed in individual boxes (boxed medication) for when people needed them.

We checked a sample of seven people's medication administration records (MAR). We found that people's monitored dosage medication was administered accurately. There were some minor discrepancies in the amount of boxed medication for two people which meant some medicines could not be accounted for. For example, according to one person's medication record there should have been 26 tablets left but when we counted the tablets remaining, there were only 24 tablets. This meant that two tablets had not been signed for but not given.

We saw that details of some people's 'as and when required ' medication had been handwritten on their medication administration records (MARS) without being appropriately signed for or double checked by a second member of staff. This meant they had not been verified as correct. We saw that people's medication administration records contained details of medicines that were no longer prescribed with no indication these medicines were no longer required. This meant people's medication records were confusing and inaccurate to follow. This increased the risk of medication errors being made.

Some people's medication records showed that they often refused to take some of their prescribed medication for significant periods of time. There was no evidence that any action had been taken in relation to this. For instance by discussing with the person and their GP or by investigating what potential complications could arise from not taking this medication as prescribed.

People did not have adequate 'as and when required' plans in place for the administration of topical creams. This meant staff had no clear guidance on when or how to apply these creams and we found that people's creams were not applied on an inconsistent and ad hoc basis.

These incidences demonstrate the way in which some of the medication was stored, administered and recorded was not safe. This was a breach of Regulation 12 of the Health and Social Care Act 2014 Regulations.

The home's gas, electric, fire and moving and handling equipment had all been inspected and certified as safe but as we walked around the building we saw that parts the home were unsafe and unclean.

At our last visit, we advised the provider that some of the windows in the home were not restricted from fully opening. This meant that people could be at risk of falling out and hurting themselves. During this visit, we saw that window restrictors were installed but they were of a poor safety standard and not fit for purpose. Health and Safety Executive's 'Health and Safety in Care Home' guidance states that window restricting devices must be sufficiently robust to restrain a fall, should only to be able to be disengaged from use by using a special tool or key and must have tamper proof fittings. None of the window restrictors complied with this guidance. This meant that there was a significant risk of them being ineffective in preventing a fall and potential injury.

A significant number of bedroom windows were sealed shut due to having been painted over. This meant some people were unable to open their windows. Windows in some communal areas were the same. This meant that parts of the home were not properly ventilated. We saw that some windows were also propped open with a cushion or piece of wood and that some windows contained glass panes that were cracked. Guidance issued by the Health and Safety Executive advises that where window openings are restricted people should have access to alternative cooling systems for example, fans or air conditioning.

We found one of the communal bathrooms to be unclean. The shower chair was dirty and the bathroom contained a commode which looked like it had encrusted faeces on it. One person's en-suite bathroom had a dirty raised toilet seat discarded on the floor and a communal bathroom on the ground floor contained a clinical waste bin that had not been securely fastened. This meant people's used continence pads were visible and the bathroom smelt.

We saw that the communal toilet on the ground floor adjacent to the lounge did not provide people with enough space to access the toilet safely with their mobility aid. People had to leave their mobility aid outside of the toilet in order to use it. This meant people were at risk of a fall. It also meant their ability to use the toilet independently was hindered.

Two people's en-suite baths contained excess stock of continence supplies, pressure cushions, and other personal care equipment. This meant people were unable to use or enjoy a bath in their own bathroom as the bath was inaccessible.

These incidences were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider failed to ensure the premises and its equipment was safe, suitable for purpose and met statutory requirements.

We looked at six staff files and saw that staff were recruited safely. Each staff member had an application form in place, previous employer references and a criminal conviction check done to ensure they were suitable to work with vulnerable people prior to employment. We found however that a staff member had been promoted to more senior role without any robust evidence of their suitability and competency to do so or a proper recruitment process. There was also no evidence that they had received an induction into this new job role.

Records relating to one staff member showed they were formally disciplined but there was no evidence that the alleged misconduct had been investigated appropriately or that the provider's disciplinary process had been followed. We asked the acting manager and consultant about this. They told us that they had dealt with it informally. This meant that they had not followed the correct procedures to investigate and respond to concerns about a staff member's fitness to work at the home or carry out their duties in order to mitigate risks to people's health, safety and welfare.

These examples demonstrate a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because the provider did not robust systems in place to ensure persons employed were suitable for their job role and fit to work at the home

Inadequate

Is the service effective?

Our findings

People we spoke with told us that staff had the skills and experience to look after them but some people had mixed feedback about the manner in which their support was provided. One person said "Yes, they're good girls, they know what's needed. Another said "They're good workers" whereas other people's comments included "I feel some people don't want me here, there's one staff member who has a terrible way about them". Another person told us that ability and attitude of staff was "Mixed, some good, some not so good". We discussed some of this feedback with the acting manager and consultant.

We looked at how staff were supported in their job role and found the arrangements in place to be inconsistent. Out of the six staff files we looked at, only three members of staff had documentation in place to show that they had supervision and this documentation was minimal. Three staff had been employed by the provider less than 12 months but none of their files contained any evidence that they had been supervised since they commenced working at the home. None of the staff files contained evidence that staff members received an appraisal of their skills and abilities to ensure they performed their job role to an acceptable standard.

The provider offered training in a variety of health and social care topics such as safeguarding, moving and handling, dementia, infection control, fire, food hygiene and first aid but we found a significant number of staff had not completed the required training in 2017 or 2016. For example, only 24 out of the 51 staff had completed safeguarding training; only 32 had completed safe moving and handling, only 14 had completed training in infection control and only seven staff had completed training in the mental capacity act. This indicated that staff were not sufficiently trained to do their job role effectively and meant that the provider could not be assured that staff were competent in the provision of safe and appropriate care.

These examples demonstrate a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to ensure staff received appropriate training, supervision and appraisal in their job role.

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. We found this legislation was not properly followed.

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 Mental Capacity Act 2005. The application procedures for this in care homes and hospitals are called the 'Deprivation of Liberty Safeguards' (DoLS). We checked that the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found this legislation was also not properly followed.

We viewed the care records of three people with dementia type conditions and/or complex needs.

Information in relation to their ability to make specific decisions was contradictory and confusing.

One person's admission information stated they had capacity to make their own decisions and a do not resuscitate decision (DNAR) made in June 2017 indicated the person had the capacity to make an end of life care decision. We saw however that a decision to install bed rails was made without involving the person or gaining their consent. The reason for this was cited as 'vascular dementia' which suggested the person's lacked capacity to make this decision. Despite this the MCA had not been followed. Bed rails are used to prevent people accidentally falling, slipping, sliding or rolling out of bed but they require formal consent for use, as they are considered a form or restraint. Where people's capacity to consent to bed rails is in question, the mental capacity act must be followed. In this person's case it had not. This meant there was a risk that this decision was unlawful.

Applications to deprive people who lived at the home of their liberty had been made by the provider. We found that the correct legal processes had not been followed to ensure these deprivations were legal. For example, one person had a deprivation of liberty application in their care file but there was no evidence their capacity to keep themselves safe outside of the home had been assessed in accordance with the MCA. There was also no evidence that they were unable to keep themselves safe outside of the home as their ability to do so, had not been risk assessed.

One person had two mental capacity assessments on file which were generic. This meant it was difficult to tell what decisions the person's capacity was being assessed for. Under the MCA, a capacity assessment must detail the specific decision the person's capacity is being assessed for at any given time. We saw that an application to deprive the person of their liberty had been submitted to the Local Authority. We were unable to match either of the two capacity assessments in the person's file with this application as they were dated after the DoLS application was submitted to the Local Authority. This meant there was no evidence that the person was unable to keep themselves safe outside of the home in order to justify the decision to deprive them of their liberty. We saw that this application was subsequently refused by the Local Authority.

This was a breach of Regulation 11 of the Health and Social Care Act. This was because the provider failed to have suitable arrangements in place to obtain and act in accordance with people's consent in relation to their care and treatment.

People had mixed opinions about the quality of the food provided by the home but everyone said they were given a choice of what to eat and drink. People's comments included "It's alright, if you don't like it, they give you something else"; "I like the scrambled egg but not the toast, it's very hard"; "The breakfasts are good. I have Rice Krispies, bacon toasted sandwich and a sausage on toast. Breakfast is my favourite; "I don't want to criticise the food but we get baked beans with everything" and "It's alright you get a choice, we get fresh veg".

People told us they got enough to eat and drink. One person said "So far the food is good, I get enough. If the food comes and you don't want it, they will make me something else instead".

We observed the serving of lunch and saw that people's meals were served promptly and pleasantly by staff. In the nursing unit however there was only one member of staff to serve and assist people with their meals. We saw one person pushing food onto their fork with their fingers. We asked the staff member serving people's meals if the people had plate guards to stop the food falling of their plates. They told us "Plate guards have never been plentiful, they're in short supply".

People's care plans contained some information about their nutritional needs but this information was limited. We saw that catering staff had information on people's special dietary requirements which meant that were able to ensure people received the diet they needed.

On our visit to the kitchen we checked the food stores and found that the amount of stock in the home's fridge and freezer facilities was limited. Access to the kitchen was unsecure and accessible from the communal corridor by unauthorised persons. When we visited the kitchen, no staff were present but a gas jet had been left on, on the hob and the frying pan in use looked to be encrusted around the edges with grease. We were concerned about the safety and security of the kitchen as we were able to access the kitchen without being noticed. We spoke with the acting manager and consultant about this.

Inadequate

Is the service caring?

Our findings

At our last visit to the home in November and December 2016, we identified serious concerns with the effectiveness of the service. People we spoke with and their relatives raised concerns about the attitude and standard of care they received from staff, the use of agency staff who were unable to speak fluent English and the quality of the bedding and towels in use. The rating for this domain at the last inspection was inadequate. During this visit we found that although some improvements had been made, these improvements were insufficient to change the provider's rating.

We checked all 14 personal care charts for people who lived in the nursing unit. Their charts showed that some people received a bath or shower or a bed bath on average at least once a month but some people's charts showed no evidence that they had access to a bath, shower or bed bath for over four months. We checked eight people's care charts from the residential unit and saw that in the month of June 2017, only one of the eight people had received a shower, the rest had only been given a full body wash. This did not demonstrate that people were receiving the care they needed to maintain their dignity or preserve their skin integrity.

On the second day of our visit, the hairdresser who visited the home was doing people's hair. We found that the way in which this was organised was undignified. Staff asked people if they wanted their hair done and if they did, they were taken down to the hairdressing salon. We saw that people were taken down to the hairdresser in no particular order or with no regard to how long they would have to wait to be seen and we saw several people lined up in their wheelchairs in a queue outside of the hairdressing salon. When one person's hair was finished we observed the hairdresser bring the person out of the salon and leave them in the communal corridor in their wheelchair for staff to collect. This was not very dignified and gave the impression that people were on a 'conveyor' belt.

We saw that two people's en-suite bathrooms did not have any blinds or window coverings in place to protect their dignity when they used the bathroom. One of the locks on the communal toilets was also broken which meant people could not lock the door when using the toilet. This did not show that people's right to privacy was promoted.

During our visit, we heard an alarm on one of the fire exits ringing for some time. This alarm sounded to alert staff to the fact that the fire door leading into the grounds of the home had been opened. None of the staff at the home however went to check why the door alarm was ringing or checked if anyone who lived at the home had left the home unnoticed via this exit. We asked the deputy manager to check this immediately. It was later confirmed that the maintenance officer had opened the door. Nevertheless, the lack of action by staff did not show that they cared about people's safety.

People's residential care files were stored in a cupboard in the communal corridor and people's nursing care files were stored in cupboard behind the nursing station. Both of these areas were accessible to unauthorised persons and during our visit both cupboards were left unlocked. This meant that people's personal information was not secure. This did not show that the provider cared that people had the right to

confidentiality.

When we looked at the care files of people who lived at the home we found that they lacked sufficient information about people's preferences for how they would like to be cared for at the end of their life. Some people had do not resuscitate decisions in place but people's wishes in relation to their end of life care had not always been documented for staff to follow. When we checked staff training records we saw that staff had not received training on how to support people who were at the end of their life. This meant that people could not be assured they would receive end of life care in line with their wishes.

These examples demonstrate a breach of 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people using the service were not always treated with dignity and respect at all times.

The provider's reliance on agency staff had reduced and the staff we spoke with, all spoke fluent English. People's feedback indicated this had a positive impact on their relationships with staff. People's comments included "Excellent, very caring and we have a laugh"; "They make me feel at home" ; "The staff are very good, we have a good laugh" and They're more than staff, they're friends". Two people gave mixed reviews. One person said "Some are quite caring, some could be better and say I'm too busy to do that" and the other person told us "Mixed, some good, some not so good".

We observed positive interactions between staff and people who lived at the home whilst support was provided but found that staff had little time to chat to people or interact with them in any meaningful way. There was little interaction between staff and the people who lived at the home unless care was being carried out. The staff and the people we spoke with confirmed this.

Staff we spoke with demonstrated a caring attitude towards people's care and spoke about the people they cared for with genuine affection. During our conversations we found that staff where able to tell us about the people they cared for and the support they needed. All of the staff spoken with felt that having more staff on duty would improve their ability to provide care. One staff member told us it would "Mean we could give more time to people". Another said "The majority of us really care we just need a bit more time".

Requires Improvement

Is the service responsive?

Our findings

At our last visit to the home, we had concerns with regards to how the service responded to people's needs. This was because insufficient staff were on duty and people were often cared for by agency staff. We also identified serious concerns with the standard of the nursing care people received. During this inspection, we found that some improvements had been made but further improvements were required.

We viewed the care files of 11 people. Seven people required support with their nursing needs and four people required support with their personal care only. We found that some of the nursing care plans we looked at had been improved. For example, one person in receipt of nursing care had a catheter in place. We saw that the person's care plan gave details of the correct procedures to follow with regards to changing the person's catheter and ensuring it was regularly cleaned to prevent it becoming blocked. One person had pressure sores and we saw that these wounds had been assessed and documented appropriately.

However although some of the care plans we looked at had been improved upon since our last visit, others still required updating to accurately reflect the person's needs and contain sufficient detail about the care people required. All of the care plans we looked at contained limited information about the person's preferences and wishes in relation to their care and only one of the people we spoke with told us they been involved in the developing their own care plan. This did not demonstrate that people were given the opportunity to openly discuss and agree on the care they wanted to receive.

We saw that people's needs were reviewed regularly but information about the person's progress was very limited. There was no evidence that the person or their representative had been involved in any care reviews to ensure the care provided continued to meet their needs and wishes.

These incidences were a breach of Regulation 9 of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to ensure that people were involved in the assessment and planning of their care so that person centred support could be provided.

The provider had previously employed an activities co-ordinator to provide activities for people who lived at the home but since our last inspection, the activities co-ordinator had left the employment of the provider and had not been replaced. During this visit, people told us there were no activities and nothing to do at the home. When we asked people how they spent their time, people's comments included "Just sitting about, we used to have activities but now we haven't"; "I just sit in the dining room at the table, unfortunately the girl doing the activities has left"; "I watch telly and listen to the radio"; I sit here and watch television" and "We don't get the chance to go out, I'd like to go out".

A relative we spoke with said "They (name of person) just sits there, there are only activities now and again".

We asked staff about whether people had activities to participate in if they wished. They confirmed that there were no activities currently provided.

These incidences were a breach of Regulation 9 of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to ensure that people's social and recreational needs were met.

People told us that staff sent for the doctor promptly if they became unwell and during our visit we found that improvements with regards to how the service responded to people's ill-health and nursing needs had been achieved.

On reviewing people's care records we saw that a range of healthcare and social professionals were involved in people's care. We saw that GP's, district nurses, tissue viability services, speech and language therapy, dieticians, optician and chiropody services supported people's well-being as and when needed. For instance, one person's weight loss had been responded to appropriately with the involvement of other health and social care professionals. We saw that one person had a health condition that sometimes meant they suffered with recurrent chest infections. We saw that the person's GP was called promptly when they became unwell.

During our visit we spoke with a healthcare professional. They told us that they had a good relationship with staff at the home and that "They will ring if there are any problems" but that communication had sometimes depended on what staff were on duty.

The provider had a complaints policy in place but it did not contain the name or contact details for the manager, the provider, the Local Authority of the Local Government Ombudsman to whom people could complain to. This meant there was a risk that people would not know who to direct their complaint to.

We saw that where people or relatives had raised a complaint, these had been responded to adequately.

Inadequate

Is the service well-led?

Our findings

At our last visit in November and December 2016, the manager in post was not registered with CQC. This manager has since left the provider's employment. At this visit, an acting manager was in post but they had only been working at the home for a short time at the time of our visit. The acting manager was supported in post by a consultant who had been assisting the provider to make improvements to the service since the last visit. We found that the improvements made to the service since our last inspection were inadequate and did not demonstrate that the provider had taken our concerns seriously.

At this inspection we found similar concerns with regards to quality and safety of people's care. Concerns were identified once again in respect of risk assessment and management; person centred support; the implementation of the mental capacity act, privacy and dignity and the identification and prevention of abuse. This did not demonstrate that the provider had taken immediate and effective action to ensure risks posed to people's health, welfare and safety were acted upon. This clearly showed that the management and leadership of the service remained inadequate.

We saw that the previous manager had undertaken a variety of audits to monitor the quality and safety of the service but we found the majority of these were ineffective. For example, the audit of people's care plans had not identified that people's information was often inconsistent, confusing and out of date. There was no evidence that any proper health and safety audits and environmental audits had been undertaken since January 2016 and during our visit we identified that parts of the home were unsafe and unclean. Medication audits were undertaken but were ineffective in ensuring improvements to the way medicines were managed had been made.

There were no adequate systems in place to ensure staffing levels were sufficient and during our visit we observed the number of staff on duty was not always sufficient to meet people's needs. There were no robust systems in place to ensure that staff were trained, supported and competent to care for people effectively.

There were no arrangements in place to ensure people's social and activity needs were met or to ensure they had a good quality of life. There were no adequate mechanisms in place for people and their relatives to feedback their views of the service or to suggest improvements to their care.

One of the relatives told us that they had been called to a meeting in June 2017 and were informed that provider had decided to close the nursing unit in the home. They told us the provider had given them a few months to find an alternative nursing home for their relative to move to.

This lack of adequate service management and leadership was reiterated in some of the comments people made to us during the inspection. Some of the people we spoke with told us they did not know who managed the home. One person said "The manager left and I don't know who the manager is now". A relative we spoke with told us "We do a lot of (name of the person) care. I am not sure just how good her care would be if we did not come so often. The management are worse than useless. We have no contact

with them now". The healthcare professional we spoke with said "It's not clear who is managing the home".

These examples clearly demonstrate that the service was not well led. The provider had not done all that was reasonably practicable to improve the service so that risks to people's health, safety and welfare were minimised. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our visit, the acting manager and the consultant were co-operative and tried their best to assist us. Staff told us that the acting manager was approachable and that they felt they listened to. The staff we spoke with were pleasant, friendly and worked hard.

At the end of our visit, we discussed our concerns with the acting manager and the consultant. They acknowledged that significant improvements were still required to the management of the service and the delivery of people's care. They accepted the concerns we raised and said that they were already aware of the majority of issues brought to their attention.