Flightcare Limited

Swansea Terrace

Inspection report

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16 October 2015

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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 08, 09, 12 and 16 October 2015 and was unannounced.

Swansea Terrace is registered to provide 24 hour nursing and personal care for up to 44 people and is located close to Preston city centre. There are two large communal rooms, communal bathrooms and en-suite washing facilities. at the time of our inspection there were 40 people who were using the service.

The service is required to have a registered manager in post. 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.

People were not protected against the risks of avoidable harm and abuse. Staff had not been discharging their responsibilities with regards to safeguarding people who lived at the home. The service had not ensured that assessments of risk and associated risk management plans were up to date and accurately reflected people's circumstances. This left people vulnerable to significant risks to their health and well-being.

Staffing levels at the home were not adequate to provide people with safe and effective care. People were not cared for by staff who had the knowledge, skills, experience and support to carry out their roles. Staff did not receive appropriate supervision, appraisal or training to enable them to fulfil their responsibilities.

The service was not operating effective systems for the proper and safe management of medicines. Some people had gone without important medicines for significant periods of time due to a breakdown in the service's systems and poor communication between staff.

The home was not operating effective systems to assess risks around cleanliness and infection control. Bathrooms and shower rooms were found to be cluttered and had inadequate floor coverings which prevented thorough cleaning and disinfection.

The service did not always seek consent in line with legislation. People or, where appropriate, their representatives were not routinely involved in the assessment of people's needs or the care planning process. People's written plans of care did not reflect accurately their needs and preferences.

Staff had a caring approach to the people they cared for, but due to low numbers of staff and a task-focussed culture at the home, positive, caring relationships between staff and people who lived at the home had not been developed.

People were not supported to eat and drink enough to meet their needs. We found some people had gone without food and fluid for significant periods of time. People were put at serious risk because professional

guidance had not been followed by the service.

People were able to access healthcare services. However, the home did not always make referrals to professionals or follow them up in a timely manner. When guidance or advice was received from other healthcare professionals, it was not always incorporated into people's plans of care.

People's privacy was maintained during personal care interventions. However, we found people's dignity was not always promoted and maintained.

The home employed an activities coordinator. However, much of their time was spent delivering care to people, which meant the level of activities provided by the home was inadequate. People were not enabled to participate in activities which were meaningful to them. Some people were left in their bedrooms without any stimulation or interaction for long periods of time.

The service did not hold regular meetings for residents, relatives or staff, for them to discuss ideas, make suggestions or raise concerns about the service with management. The service did not operate any formal surveys or other mechanism for gaining feedback about the quality of the service.

Systems and process that were in place to assess, monitor and improve the quality of the service were not being operated effectively. We found significant gaps in audits and safety checks. Where audits and checks had identified issues, the service was unable to demonstrate any action taken to address them.

The service did not have clear lines of responsibility and accountability at all levels. Leadership at each level of the service was poor and staff were not fully aware of what was expected of them. The registered manager had identified concerns with regard to the culture of the staff team, but had not taken any action to address the issues.

The service had not notified CQC of significant events which had taken place at the home since our last inspection.

We found multiple breaches of regulations and took urgent enforcement action against the service. You can see what action we took at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

registration.

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

Where we found risks to people's safety and well-being, we made referrals to the Local Safeguarding Authority in order to help protect them from risks of harm.

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 against the risks of avoidable harm and abuse. We found examples of people not receiving adequate care and treatment to keep them safe.

Emergency evacuation plans were not up to date, which placed people at risk in the event that they needed to be evacuated.

People's care records did not contain accurate and up to date information, for staff to rely upon to deliver care that was safe and appropriate to the person.

Staffing levels were not sufficient to enable staff to provide safe care and treatment.

The service did not operate effectively adequate systems for the proper and safe management of medicines.

The service did not properly assess the risk of, prevent, detect and control the spread of infections.

Is the service effective?

Inadequate

The service was not effective.

People were not supported by staff who had the appropriate level of knowledge and skills to carry out their role. Staff did not receive adequate support, supervision, appraisal and training as was necessary.

The service did not always seek consent in line with legislation and national guidance. Staff did not fully understand their responsibilities with regard to the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards.

People were not supported to eat and drink enough to maintain a balanced diet. Monitoring of people's food and fluid intake where they were at risk was incomplete and inaccurate. Professional guidance with regard to nutrition and hydration had not been incorporated into people's plans of care.

Is the service caring?

Inadequate

The service was not caring.

Staffing levels and the task-oriented culture at the home meant it was very difficult to foster positive, caring relationships between people who lived at the home and staff.

A high staff turnover and lack of adequate information about people had led to inconsistencies in the care delivered to people.

People's privacy was respected during personal care interventions, however staff were observed to discuss sensitive, personal information about people within earshot of other service users.

We found examples of people who has suffered distress and undignified treatment.

People and, where appropriate, their relatives were not routinely involved in making decisions about the care ad treatment provided.

Is the service responsive?

Inadequate

The service was not responsive.

People and, where appropriate, their relatives had not been involved in planning care and, as such, people's individual preferences had not been explored or taken into account when care was planned.

Assessments of people's needs and associated care plans had not been reviewed regularly and did not reflect people's current circumstances.

Activities provided within the home were minimal, as was access to the community. Staffing level had meant the activities coordinator had been used to deliver care tasks rather than activities. Due to this, people did not participate in activities that were meaningful to them.

People were not actively encouraged or supported to share their views and experiences. There were no formal methods in place to gain feedback from people or their relatives. Similarly, there were no formal processes in place with regard to learning from complaints.

Is the service well-led?

Inadequate

The service was not well-led.

There were not clear lines of accountability and responsibility at each level of the organisation. Staff were unsure about what was expected of them and leadership from senior members of staff was seen to be poor.

The service did not hold regular meetings or carry out surveys to gain feedback from people, relatives or staff.

The service did not operate effective systems to assess, monitor and improve the quality of the service provided.

The service had not submitted statutory notifications, as required, in light of adverse incidents.

Swansea Terrace

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 08, 09, 12 and 16 October 2015 and was unannounced.

The inspection team included two adult social care inspectors, a pharmacist inspector and a specialist professional advisor in the care of elderly people, as well as support from an adult social care inspection manager.

Prior to the inspection we looked at all the information we held about this service. We reviewed notifications about significant events that we had received from the provider and their Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also requested feedback from local commissioners, local safeguarding teams and community professionals.

At the time of our inspection there were 40 people who lived at Swansea Terrace. During the inspection we spoke with ten people who used the service, eight people's relatives, seven staff and all levels of management at the home, including the registered manager, care quality manager and the nominated individual of the provider company. During the final two days of the inspection, we also spoke with the manager from another service in the provider group who had been drafted in to support the registered manager.

We looked in detail at care records and associated documentation for 18 people who used the service and medicines records for 17 people who used the service. We also looked at a range of records in relation to the management of the service and spent time observing the environment and interactions between staff and people who lived at the home.

Inadequate

Is the service safe?

Our findings

None of the people we spoke with or their relatives raised any concerns about people's safety. However, concerns were raised about staffing levels, medicines management and cleanliness.

People told us; "I feel quite safe...The staff are good, there just aren't enough of them"; "I feel safe enough"; "Yes, I feel safe...It sometimes takes a long time for them to help me when I need them" and; "I feel safe. I just think they could do with more staff. They are always rushing about and things get missed".

Relatives we spoke with told us; "Staffing levels seem low, they always seem pushed"; "The staff are brilliant, there just don't seem to be enough of them"; "We've been back from a trip out and have been waiting over an hour for them to help [relative] to the toilet" and; "In general, we work between us and do what we can...Can trust them to do everything...Staff are too busy to spend time on a one to one basis with [relative]".

People were not protected against the risks of avoidable harm and abuse. We found examples of people not receiving adequate care and treatment to keep them safe. We found examples of people who spent the majority of their time alone in their bedrooms without any stimulation. This could lead to people becoming isolated and suffering emotional harm as a result.

We found one person alone in their bedroom in the late afternoon. The temperature in their room was hot and their bedding and clothes were wet, due to the amount of sweat they were expelling. This person was observed to be distressed and uncomfortable and expressed to the inspection team "please get me up". On reviewing this person's care records, we found no records of personal care or positional change since early the same morning. The inspection team immediately summoned assistance from staff. When we asked staff whether the person had received any personal care and why they had not been assisted out of bed, they were unable to provide an answer.

This person's food and fluid intake record showed that their intake was very low, but staff had not taken any action to assist them to eat or drink the amount they required. This showed the person had not received adequate care to keep them safe.

We interviewed the registered manager under caution, with regards to a separate incident when a person had not received any diet and fluids for a period of over 24 hours, despite involvement from the inspection team. The manager was unable to provide any reasonable excuse as to why the person had not been assisted with diet and fluid intake, following our prompting. The registered manager and registered nurses on duty failed to protect this person from avoidable harm.

Staff had not been discharging their responsibilities with regards to safeguarding people who lived at the home. The above examples demonstrate how concerns were not acted upon appropriately. We found that safeguarding concerns, following incidents had not been reported to the local safeguarding authority or the CQC, as required.

We were unable to establish from staff training records whether all staff had completed training on safeguarding. Staff told us they would feel confident to raise concerns but did not refer to an established policy and procedure with regards to safeguarding.

The above matters constituted a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people had not been protected from abuse and improper treatment. Systems and processes established to prevent abuse of service users were not being operated effectively.

We looked in detail at people's care records and associated documentation to see how well the service assessed and managed risks to people. We found risk assessments, including those around falls, moving and handling, nutrition and pressure care, had not been reviewed and updated regularly. This meant they did not reflect people's current circumstances.

In addition, we found that risk assessments were not always completed accurately. This left people vulnerable because levels of risk were not always highlighted properly. This meant management plans to mitigate risks to people could not be properly implemented.

People were not involved in making decisions based around risks to them as an individual. For example, we found one person who was living with enduring mental health illness had not been assessed against the risk of suicide. This was despite management at the home being aware of historical ideation and suicide attempts. This person had attempted suicide whilst living at the service. The management at the home were unable to give any reasonable excuse as to why no assessment or risk management had been undertaken.

We looked at personal emergency evacuation plans (PEEPs) for people who used the service. We found a folder in the manager's office labelled PEEPs contained outdated plans and plans for people who no longer resided at the home. In addition, plans for other people who had moved into the home since the PEEPs were last updated were absent.

We discussed this with the registered manager who admitted they hadn't reviewed PEEPs since taking up their post. The care quality manager assured us that PEEPs were in place for everyone who lived at the home and there would be a copy in their individual care records. They were unable to provide these documents and we were unable to locate them during the course of the inspection. This left people exposed to significant risks in the event of an emergency where they needed to be evacuated.

On touring the home, we found many fire doors were held open with wooden wedges. This would prevent them closing automatically in the case of a fire, leaving people at risk due to fire being able to spread more freely. We raised this with the registered manager on the first day of our inspection and were given assurances that they would remedy the situation. However, we found fire doors were still being wedged open on each day of our inspection.

We raised the above concerns with the Local Safeguarding Authority and commissioners in order to take a joined up approach with regard to addressing issues around people's safety.

The matters above amount to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because care and treatment was not provided in a safe way for people who used the service. Assessments of the risks to people's health and safety had not been completed accurately or were out of date. The service had not done all that was reasonable practicable to mitigate such risks.

The incompleteness and inaccuracy of people's care documentation was in breach of Regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which requires registered persons to maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and decisions taken in relation to the care and treatment provided.

We looked at how the service was staffed, to assess whether there were sufficient numbers of suitable staff to keep people safe and meet their needs. People we spoke with, their relatives and staff all raised concerns about staffing levels. Through our observations, we could see that staff were very stretched. This led to a task oriented culture at the service, with the focus of staff being on completing tasks, rather than delivering care that was person centred.

For example, we saw and were told that people often had to wait around 25 minutes for assistance with personal care. One person we spoke with told us it could be up to 90 minutes. We also saw and were told that the activities coordinator was unable to carry out their role because they were drafted in to perform caring tasks and to support people at mealtimes.

The service had experienced a high turnover of staff during the months prior to our inspection and were actively recruiting registered nurses and care staff. At the time of our inspection, the home relied heavily on agency nurses to cover both day and night shifts. This gave rise to concerns around continuity of care, especially when considered in conjunction with the unavailability of accurate and up to date information about people's needs as mentioned earlier in this section.

During the course of the inspection, we found inconsistencies in staff practices. For example, with regards to preparing drinks for people who required a modified diet due to swallowing difficulties. When asked, some staff knew that people needed thickened fluids, other staff were not sure.

In addition, we witnessed a new member of staff, on their first shift, was asked to assist a very vulnerable person with their meal at lunchtime. The new staff member did not know the person or their needs but had been instructed by a senior member of staff to assist the person. The inspection team had to intervene as the new member of staff did not know the person needed thickened fluids and if they had continued, could have put the person at risk of choking or aspiration.

We discussed staffing with the registered manager who confirmed that they did not use a formal tool to assess staffing levels, in line with the level of dependency of the people who lived at the home. As a result, the staffing levels that were in place at the time of our inspection did not ensure the needs of people were met consistently.

The matters above constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because sufficient numbers of suitably qualified, competent, skilled and experienced staff were not deployed at all times.

We checked a sample of the medicines and records for 17 people. We spoke with two nursing staff, two care workers and three residents about how medicines were managed in the home. We also observed medicines being prepared and administered to people.

Medicines were organised separately for nursing and residential residents. Systems for ordering, recording and administering medicines were in place but we found current national guidance regarding safe handling of medicines in care homes was not reflected in the medicines policies. We found a number of examples of

medicines being unsafely handled that placed people at risk of harm.

Ordering of medicines was not well managed; we saw a number of people go without prescribed medicines because stock was not available.

For example, one person missed a medicine used for anxiety and sleeping for seven consecutive days and told us they had not been sleeping well for the last few days. Another person missed a medicine to help control their incontinence for ten consecutive days and they told us they were going to the toilet more often than normal. Omissions in prescribed medicines placed people's well-being at significant risk.

We identified these issues during the first two days of our inspection, but by the end of our inspection, little progress in improving the way medicines were managed had been made.

We found a number of people were not given their medicines because they were asleep or refused them. We found examples where staff had not managed this properly. For example, when people were asleep during a medicines round staff recorded 'sleeping' on their records but did not return to administer the medicines later when the person had woken up. This meant people were often missing medicines unnecessarily.

Records were not always completed and managed safely. We saw a number of gaps on the records so we could not be sure if medicines had been given to people. When we checked stock levels against the records we found a number did not add up correctly showing medicines had been signed for by staff but not administered.

One person's record was signed for a medicine being given the previous ten days but no stock was in the home. Medicines such as pain killers that were prescribed 'when required' had some care planning information to support their safe administration but we found this was not regularly reviewed and as a result some of the information was not current and inaccurate.

Medicines including controlled drugs and medicines that required refrigeration were stored in trolleys and in a main store room. The controlled drugs cupboard was not compliant with the law because it was not properly fixed to the wall. In the medicines fridge we found a stool sample kept next to medicines which is unhygienic and an infection risk. Medicines awaiting disposal were not stored according to national guidance so there was a risk of misuse. We also noted excessive amounts of medicines were disposed of at the end of the month which was unnecessary and wasteful.

We saw medicines audits had not been completed regularly and had not identified any concerns that we had identified. National guidance expects an annual review of staff knowledge, skills and competencies relating to managing and administering medicines but we saw no evidence of how this was implemented.

We ensured safeguarding referrals were made to the Local Safeguarding Authority for people who had missed their medicines.

The above failings constituted a breach of Regulation 12 (2) (g), the proper and safe management of medicines; of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection, we observed the cleanliness of the premises including people's bedrooms, communal areas and bathrooms. We also observed staff practices in relation to infection prevention and control. We were unable to ascertain from training records whether staff had all received training in this area, because the training matrix was not up to date.

Staff displayed some good practice with regard to infection control. They used appropriate personal protective equipment, such as disposable gloves and aprons when delivering personal care. These were disposed of appropriately. However, when we observed the environment, we found issues which raised concerns. For example, we found sluice rooms were routinely left unlocked, which meant they could be accessed by people who used the service.

We raised this with the registered manager during the first day of our inspection, but despite this, we found sluice rooms were still being left unlocked throughout the course of the inspection. We also observed a build up of dust in several areas of the home which had not been addressed. We raised this with the registered manager and saw improvements on the third and fourth days of our inspection.

We looked at communal areas, which we found to be clean and tidy, and people's bedrooms which were also clean. However, we did find waste bins in some people's rooms were not emptied frequently enough and people we spoke with raised this as an issue. People told us that if there are no domestic staff on duty, for example if they call in sick, people's rooms do not get cleaned and bins do not get emptied.

We also saw a variety of equipment, such as hoists, slings and wheelchairs were being stored in bathrooms around the home. This made it very difficult to thoroughly clean and disinfect these areas. In addition, we found the flooring in bathrooms and toilets required maintenance. The floor covering was not sealed properly to the wall and floor which prevented thorough cleaning and disinfection and provided a space which could harbour bacteria.

The registered manager was unable to provide us with an up to date audit with regards to infection prevention and control.

The above matters amounted to a breach of Regulation 12 (2) (h), assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

People did not receive effective care, which was based on best practice, from staff who had the knowledge and skills to carry out their roles and responsibilities.

We found multiple examples of where the standard of care had fallen significantly short of meeting people's needs. Best practice national guidelines, such as NICE guidance, were not being followed.

The registered manager was unable to evidence staff training levels and competence. Competence checks had not been carried out with regards to medicines administration. Allegations had been made by people who used the service about staff using inappropriate moving and handling techniques. Training had been scheduled to address this.

We witnessed one member of staff on their very first shift was asked to give food and fluids to a person who required a modified diet. The inspection team had to intervene to prevent this person from being put at risk of harm as the member of staff did not know the person's needs and had not been given a modified diet or thickened fluids to give to them. Communication between staff with regard to people's needs and any changes in circumstances was poor.

We looked at the level of supervision and appraisal staff received. We found that staff had not received regular supervision or appraisal. The registered manager confirmed that this was an area in which they needed to improve.

Regular and effective supervision and appraisal provides an opportunity to discuss performance against expected standards, career aspirations, development opportunities for staff and any concerns. Staff told us the only supervision sessions they had received since the registered manager had taken up their post were group supervision sessions following adverse incidents.

This above failings amounted to a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because persons employed by the service provider in the provision of the regulated activities had not received appropriate support, training, professional development and appraisal as was necessary to enable them to carry out the duties they were employed to perform.

We looked at how the service sought consent to care and treatment from people who used the service. We found valid consent was not always sought in line with legislation and national guidance.

In all the care records we looked at, there was very little evidence that care and treatment had been discussed with people and their consent gained. People we spoke with told us they had not been involved in choosing how the service provided care and treatment for them. We found examples of people's family members having signed to give consent on behalf of their loved ones. This was without confirmation of a lasting power of attorney for care and welfare and without assessments of people's capacity to make

decisions having been undertaken.

We also saw examples in people's daily records where the service had acted on the request of family members without giving the person concerned choice. For example, one entry read "[Person] brought down to the lounge on daughter's request".

The matters above were in breach of Regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because care and treatment was provided to people without valid consent having been gained from the relevant person.

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

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the home was not working within the principals of the MCA. Capacity assessments were not carried out as required, within the MCA code of practice. Where capacity assessments had been carried out and recorded, they were not decision specific. We found no record of best interests discussions in people's records. We looked at DoLS records for three people who lived at the home. We found that conditions stipulated within the authorisations were not always adhered to and care and treatment was not provided in line with the authorisation.

This was in breach of Regulation 11 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered person had not acted in accordance with the MCA.

Staff knowledge around MCA and DoLS was poor. Nurses and care staff were unaware of exactly who was subject to a DoLS authorisation and only two members of staff we spoke with were able to describe the principals of the MCA and DoLS.

We spoke with one person who told us that staff prevented them from leaving the home. We looked at their care records and could not find any record of a capacity assessment or application under DoLS. The registered manager and care quality manager both confirmed that the person was free to leave when they liked. When we queried this with a staff member, they told us that because the person had experienced dizzy spells, they were prevented from leaving the home on their own. This demonstrated how a person's liberty was being unlawfully restricted. We made a referral to the Local Safeguarding Authority regarding this person's treatment.

This was in breach of Regulation 13 (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because a person had been deprived of their liberty without lawful authority.

We looked at how people were supported to eat and drink enough to maintain good health. We observed mealtime experiences, spoke with people who used the service, relatives, staff and reviewed people's records to make a judgement. We found people were not supported to maintain a balanced diet and to

receive a sufficient amount of fluids. We raised serious concerns in this regard.

We found supplementary records, relating to food and drink intake, were not completed accurately. Staff were completing the records when food and drink were provided to people, rather than recording people's actual intake.

We raised concerns about a number of people because it was noted that they had taken very small amounts of food and fluids over the course of our inspection and no action had been taken by the service to support these people to eat or drink. For example, one person had not eaten or drunk anything for over 24 hours. We raised this with the registered manager on the first day of our inspection and were given assurances that action would be taken. The following morning, we found the person still had not been supported to eat or drink anything. When interviewed under caution, the registered manager was unable to give any reasonable excuse regarding this.

Relatives we spoke with raised concerns that they felt their loved ones would not receive adequate diet and fluid intake if they did not spend time at the home to support them. One relative gave us an example of their loved one being prescribed fortified drinks to help maintain their health. The relative explained that their loved one should have received two of these drinks per day, but they noticed that when they did not visit, the person did not receive these drinks. The relative explained this was down to staff not having enough time.

We also found examples of people's nutritional needs not having been assessed properly and a lack of response to significant losses in people's weight. Referrals to healthcare professionals, such as dieticians and Speech and Language Therapists (SALT) were not always made as required. In some cases referrals were made, but were not followed up by the home in a timely manner. Where guidance had been received from, for example SALT, the guidance was not always followed to ensure people's needs were met. This put people at risk of receiving inadequate nutrition and hydration and also put them at risk of harm due to choking and swallowing difficulties when guidance was not followed.

People we spoke with told us and the registered manager confirmed that people had not been involved in choosing what food they would like to see on the menu. People and their relatives expressed dissatisfaction at the quality and variety of food on offer at the home.

During our inspection we observed that there were no supplements or fortified foods provided to people who required them on the morning or afternoon snack trolley. Thickener for fluids was also absent from the trolley until the fourth day of our inspection. However, when the thickener was provided, it was one tin that was prescribed to one person that was on the trolley. We raised this with the registered manager and alerted them to the fact that this was not in line with national guidance.

There were a number of people who lived at the home who could not take food and fluids by mouth, but instead received them via enteral feeding, which is a tube direct to the stomach. We were able to see from records that there were many gaps in records of enteral feeding. This meant we were unable to ascertain whether these people received adequate food and fluids. These people were unable to articulate their views.

This was in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the nutritional and hydration needs of all people who used the service were not being met.

People told us and records we looked at confirmed that people were able to access other healthcare services, such as GPs, dentists, chiropodists, dieticians and SALT. However, we found communication between the home and these services was not always of a good standard.

In addition, where professional guidance was provided to the home to assist them in supporting people, this guidance was not always followed which meant people may receive care or treatment which is inappropriate for them. This was in breach of Regulation 12 (2) (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because where responsibility for the care and treatment of people who used the service was shared with other persons, the service had not worked with them to ensure that timely care planning took place to ensure the health, safety and welfare of people who used the service.

Inadequate

Is the service caring?

Our findings

We asked people who lived at the home and their relatives whether staff were caring. Comments we received included; "The staff are great. They work with us to try and make sure Mum gets everything she needs, but they are too busy to spend time with her one-to-one" And; "The staff are brilliant. There just don't seem to be enough of them". We were told that staff were kind and caring, however, the organisation of staff and staffing levels did not lend itself to the fostering of positive, caring relationships between people who lived at the home and staff.

Staff we spoke with, who were employed by the service had a good general knowledge of the people they supported, including their needs and preferences. However, this was not the case with the agency staff we spoke with. Agency staff did not know important details about people's needs and preferences. Staff relied upon written plans of care for key information about the people they were caring for. We found care plans were not reviewed adequately, which meant information available to staff was often out of date and not reflective of people's current circumstances. This left people at risk of receiving care and treatment that was not in line with their needs or preferences.

During our inspection, we observed staff showed concern for people's well-being, however they were not always quick to respond to people's needs. The inspection team had to prompt staff on several occasions to assist people, for example, with changing catheter bags and preventing people from falling out of chairs. Additionally, we observed people, on each day of our inspection, who were distressed and uncomfortable. We found several people were left in their bedrooms for the majority of the day, some without any stimulation and very little interaction with staff. This showed the service had failed to make sure people were well cared for and not distressed nor uncomfortable.

Staff we spoke with told us that the care of people who lived at the home was their top priority, However, they expressed frustration at low staffing levels, high turnover of staff and consistency of the staff team which they felt sometimes prevented them from delivering care in the way they would like to.

The above matters constituted a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because the care and treatment of people who used the service was not appropriate, was not meeting people's needs and did not reflect their preferences.

People we spoke with and their relatives told us that they were not regularly involved in planning their, or their loved one's, care. We looked at people's care documentation which confirmed what we had been told. There was very little evidence to show that people or those close to them, where appropriate, had any input into the care planning process. This meant people's views and opinions were not taken into account when their needs were assessed, or when their care was planned and delivered. This was in breach of Regulation 9 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home did not have any links with advocacy services, nor was there any information available at the home for people who used the service on how to access such services. An advocate is an independent

person who can represent someone's wishes and act in their best interests, without judging or giving their own opinion. Advocates can be very helpful to people who do not have anyone else to represent them, for example, someone who does not have regular visits from family members or friends. The lack of information and signposting to such services within the home meant that people who may have benefitted from the use of an advocate were unable to access them.

We looked at how the service respected people's privacy and promoted their dignity. We observed staff discussed, within earshot of other service users and their relatives, sensitive personal information about other people who lived at the home. This showed the service did not respect confidentiality.

We found people's privacy was maintained during personal care interventions, for example, by closing doors and curtains. However, we found people were not always treated with dignity. For example, people and their relatives gave us examples of cases where people had been waiting for assistance to go to the toilet and had soiled themselves because staff had not assisted them in a timely fashion. Additionally, personal care, such as washing, shaving and mouth care was observed to be lacking during our inspection.

This was in Breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because people were not treated with dignity and respect.

People and their relatives told us there were no restrictions on visiting times.

Inadequate

Is the service responsive?

Our findings

People did not receive personalised care that was responsive to their needs. People or those close to them, where appropriate, were not routinely involved in making decisions about their care. People told us and we saw care documentation which showed people's individual preferences were not explored and taken into account in the way care was delivered to them. There was no evidence available to show that people were involved in regularly reviews of their care and treatment.

We looked at assessments of people's needs and care planning documentation. We found that assessments had not been reviewed regularly, in line with changes in people's needs and in some cases were completed inaccurately. Similarly, we found written plans of care were not reviewed on a regular basis or when someone's needs changed. This showed the service was poor at responding to people's needs by way of assessing their needs and planning and delivering care which met their identified needs.

We found where the service had made a referral to other healthcare professionals, for example physiotherapists or dieticians, for guidance or advice, this was not followed up in a timely manner. One person explained they had been waiting months for a referral for physiotherapy and felt this had severely hindered their progress with regard to rehabilitation. We found numerous other examples where the service had; not followed up on referrals once they had been made; not made referrals for people when needs had been identified and; had not followed professional guidance or advice with regard to the delivery of people's care.

The home employed an activities co-ordinator. This member of staff had the role of exploring people's preferences and abilities with the aim of providing activities within the home and organising visits to events outside of the home. However, people we spoke with, their relatives and staff told us that there were very few activities provided because the activities co-ordinator was usually tasked with providing care to people who used the service, for example assisting with mealtimes and personal care. During our inspection, we observed very little provision by way of activities within the home and no organised trips out into the community. We looked at people's written plans of care, which showed the service had not explored and recorded people's interests and aspirations.

One person told us they felt unable to follow their interests in stamp collecting and country music, because they were unable to leave the home and the service had not tried to assist them in maintaining these pursuits by any other means. We spoke with four people who told us they preferred to stay in their rooms rather than use the communal areas, because there was nothing going on that was of any interest to them. The communal areas at the home were arranged with chairs around the outside of the room, with a television as the focal point. The set up of these rooms felt very institutionalised.

The matters above constituted a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the service had not ensured they worked collaboratively with the person to deliver responsive care which met people's needs and reflected their preferences.

We observed some people who, due to their physical condition, were unable to get up out of bed by themselves, were left in their bedrooms for very long periods of time without any interaction with staff and, in some cases, without any other stimulation whatsoever. This showed the service had not taken proper steps to reduce the risks of social isolation for these people. We found this treatment was discriminatory toward the people concerned.

We looked at how the service listened to and learned from people's experiences, concerns and complaints. We found people were not actively encouraged, nor were they supported, to share their views and experiences. There were no formal methods used to gain feedback about the service and people we spoke with told us they did not feel any informal feedback they gave to staff or management was listened to or acted upon. People told us they felt that whatever they said, it "won't make any difference". There were people who approached us during our inspection who wished to raise concerns but did not want their identity to be known to the service. They told us this was because they feared they would receive less favourable care and treatment if the service knew they had raised concerns with us.

Although people we spoke with and their relatives were not satisfied with the care delivered by the service, no-one we spoke with had raised a formal complaint with the provider. We were told by the care quality manager that complaints had reduced significantly since the registered manager had taken over from the previous manager. However, when we asked to see the complaints log, they were unable to locate and provide it for inspection.

We found the service had no formal mechanism for feedback and learning from complaints. Staff we spoke with confirmed they were not aware of any such mechanism.

The matters above were in breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered person had not established and operated effectively, an accessible system to identify, record, handle, and respond to complaints by service users and other persons, in relation to the carrying on of the regulated activity.

Inadequate

Is the service well-led?

Our findings

During our inspection, we found that people who lived at the home, their relatives and staff members were not actively involved in developing the service. People we spoke with told us there had not been a resident's and relative's meeting "for some time". These sort of meetings provide a forum for people who live at the home and their loved ones to contribute ideas and suggestions about how the service is delivered and also give people the opportunity to discuss experiences and concerns openly with other people and managers.

When we asked the registered manager about the meetings, they admitted they had not taken place since they took up their post six months prior to our inspection. Staff we spoke with told us that they did not have regular staff meetings, where they were able to discuss concerns or make suggestions about how the service was delivered. The registered manager was able to provide minutes from one meeting which took place in April 2015, but told us no further staff meetings had taken place.

We asked people and their relatives whether they were asked to provide feedback on their experiences of how the service delivered care to them or their loved ones. They told us they were not aware of any formal routes for feedback and had not been asked to complete, for example, a satisfaction survey or been asked for their opinions on the care delivered.

People also told us they were not regularly involved in reviewing and making decisions about their care. This showed the service did not seek and act on feedback about the service provided, for the purposes of continually evaluating and improving the services provided.

We looked at how the service assessed, monitored and improved the quality of care provided to people. We found quality assurance systems were not operated effectively.

A suite of audits was available to the registered manager to monitor areas including medication, the environment and care planning. We found significant gaps in the audit records we looked at and a lack of action taken in response to any issues that were identified. The same was true of audits and visits carried out by other managers from the provider group and the care quality manager.

It became apparent that the management team had not fed back any of the concerns identified from audits or monitoring visits to the company director, who was the Nominated Individual for the provider group. As such there appeared to be a disconnect between the Nominated Individual and the home, which had led to poor oversight of the performance of the service. A Nominated Individual serves as the main point of contact between CQC and the service provider. They have a responsibility to supervise the management of the regulated activity.

The matters above constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because systems and process had not been established and operated effectively to assess, monitor and improve the quality and safety of the services provided and the experience of service users. Feedback from people who used the service and other relevant persons had not been

sought and acted upon for the purposes of continually evaluating and improving the service delivered.

The service had a whistle-blowing policy and procedure in place which was last reviewed in March 2015. The policy did not reflect current best practice guidelines. Staff were directed to raise concerns with the registered manager or the company director. There were no contact details provided to raise concerns externally, for example with the Local Authority or CQC. This meant staff may not be aware they could report concerns externally if they had already raised concerns with management without seeing improvements, which potentially left people who used the service vulnerable to substandard levels of care and treatment.

During discussions with the registered manager and the care quality manager, we were told that issues had been identified with regard to the culture of the staff team. Concerns were raised about staff morale, staff not carrying out their duties and staff being resistive to change. However, the management at the home were unable to provide any evidence of action they had taken with a view to improving the culture of the staff team.

Staff told us they had not been receiving constructive feedback about their performance from the registered manager. They also told us that they only received supervision sessions as part of a group, following adverse incidents. The registered manager confirmed that, since they took up their post, they had not provided individual supervision sessions for staff to discuss their performance. This was a contributory factor in the lack of understanding around responsibility and accountability at each level of the organisation. Staff did not have a clear understanding of what was expected of them and were not being actively managed to improve their performance.

We found communication between staff at the home and between staff and external professionals was poor. Important information about people's needs, how their care should be delivered and how risks should be managed was often missed or not relayed to staff that needed it. This meant people may be put at risk of receiving unsafe care or treatment, or treatment that did not meet their needs, because important information about them was not dealt with appropriately.

We found the standard of management and leadership at the home was poor. During the course of our inspection, the registered manager did display some leadership qualities and the management team were open and honest with the inspection team. However, we found that leadership was not visible at all levels.

We observed, nurses and senior care assistants did not provide leadership for care assistants on each shift and the support the registered manager received from the care quality manager was lacking. For example, we raised concerns with the management team about a particular person on day one of our inspection, because they had not received adequate food or fluid to meet their needs. We were assured that investigations would be undertaken and that the person concerned would be provided with support to eat and drink that evening. The following morning, the inspection team were informed that no investigation had been undertaken and the person had not had anything to eat or drink. The registered manager, when interviewed, was unable to provide any explanation as to why this had been allowed to happen. This demonstrated a lack of leadership.

Additionally, the registered manager had been made aware of the relative of a person who lived at the home going against professional guidance with regard to food and drink for their loved one. The person's relative had written on their care plan that they were not going to follow guidance. This put the person at serious risk of choking and aspiration.

The registered manager had taken no action whatsoever to try to keep the person safe, in line with local

safeguarding protocols. This led to the person experiencing harm and being admitted to hospital. The registered manager was unable to provide any explanation as to why they had not taken action to safeguard the person. This showed the manager was not leading by example, as a good manager could be expected to.

We found the service had not met requirements of registration with regard to submitting Statutory Notifications. These notifications should be completed and submitted to CQC where, for example, adverse incident have occurred, such as accidents resulting in injury, allegations of abuse or any incident that has been reported to the police. This was in Breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.