Londesborough Court Limited

Londesborough Court Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 13, 14 and 29 December 2016 and was unannounced. We carried out the third day of inspection on 29 December 2016 to follow up urgent actions we required the registered provider to make following our inspection on 13 and 14 December 2016.

Our last inspection to the service took place on 21 March 2015 and the registered provider was compliant with the regulations in force at that time.

Londesborough Court Care Home provides care and support for up to 30 older people and people living with dementia; the service does not provide nursing care. It is located in the small market town of Market Weighton in East Yorkshire. Accommodation is provided on the ground and first floors; there are 17 single rooms and five shared rooms. Fifteen rooms have their own en-suite toilet and wash hand basin facility and there is a passenger lift to the upper floor. The service has an enclosed courtyard and garden. At the time of this inspection there were 26 people using the service.

The registered provider is required to have a registered manager and the manager in post was registered with the Care Quality Commission (CQC) in July 2016. 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.

During this inspection we found evidence to confirm the registered provider was in breach of regulations pertaining to treating people with dignity and respect. We found staff actions did not always ensure people received respect and were treated in a dignified way.

We found evidence to confirm the registered provider was in breach of regulations pertaining to safeguarding people from abuse and improper treatment. We also found evidence that staff were verbally abusing people using the service. We reported one piece of evidence we found during the inspection to the local authority safeguarding team to investigate due to the nature and seriousness of the incident.

During this inspection we found evidence to confirm the registered provider was in breach of regulations pertaining to staffing. There were insufficient numbers of staff on duty to meet people's needs and staff were not provided with the skills and knowledge they needed to carry out their roles effectively.

We found evidence to confirm the registered provider was in breach of regulations pertaining to meeting people's nutrition and hydration needs. People were not supported to have adequate nutrition and hydration to maintain good health and reduce the risks of malnutrition.

During this inspection we found evidence to confirm the registered provider was in breach of regulations pertaining to providing safe care and treatment. People who used the service did not receive safe care and

treatment and avoidable harm or the risk of harm was not prevented.

We found evidence to confirm the registered provider was in breach of regulations pertaining to providing person-centred care. Care plans were not appropriate and did not meet the needs of the people who used the service or contain accurate information about them.

During this inspection we found evidence to confirm the registered provider was in breach of regulations pertaining to good governance. Effective systems were not in place to monitor assess and mitigate risks to people who used the service or ensure compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Through the inspection process we found numerous failings within the service including evidence of breaches of regulation in respect of the 2014 Regulations. The breach of regulations included; safe care and treatment, dignity and respect, person-centred care, safeguarding service users from abuse, meeting nutrition and hydration needs, staffing and good governance.

We wrote to the registered provider on 16 December 2016 requiring urgent action from them with regard to breaches of Regulations 12 and 18: Safe care and treatment and staffing. The registered provider responded within the given timescales with an action plan which was followed up by the Commission on 29 December 2016. We also received written confirmation from the registered provider on 19 December 2016 of their intention to close the service by the end of January 2017.

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

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

People were not protected from abuse and avoidable harm and health and safety risks to people were not recognised or managed appropriately putting people at risk of harm.

People's care plans did not contain appropriate information to enable staff to support people to manage their behaviours that challenged the service and others.

People were not cared for in a clean and hygienic environment. Infection control practices were not followed and this increased the risk of infection or cross contamination.

People did receive their medicines as prescribed. Suitable arrangements were in place for the safe storage, administration and recording of medicines.

Is the service effective?

Inadequate

The service was not effective.

Staff employed by the service did not have the skills, knowledge and abilities to deliver care in line with people's needs.

People were not supported to eat and drink sufficiently to maintain their health and wellbeing.

People were supported by a range of healthcare professionals but the service failed to implement their advice and guidance appropriately.

Is the service caring?

Inadequate

The service was not caring.

People were not treated with dignity and respect by staff.

Action was not always taken to meet people's needs in a caring way and the care provided was not always in accordance with people's wishes.

We witnessed some positive interactions between staff and the people they supported.

Is the service responsive?

Inadequate

The service was not responsive.

People did not receive personalised care that met their individual needs.

People's needs were not planned for and the service was not responsive to their changing needs.

The registered provider had a complaints policy in place at the time of the inspection, but not all complaints were recorded.

Is the service well-led?

Inadequate

The service was not well-led.

The quality assurance systems in place were inadequate and not operated effectively; it was not used to drive improvement within the service.

People did not receive high quality care in line with best practice.

Londesborough Court Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered provider 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 13, 14 and 29 December 2016 and was unannounced. The inspection team consisted of one adult social care inspector and an expert-by-experience on day one and one adult social care inspector and an inspection manager on day two. 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-by-experience who assisted with this inspection had knowledge and experience relating to older people and people living with dementia. We carried out a further day of inspection on 29 December 2016 to follow up urgent actions we required the registered provider to make following our inspection on 13 and 14 December 2016.

We looked at information we held about the service, which included notifications sent to us since the last inspection. Notifications are when registered providers send us information about certain changes, events or incidents that occur within the service. The registered provider submitted a provider information return (PIR) in December 2015; we had not asked for a more recent PIR prior to this inspection. The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

As part of the inspection process we contacted the local authority safeguarding adults and commissioning teams to enquire about any recent involvement they had with the service. East Riding of Yorkshire council had undertaken three recent visits to the service as part of their quality assurance reviews and in response to concerns and safeguarding issues raised with them. We were notified that some recommendations from the visit were made and that the service was working with the teams to resolve the issues. Due to health and

safety concerns about the service we asked a health and safety enforcement officer to visit the service during our inspection.

At this inspection we spoke with the registered manager, the director of care and six members of staff including care staff and ancillary workers. We spoke in private with four relatives/visitors, eight people who used the service and five health care professionals who were visiting the service. We observed the interaction between people, relatives and staff in the communal areas and during mealtimes.

We walked around the service with the registered manager and spent time looking at records. These included the care records and associated documents for three people who used the service and the recruitment, induction, training and supervision records for three members of staff. We also looked at other records relating to the management of the service including health and safety files, maintenance certificates, staff rotas, staff training plans, infection control records, accident and incident documents and quality assurance files.

Inadequate

Is the service safe?

Our findings

The service was not safe. During our inspection on 13 and 14 December 2016 we found significant breaches of regulations with regard to safeguarding people who used the service from abuse, cleanliness and infection control, staffing and health and safety risks.

The registered provider had policies and procedures in place to guide staff in safeguarding adults. The registered manager described the local authority safeguarding procedures and our checks of the safeguarding file and the information we already held on the service showed that there had been ten alerts made by the registered manager in the last twelve months. Discussion with the five health care professionals visiting the service indicated they had significant concerns about the health and wellbeing of people using the service. They told us that the district nursing team had submitted 17 safeguarding alerts in the last two months alone. We verified with the Humber safeguarding team and the East Riding of Yorkshire safeguarding team that at least 11 alerts had been made since September 2016, some of which were still being investigated. We saw that the service had worked with the safeguarding teams to resolve a number of the concerns and, prior to our inspection arrangements had already been made to meet and discuss with the district nursing team on a regular basis about any new concerns as they arose. We saw the minutes of the initial meeting between the service and the district nursing team.

Checks of the staff training plan indicated that all staff had completed safeguarding adults training in the last year. However, during our interviews a member of staff raised an issue with us that should have been reported immediately to the registered manager; the alleged incident had taken place the week before our inspection. This showed that one member of staff was not putting into practice the training they had received.

We looked at the safeguarding file kept within the service and saw that there was another allegation of a member of staff shouting at a person using the service in November 2016. The registered manager had investigated the incident by speaking with the member of staff. The staff member stated they were shouting as the person was deaf. However, we found that the staff member was new in post, lacked previous care experience and had not completed dementia care training. None of this was considered by the registered manager when completing their investigation and there was no evidence that the member of staff received additional support through supervision or any additional training. Following the inspection we were told by the registered provider that the staff member was given supervision and received training in Dementia challenging behaviour, prior to returning to duty. An employment review and back to work interview followed once the staff member returned to duty. We were sent additional paperwork to confirm this.

These findings evidence a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had a number of serious concerns about the health and safety of people using the service. We asked the health and safety enforcement officer from the local authority to attend and they did so on the afternoon of 13 December 2016. We found that there was a high risk of scalds in the service from hot water in the

bedrooms and bathrooms. We saw that the registered manager had carried out monthly checks of the hot water temperatures in the service. The records showed that from May 2016 through to December 2016 the registered manager had recorded temperatures in excess of 50 degrees Celsius for between 12 and 16 of the 42 areas tested each month. There was no evidence to indicate any remedial action had been taken to reduce these temperatures. We tested some of the temperatures during our inspection with the equipment in the service; we also found temperatures above 50 degrees Celsius, with water so hot we could not put our hands in it. This indicated that where risks were identified there was a failure to take action to mitigate any such risks and this put people and staff at risk of harm.

In contrast to this we found some bedrooms had hot water temperatures as low as 15 degrees Celsius, which meant people using these rooms only had access to tepid water. For example, one bedroom water temperature had been consistently recorded as between 15 degrees Celsius and 27 degrees Celsius over the past eight months by the registered manager. Staff confirmed to us that there was often a problem with only cold water being available in some bedrooms.

We found there were on-going infection control risks to people using the service that had not been identified by the quality assurance systems within the service. We observed that one bathroom had a dirty bath and bath seat and that staff had stored new bed rail bumper covers in the bath. This meant this new equipment was contaminated and would require cleaning before use. The registered manager confirmed with us that the bathroom was not currently in use, however it should be cleaned to prevent further cross contamination.

We were aware of malodours on entering the service on both days of our inspection and also in the upstairs corridor. Staff could give us no explanation for the odours. The malodour in the treatment room was explained as from the yellow bag used for disposal of wound dressings. These malodours need addressing as they made the environment unpleasant for people using the service and visitors.

We found evidence of one bed with stained but clean linen and one bed where a dirty sheet had not been removed. We drew the registered manager's attention to the fact that the sheets were stained and dirty, but had not been changed by the staff when they made up the beds. The two inspectors also found evidence of food debris in both beds. The en-suite in one bedroom was dirty and the toilet seat was contaminated with faeces. We saw from the rotas that there was one domestic on duty five days a week, but no cover for the other two days. Discussion with the registered manager indicated there was a domestic vacancy for 16 hours that was currently being recruited to. We were given additional information following the inspection that the gaps in the domestic rota were covered by other members of the ancillary team.

One health care professional told us, "[Name of resident] was laid in faeces and it took staff 20 minutes to change them. They used flannels and not cleaning wipes to clean them, which was unhygienic." We asked the staff about this and they confirmed that they had different coloured flannels to clean people with; they said, "If families have brought in wipes then we used these." This meant there was a high risk of infection from the use of flannels for cleaning of bodily waste and fluids.

We looked at risk assessments and premises safety. We had a number of concerns about fire safety and health and safety, which were raised with the director of care and the registered manager both during the inspection and at our feedback at the end of the inspection.

We looked at documents relating to the servicing of equipment used in the service. These records showed us that service contract agreements were in place which meant equipment was regularly checked and serviced at appropriate intervals. The equipment serviced included the fire alarm, the nurse call bell, moving and

handling equipment including hoists, portable electrical items, water systems and gas systems. We saw there was a fixed wiring certificate for the electrics in the service. We noted that minor recommendations were recorded on the certificates for the lift and the hoists. Discussion with the director of care indicated that these repairs had been completed by the maintenance person, but we found no documented evidence of this and we were not provided with evidence of the maintenance person's competence to carry out these repairs.

There had been a fire safety audit of the premises by the fire and rescue service in March 2016. The health and safety enforcement officer looked at the report, which itemised some minor deficiencies within the service. One of the recommendations related to the fire resisting door to the kitchen needing attention as the gap between the door edge and frame exceeded 3-4 mm. The health and safety officer told us that no remedial action had been taken in response to this repair highlighted within the report.

We found that each person using the service had a personal evacuation plan (PEEP) in place. These included individual details for the people who would require assistance leaving the premises in the event of an emergency. However, some of these dated back to 2012 and there was no evidence they had been updated, which meant people's needs for evacuation may not have been correct. After our inspection the registered provider told us their review sheet used to evidence that the PEEPs had been reviewed had gone missing.

The registered manager spoke with us about the registered provider's business continuity plan for emergency situations and major incidents such as flooding, fire or outbreak of an infectious disease. The plan identifies the arrangements made to access other health or social care services or support in a time of crisis, which would ensure people were kept safe, warm and have their care, treatment and support needs met. This document was sent to us on the day following the inspection.

We saw that the last recorded fire drill was in March 2016, when the record stated that one member of staff did not respond to the alarm, as they were on a break and using their mobile phone. This could have had serious risks to people's health and safety if it had been a real emergency. The staff training plan indicated that all staff had completed on-line fire safety training, but the staff who spoke with us said they were unsure of the evacuation procedures as they had never attended a fire drill. There was no evidence in the fire records to indicate that the registered provider took any action to ensure fire drills were brought up to date and completed regularly following this incident.

We wrote to the registered provider separately from this report and required that they take urgent action to address our concerns within a given timescale.

These findings evidence a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection we looked at the levels of staff on duty within the service. On our arrival at the service we found that the registered manager was working as a member of care staff due to staff absence and vacancies, however the rota had not been updated to reflect this. The registered manager told us that the gaps in the staffing levels were usually covered by the existing staff, the director of care and the registered manager. At the time of our inspection there were vacancies for one full time night senior care staff (44 hours) and one part-time night care staff (33 hours). There were two full time day shift vacancies for a senior care staff and a junior care staff (88 hours) and one part time domestic staff (16 hours). We were told these vacancies were being recruited to, but filling the posts was slow going. We saw that one member of care staff had worked between 55 and 69 hours for the last three weeks; this level of work could not be sustained indefinitely.

We were given a copy of the staff rota by the registered manager for the four weeks leading up to our inspection on 13 December 2016. This showed that there should be four care staff on duty each day between the hours of 07:00 and 19:00. At night there should be three members of care staff on duty. However, the day staff told us that they often worked one member of staff down on a shift which made it extremely hard work for those on duty. The rotas were not clear as to when the senior management worked as care staff, which meant it was difficult to audit what staff were on duty and when. We saw from the rotas that there was one domestic on duty five days a week. Discussion with the registered manager indicated there was a domestic vacancy for 16 hours that was currently being recruited to. Another ancillary member of staff covered these hours up to 11 December 2016.

At the time of our inspection there were 26 people using the service. We asked people if they felt there was enough staff on duty. One person told us, "I am dependent on the care staff for all my needs as I cannot mobilise very well. When I press my call bell I have to wait until the staff come to answer it and sometimes this can be over half an hour." Another person said, "If I use the call bell at night it is answered quickly, but not during the day." We were told by a male service user that, "The person who gives me a shave is off sick, so I have been a week without a shave so far." People said, "Quite often there are only two staff on duty. Those who work here are kind and polite, but really busy."

Staff who spoke with us said they struggled to meet the needs of people using the service when they were down on staff numbers. They said that records and documentation did not always get completed, or as one member of staff told us, "We just fill it in when we can."

We wrote to the registered provider separately from this report and required that they take urgent action to address our concerns within a given timescale.

Our findings evidence a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the recruitment files of three members of staff. Application forms were completed, references obtained and checks made with the disclosure and barring service (DBS). DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands. DBS checks help employers make safer decisions and prevent unsuitable people from working with vulnerable client groups. Interviews were carried out and staff were provided with job descriptions and terms and conditions of employment. This ensured they were aware of what was expected of them.

Staff told us that only senior staff administered medicines to people using the service. However, checks of the training plan showed that not all staff were recorded on this including the senior in charge during the second day of our inspection. This meant we could not be certain that these staff had completed their training in safe handling of medicines. This has been discussed further in the effective section of this report.

We looked at how medicines were managed within the service and checked the person's medication administration records (MARs). We saw that medicines were stored safely, obtained in a timely way so that the person did not run out of them, administered on time, recorded correctly and disposed of appropriately. Controlled drugs (CDs) were regularly assessed and stocks recorded accurately. CDs are medicines that are required to be handled in a particularly safe way according to the Misuse of Drugs Act 1971 and the Misuse of Drugs Regulations 2001.

We wrote to the registered provider following the first two days of inspection requiring them to take urgent action to address breaches of Regulations 12 and 18: Safe care and treatment and Staffing. Their response

was followed up by a further inspection day on 29 December 2016.

During the inspection on 29 December 2016 we found the registered provider had taken action to reduce water temperatures so they did not exceed 45 degrees Celsius. The maintenance person had carried out repeat checks of all water outlets every two days as some outlets continued to show fluctuations of temperature. The maintenance person told us they would adjust the water valves to regulate the temperatures and ensure they remained safe for people to use.

A fire drill had been carried out on 23 December 2016 and a start had been made on updating people's PEEPs as five had been reviewed. We were given a copy of the fire evacuation plan that the director of care said had been updated in April 2016, but this was not dated or signed to evidence this. The registered provider confirmed in writing that repairs to equipment were only carried out by appropriate contractors.

We saw that action had been taken to improve infection control practices within the service. For example, we saw that beds were made up with clean linen and staff had been reminded about this in the supervision sessions on 23 December 2016. We observed that the bathroom had been cleaned. We also saw that the registered provider had used agency staff to cover staff vacancies over Christmas and they were planned to cover vacancies across the New Year Period.

Inadequate

Is the service effective?

Our findings

The service was not effective. During the inspection we found significant breaches of regulations with regard to staff training, supporting workers and meeting nutritional needs. Discussion with healthcare professionals at the service showed there were a number of concerns about staff not following professional advice and guidance which left people at risk of harm.

We asked six staff about the induction process for new staff within the service. We were told by the staff that new staff received a basic one day induction to the service, in that they were taken around the building and shown where paperwork was kept and where the fire exits were. We saw basic induction records to confirm this in the employment files for three care staff. The director of care told us that they were using the 'Care Certificate' and showed us one staff file where it was in use. The 'Care Certificate' induction was introduced by Skills for Care in April 2015. Skills for Care is a nationally recognised training resource.

We asked the staff what support or supervision new employees received. We were told that new employees could shadow a more experienced worker for a couple of shifts and that they would receive a supervision session at the end of their three month probationary period. Supervisions are meetings that take place between a member of staff and a more senior member of staff to give them the opportunity to talk about their training needs, any concerns they have about the people they are supporting and how they are carrying out their role. This meant that new employees did not receive appropriate supervision during their first three months of employment. This put people who used the service at risk of harm from staff who lacked the skills and knowledge to meet their needs.

We asked the registered manager how often staff received supervision. We were told that these meetings took place every two months. However, the registered manager also said that due to the amount of time they were spending covering staff hours in the service they were struggling to achieve the timescales for supervisions. We looked at the staff supervision records for three staff members. In one staff file we found one supervision record dated 21 September 2016, and another staff file held one dated 3 February 2016. In the third staff file we saw one supervision record for 20 September 2016. The registered manager told us that it was possible more supervision sessions had been carried out and recorded, but that they had not been filed. The evidence we found indicated that staff were not being appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to people who used the service safely and to an appropriate standard.

We saw that the staff team had access to a range of on-line or computer based training deemed by the registered provider as mandatory or essential. This included subjects such as moving and handling, infection control, fire awareness, health and safety, food hygiene, safeguarding adults, first aid awareness and control of substances hazardous to health (COSHH). The staff team confirmed that they had some face-to-face training for use of the hoist and other equipment in the service. However, we found during our inspection there were serious concerns with regard to staff practice around safeguarding adults, infection prevention and control, fire safety and health and safety. These made us question the effectiveness of the staff training programme provided by the service.

We noted that more specific training had been completed by some senior staff, but not by everyone. This included (on-line) dementia awareness training that six out of the 16 staff had completed. Staff told us this course only covered basic issues about dementia and no-one in the service had training to manage the anxious and distressed behaviours that people who used the service could display at times. At the time of our inspection 19 out of the 27 people using the service were living with dementia.

We found that people who used the service were not protected from the risk of harm or actual harm, because staff did not receive appropriate induction, supervision and training.

We wrote to the registered provider separately from this report and required that they take urgent action to address our concerns within a given timescale.

These findings evidence a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visiting health care professionals spoke to us about their concerns regarding care in the service. We had received information prior to the inspection about issues raised with the safeguarding authority, by the community team, which included the physiotherapist, occupational therapist and district nurses. The Macmillan nurse also raised concerns with us on the day of the inspection. These health care professionals felt that staff did not always take on their advice and guidance regarding people's care. The examples we were given included people not being washed, pressure care not being given as instructed, mouth care not being given and people not having access to the nurse call system when in their rooms. Our observation of one person using the service showed that they required full support from the staff, but their oral care needs were not met and they looked uncared for. Discussion with the registered manager indicated that mouth care packs were available in the service, but no one had thought to do this for this individual.

In one care file we looked at, records evidenced the person had behaviours that were difficult to manage, but there was no detailed plan for staff to follow on the management of this behaviour. The risk assessment stated "Verbally and physically aggressive towards others. Their mood can change in seconds with no warnings." There was no detailed behaviour management plan showing what the triggers may be for this person's anxious behaviour and the care plan to guide staff on how they should intervene and diffuse the situation was basic. We asked the registered manager if there were any formal assessments from health and social care professionals, but were told that these were not available.

The records in this person's file showed that there had been 12 incidents recorded about their behaviour in October 2016 and staff had made a referral to the mental health community team who came out to visit on 26 October 2016. However, the record of this visit was brief and it indicated that none of the issues from the behaviour management chart had been discussed. Therefore, the mental health professionals were not made aware of the difficulties that the home were having in meeting the needs of the person and keeping them and the other people in home safe. When we asked the registered manager about this we were told, "Well it is okay now [Name] has calmed down." This did not demonstrate that the management team was thinking proactively about how to meet and reduce the incidents of anxious or distressed behaviour of people using the service.

We found that the registered provider did not actively work with others, both internally and externally, to make sure that care and treatment remained safe for people using the service.

We wrote to the registered provider separately from this report and required that they take urgent action to address our concerns within a given timescale.

These findings evidence a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Information in the care files indicated that people had access to GPs, dieticians and the Speech and Language Therapists when there were any concerns about their nutrition or hydration needs. Staff also completed food and fluid charts to indicate how much people were consuming each day. However, feedback from the health care professionals and the staff included comments that these records were not always filled in regularly or accurately.

Our observations of this over the two days of inspection also raised some concerns about the documentation. For example, one person who remained in bed was being checked by the staff on an hourly basis. We found on the occasions that we visited them during the inspection that they were able to ask for a drink of fluid and were eager to do this as they repeatedly said, "I am really dry." However, on checking the fluid charts we found that on the first day of our inspection staff had recorded on three occasions between 3pm and 6pm the person refused any fluids. When they did record an intake it was to say the person only drank 10 to 50mls for most of the time. When we offered them a drink they consumed much more than this. On 11 December 2016 there were no documented records between 1pm and 8pm and on the 12 December 2016 no records between 3pm and 8pm. Daily fluid intake between 8 December and 13 December 2016 was recorded as between 100mls and a maximum of 490mls. However, on one occasion staff had written the person consumed 300mls in one sitting. This indicated that staff were not providing this person with sufficient fluids even when they were wishing to drink.

Our observation of the dining experience of people found that this was a disorganised, slow service and did not meet the needs of people. We saw that people living with dementia were left sat at dining tables for over half an hour without receiving a meal. This meant they became distressed and got up to walk out of the dining room, only to be returned by staff. People who ate their meals in their rooms complained to us that their food was often cold and unappetising by the time they received it. The kitchen assistant was knowledgeable about diets and ensuring people ate sufficient calories to maintain their weight. However, one person using the service was on a special diet for a medical condition and they told us, "I have no dietary choice each day. I have to eat the option that is offered."

These findings evidence of breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

People can only be deprived of their liberty 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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Records showed that where needed people who used the service had a DoLS in place around restricting their freedom of movement.

We wrote to the registered provider following the first two days of inspection requiring them to take urgent action to address breaches of Regulations 12 and 18: Safe care and treatment and Staffing. Their response

was followed up by a further inspection day on 29 December 2016.

During our inspection on 29 December 2016, the director of care showed us evidence that three members of staff had completed the Care Certificate and said that a new member of staff without previous care experience would be enrolled on this induction programme in the New Year. We saw that three care staff had received a supervision session on 23 December 2016 and the director of care told us they planned to complete further sessions in January 2017.

We were shown three behaviour management plans that had been written since days one and two of the inspection. These were more detailed with regard to the triggers for people's behaviours and the action staff should take to reduce the person's anxieties and defuse any incidents.

Inadequate

Is the service caring?

Our findings

The service was not caring. Staff had made efforts to offer people choice, but some of their basic care needs were not being met. People were not consistently treated the way they wanted to be treated.

We observed some good interactions between staff and people living in the service, staff were polite and friendly to people and relatives and visitors were made welcome to the service. However, people and relatives told us about instances when they did not receive the care they needed in a timely way. For example, one person said, "There are some good staff here and some bad ones. They can be efficient, but their favourite saying is 'we are short staffed'. I need everything doing for me, but at times I feel I am being a nuisance. You may be shocked but I go three or four days without staff washing my hands and face and I worry that I might smell. I regularly go four or five weeks without a bath. I would like a shower twice a week and a daily wash." Another person also told us, "I get a strip wash each day but it must be a month since I was offered a bath."

We asked to see the bathing records for the service and these were supplied to us by the registered manager. We saw that the records showed people were often going two to three weeks without a bath or shower. One member of staff told us, "Sometimes there is only cold water in the bathrooms and bedrooms. One room is really hot and another really cold. When I am here I try to do three or four showers and I record these on the bath charts."

When we asked about the staff people said, "Most of them are lovely. The chap who gives out lunches is very nice" and "The staff are okay." Two people using the service told us that they were challenged by a member of staff about their choice to use their commodes during the day. As they explained to us, the medical condition of one of them meant they were unable to walk to the toilet along the corridor without staff support. They also said, "When you do ask for staff support, they say they will be back in a minute and then forget all about you." One relative told us, "The staff are very slow on the uptake such as when my relative wishes to use the bathroom. They do not understand their needs and requirements." When we asked staff about this we were told, "Sometimes staff numbers are really hard – we need more staff. We don't have much time for residents. Sometimes, we make mistakes as we are tired."

One visitor commented that they often visited as they were not confident that staff were considering their relative's comfort needs and repeatedly left them in their wheelchair instead of putting them into a comfortable armchair. Other visitors said, "There are language difficulties with some of the staff" and "When staff lift my relative on and off the commode they are rough with them." One family told us, "We had an issue about the staff turnover and the new staff not knowing about our relative. They had a problem and needed help to sit up in bed and ended up waiting for 30 minutes."

Discussion with the staff indicated that they had some issues with moving and handling equipment. We were told, "There is only one battery working so we share it between the hoists", "We did not have the right equipment for one person so the senior care staff told us just to lift them – we couldn't as they were too heavy. They did eventually come and give us a hand." We were told that staff were physically lifting one

person in the service and the staff demonstrated to us how this was done using an under arm lift and holding the back of the trousers. We asked staff if they had raised these concerns with the management team and they said, "No, a formal complaint would go against you."

We asked people about their experiences within the service. We were told by one person that they were very concerned about being overheard talking to us and another person said "How do we know there won't be reprisals?" This showed that people who used the service were nervous about expressing their views to others. One of the inspection team was challenged by the director of care, following time spent talking to people using the service and relatives. They said they were concerned at our conversations as staff had reported to them about overhearing specific comments from people about their care. We responded that we were not sure what conversations staff had heard but their allegations of what were said were untrue. The director of care then said they could provide written evidence to verify what had been said. This demonstrated to us that the attitude of the staff and management team was not enabling and confirmed why people and relatives were wary about expressing their views and opinions of the service.

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

Our observations of the service showed that staff did not always treat people with dignity and respect and their privacy was not always maintained.

We saw that there were five shared bedrooms within the service, but only one was used by a married couple. Comments made to us indicated the decision to share a room was not always made by the individuals concerned. One person said, "I was sharing a room when I did not wish to. It has taken some doing to get moved to a single room and I still do not have my own bathroom." Discussion with the registered manager indicated that the decision to have a shared room was taken by the resident and their relatives. One of the shared rooms viewed had a broken privacy curtain, which meant that the individual's privacy and dignity may not be maintained. . This meant people's wishes about privacy and dignity were not always considered.

We have commented in the safe section of this report about staff making up beds with stained linen. This was not respectful or dignified for people using the service.

We were questioned by the management team about our private conversations with people and relatives during our inspection. This indicated that conversations held between people and ourselves were listened in to and not kept confidential. This disrespected people's rights to privacy and confidentiality.

One person on end of life care did not have end of life care plans. We observed that for one person their care file had not been updated to reflect their end of life care needs and basic care such as mouth care was not being provided. Their care plan said to bed bath once a week, even though they were incontinent and had a pressure sore. Records show that they were bed bathed on 15 November 2016, 28 November 2016 and 12 December 2016. This meant staff were not respecting people's rights to basic care to meet their needs and their dignity was compromised.

This evidences a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

The service was not responsive. We found that people's care plans and care records did not always represent their needs or ensure staff had the information to help meet people's needs.

We looked at three health care files for people using the service. People's needs had been assessed prior to them coming into the service, but some care plans were out of date and needed reviewing and rewriting. For example one person's personal care and physical care plan was written in April 2016 and said their dependency needs were low. A needs assessment was completed for this person in October 2016 and they were assessed as medium and high needs, but the care plan was not updated to show the additional support they now required. Another person's care plan said for staff to weigh the person weekly due to their assessed risk of malnutrition. However, their weight chart showed that this had last been carried out in October 2016. This meant people were put at risk of harm as their assessed needs were not being met.

We found that records of pressure care and food and fluid intake were not accurate and staff told us, "We are 'turning' two residents, they are lucky if we go in twice a day. The senior care staff tell us to fill in the charts regardless." We have already discussed our concerns about food and fluid charts in the effective area of this report. We looked at the bathing charts and found that every entry for the past two months all had exactly the same temperature recording of 37 degrees Celsius. Given that different people may wish to have different bath temperatures this raised questions regarding the accuracy of recordings. One member of staff told us, "I don't use the bath thermometer; we know the water temperature should be 37 degrees Celsius so I test it with my hand before they go in." This indicated the temperature records kept by the staff did not accurately reflect the temperatures of the bath water and put people at risk of harm.

This evidences a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People using the service did not always receive person-centred care that was appropriate and met their needs and personal preferences.

There was a lack of understanding about the basic care needs for people on end of life care. For example, our observations of one person showed their mouth was dry and their oral hygiene poor, but there were no obvious signs of mouth care taking place. Their care file showed that there was no plan for mouth care. Discussion with the manager indicated that mouth care swabs were available in the service, but even on day two of our inspection this had not been set up.

One health care professional said they had visited one person using the service the day of our inspection. They found that the person's nails were cutting into their hand (which was contracted). Staff had been asked on previous occasions to ensure that the person's nails were cut regularly, but this had not happened. We checked on this person the following day and found that the nails on their right hand were dirty and in their left hand, which was contracted, staff had put a piece of gauze in between their palm and nails to prevent further damage. Discussion with the registered manager indicated that plans were in place to hold regular

meetings with visiting health care professionals to make sure their advice was documented and actioned by the staff.

One family was very dissatisfied with the service. They told us that staff were not managing their relative's dementia care needs and we found there was a lack of behaviour management plans in people's care files. The recording on the incident forms (ABC charts) indicated that there was a lack of understanding by the staff about the impact of dementia on people's behaviours. Following one incident the staff had recorded that they told the person they would call the police if they did not 'settle' down. We spoke with the director of care about these concerns and they said they were "Appalled" by this.

This evidences a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people about their involvement in their care plans and some people said they were aware that they had a care file and that staff wrote in it, but they were not involved in the monthly review process. One person said, "I don't know about that. My family look after this for me." When we asked people if the staff spoke with and involved them in decisions about their care and treatment, one person told us, "Not really." However, they went on to say they were able to make choices about when they got up and went to bed and what they did on a daily basis. Two people told us that they had choice and control over their daily routines, but they told us, "We tend to stay in our room most of the time." Families confirmed to us that they did take part in care reviews and one family told us, "We have just finished our relative's review today."

The registered provider employed an activities co-ordinator. We were given the daily notes that they wrote about one-to-one activities they carried out in the service. We saw that activities included chats, reading the paper to people, completing shopping lists, playing snakes and ladders, baking sessions, doing crosswords and nail care. Each session lasted 10 to 15 minutes with each person. One visitor told us, "When my relative first came into the service they were just sat in their chair. Now they are involved in baking sessions which they really enjoy."

We observed that people had access to magazines and newspapers in the lounge area and there was a range of board games available such as snakes and ladders. We also saw that there were various reading books for those who wished to partake of them. We noted that people were offered tea, coffee and biscuits mid-morning and afternoon. A radio was playing background music in the lounge. One visitor said, "My relative takes part in finger painting, sing-a-longs, bingo and baking." One person told us, "We have singing once a week and I like to do bingo" and another person said, "I like to listen to my radio." Three people said, "We do not partake in the social sessions offered by the service. This is by our choice."

Families told us they were able to visit their relatives whenever they wished. One person told us, "My family is usually made welcome and they visit me once or twice a week." One visitor said, "We are a big family and someone is here most days to see our relative."

We asked people and families about the complaints process used within the service. One visitor told us, "We had an issue about staff turnover and the new staff not knowing our relative." One person said, "I have been here two years now and I have never had cause to complain."

We spoke with the registered manager as the last complaint recorded in their file was dated April 2016. However, a number of families had spoken about more recent complaints being made. The registered manager said these complaints were informal and had been dealt with but not recorded on the complaints log. We discussed with the registered manager the need to record all complaints both formal and informal

so there was a clear audit trail of all actions being taken by the service in response to any failure identified by the complaint or investigation.

Inadequate

Is the service well-led?

Our findings

When we asked people if they thought the service was well led we received mixed responses, one visitor said, "You can approach the staff and the registered manager at any time and get a positive response to your questions." One person said, "The registered manager is okay, you can talk with them at any time." However, another visitor told us, "My whole family is concerned as we have seen how the home has been in the past and what it is now. We are worried the registered manager will leave and the home will be even worse. I have tried to speak to the owners without success; there has been a total breakdown of communication with the owner."

The quality assurance systems utilised by the service were inadequate. Through the inspection process we found numerous failings within the service including evidence of breaches of regulation in respect of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breach of regulations included; safe care and treatment, dignity and respect, person-centred care, safeguarding service users from abuse, meeting nutrition and hydration needs, staffing and good governance.

The governance systems used to ensure people's needs were accurately recorded and planned for were ineffective. They failed to ensure people's care plans reflected the most recent assessments of their needs, which increased the risk to the people who used the service. For example, one person with a known pressure sore had a care plan that instructed staff to 'turn regularly', but failed to say how often. However, there had been a recent assessment on 22 November 2016 from the Macmillan Nurse which advised staff to reduce pressure care (turns) during the night to allow the person to rest and complete two hourly turns during the day. This new information was not used to update the person's care plan to ensure staff were aware of their current level of support needs. We looked at records of pressure relief given to people in the service. For one person these indicated they were 'turned' two hourly, but discussion with the staff indicated these records were filled in whether care had taken place or not. We were told, "They are lucky if we go in twice a day. Senior carer staff tell us to fill them in regardless."

Systems utilised by the service to assess, monitor and mitigate the risks relating to the health and safety of service users and others were inadequate. For example, we found that the registered manager was completing water temperature checks on a monthly basis from May 2016 up until 5 December 2016. Each month the registered manager had recorded water temperatures in excess of 50 degrees Celsius. No action had been taken about this. We tested the water in a selection of bathrooms and bedrooms. We too found that water temperatures were in excess of 50 degrees Celsius, leaving people in those bedrooms at risk of harm from scalding.

People and staff also expressed concerns that some bedrooms had lukewarm water at times. We saw that records showed at least one room had water temperatures at 15 to 22 degrees Celsius from May to August 2016 then from September to December 2016 the temperature was recorded as 50 degrees plus. Our concerns were discussed with the registered manager and director of care at the end of our inspection. Such was our concern that we wrote to the registered provider immediately following the inspection requesting urgent action be taken to reduce the risk of scalding to people using and working in the service.

The process used by the service to seek and act on feedback from relevant persons and other persons on the services provided, were ineffective. People, relatives and health care professionals had concerns that people were not getting bathed regularly, basic care such as pressure relief, food and fluid intake and mouth care was not being given. These concerns had been reported back to the service, but they had failed to act on these. For example, people told us they only had a bath or shower once a month and the records maintained by the service confirmed this. From our observations we saw that people on end of life care did not receive mouth care even when their mouth was seen to be in need of oral care.

We were given no evidence to indicate that robust quality monitoring was taking place. We found the audits that took place were not being used by the registered manager to improve the quality of the service. For example, we saw that the registered manager was completing a basic analysis of the accidents and falls within the service. The information was being put into a monthly format to show how many falls or incidents were occurring and staff had completed the accident forms appropriately. However, it was unclear what was being looked at each month as there was no documentation about where, when, why or how often people were falling or if any action had been taken in response to this. This meant the registered manager could not say that any health and safety risks were identified and actioned as needed.

Audits we looked at did not highlight any of the concerns we found around inaccurate and inadequate record keeping. For example, we saw evidence that care plans, risk assessments, end of life plans and food/fluid records were not always accurate or up to date. This meant that staff did not have access to complete and contemporaneous records in respect of each person using the service, which potentially put people at risk of harm.

There was a registered manager in post who was supported by the director of care and senior care staff (team leaders). The registered manager was inexperienced and in their probationary period; their supervision and development was being overseen by the director of care. Staff told us that the registered manager was supportive and that they could go to them if they had any issues.

We asked people if they had attended any relative/resident meetings. One visitor told us, "I have never been to one, but I believe they have them." One person told us, "Yes I attend these." Staff told us that there were staff meetings, but not regularly. We were told, "There was one during the summer time." We were shown meeting minutes that indicated that no-one attended the resident/relative meeting held on 9 November 2016 and we were not provided with minutes of any staff meetings even those these were requested mid-afternoon on day two of our inspection.

We saw that the service had sent out satisfaction questionnaires to people in April 2016 about the food provided in the service. Twenty surveys went out and seven were returned. There were mixed comments given as feedback. Some people felt the quality and quantity of food and drinks was satisfactory, but others felt menus were not informative and the dining room facilities and ambience was unsatisfactory. A further survey was sent out in May 2016 inviting people and relatives to comment on the service provided. Ten responses were received again with various comments including concerns that the turnover of staff was high and the atmosphere within the service was getting worse. The progress notes in the survey analysis indicated that the director of the company spoke with people saying that as people and staff got to know each other and staff became more competent in their roles then the atmosphere would improve. There was no evidence when or how this has been conveyed to individuals.

These findings evidenced a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We wrote to the registered provider on 16 December 2016 requiring them to take urgent action to reduce the risk of harm to people using the service with regard to breaches of Regulations 12 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We received their written response within the given timescale and carried out a further inspection visit on 29 December 2016. We found that action had been taken in response to our concerns to immediately reduce the risk of scalding to people working in and using the service. Work was on-going to continue to monitor and reduce risks in the service.

On the 19 December 2016 the registered provider wrote to us and gave notice of their intention to close the service by the end of January 2017.