Care Quality Commission

The Salvation Army Social Work Trust

Smallcombe House

Inspection report

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Date of inspection visit:
23 July 2018
30 July 2018
07 August 2018

Date of publication:
12 December 2018

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

The inspection took place on 23,30 July 2018 and 07 August 2018 and was unannounced on all three days. At our last inspection in March 2018 we found the service was in breach of one regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in relation to Regulation 17, good governance. We had found there were still shortfalls around accurate and consistent record keeping, medicines and effective systems to monitor and review the quality of the service. In addition we had made a recommendation around supporting people with their nutritional needs. You can read the report from our last comprehensive inspection, by selecting the 'All reports' link for Smallcombe House, on our website at www.cqc.org.uk.

This inspection was prompted by information of an incident of alleged serious abuse involving a person using the service. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident.

Smallcombe House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Smallcombe House accommodates up to 32 people across three floors, one of which contains the foyer, communal lounge, dining room and offices. At the time of our visit there were 24 people living at the service.

There was 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 told us they generally felt safe at the service. Their feedback was mixed, with both positive and negative responses to our enquiries about their experiences of care.

We found the service to be inadequate in safe, effective, caring, responsive and well-led. At our inspection in March 2018 the service was Requires Improvement in all five domains with one breach of regulations regarding the quality of record-keeping. The provider had sent CQC an action plan, but we found that none of the actions had been completed and the service had deteriorated. At this inspection we found the provider was in breach of an additional nine regulations.

People did not receive a caring service. We found institutional practices delivered by poorly trained and insufficient staff. During the first two days of our inspection we observed only one out of three care staff engaged with people in a warm and friendly manner.

The service was not clean, there was a strong unpleasant odour in the communal lounge and in some

people's bedrooms. Furniture in the lounge was worn and dirty with visible stains. Equipment used to support people had not been cleaned. We found toiletries left in bathrooms alongside prescribed creams for people which constituted a risk of cross infection. Communal toilets on the ground floor were not cleaned frequently enough. This lack of cleanliness did not support people's dignity. We raised this at our inspection on 23 July 2018, however action was not taken until after our second visit on 30 July 2018. We again visited on 07 August 2018 and found that the odour, whilst not being completely absent, had reduced and all furniture in the lounge had been steam cleaned. The service was generally cleaner overall, however we identified two people's rooms which needed further cleaning.

People were supported to sit in the lounge during the day, however we observed little interaction or stimulation for people. The majority of people appeared asleep or withdrawn. We observed, on the first two days of our inspection, that some staff communicated with people in a brusque and task focussed manner. On the third day we observed some staff were communicating appropriately and engaging with people.

There were not enough competent staff at the service to support people safely. The service used high numbers of agency staff. Agency staff received minimal information about people and were given a list of tasks to carry out. There was no information provided about people's preferences. The provider had sent an action plan to CQC on 06 August 2018 which stated this information had been updated. When we inspected on 07 August, we found this information had not been fully updated.

People's care records were not up to date and daily records were disorganised, making it difficult to understand people's current needs. Accidents and incidents were not recorded clearly and were not followed up according to the provider's policies on reporting incidents and safeguarding.

The management of the service was ineffective. Since the inspection in March 2018 the quality of the service had deteriorated significantly. Systems in place to monitor the quality and effectiveness of the service had not been used effectively. None of the shortfalls found in the inspection of March 2018 had been addressed. We found further shortfalls on 23 July 2018 and fed these back. No action was taken. We again inspected on 30 July 2018 and following this requested an immediate action plan from the provider. We carried out a further follow up visit to check on the safety of the service on 07 August 2018.

We found ten breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. Full information about CQC's regulatory response to any concerns found during inspections is added to
reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. People were not protected from abuse. There were insufficient competent staff to care for people. People were not protected from the risk of infection. Risks to people were not assessed and minimised. People did not always get their prescribed creams.	**Inadequate**
Is the service effective? The service was not effective. People's needs had not always been assessed. Staff did not always implement recommendations from health professionals. People were prevented from leaving the service freely.	**Inadequate**
Is the service caring? The service was not caring. There were institutionalised practices. Staff engagement with people was sometimes brusque and task-focused. The environment and practices in the service did not promote dignity and respect.	**Inadequate**
Is the service responsive? The service was not responsive. People did not receive individualised care that was responsive to	**Inadequate**

their needs.

People had to fit in around the service.

People's preferences for future care were not always documented.

Is the service well-led?

Inadequate

The service was not well-led.

There was no effective leadership within the service.

Shortfalls in the quality of care had not been identified.

The service action plan following the last inspection had not been implemented and the service had deteriorated.

CareQuality Commission

Smallcombe House

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.

The inspection was prompted by information of an incident of alleged serious abuse involving a person using the service. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk and of other incidents where people may have experienced harm. This inspection examined those risks.

At the inspection we knew of one incident being investigated by the police and an ongoing investigation by the local authority into safeguarding practices at the service. The local authority investigations included individual incidents as well as looking at the whole service. These investigations had not yet been concluded by the local authority.

The inspection team consisted of two inspectors on all three days and an expert by experience on our second day of inspection, 30 July 2018. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed information from the local authority, the provider's plan identifying how they planned to improve the service following our inspection of March 2018, and other information we had about the service including statutory notifications. Notifications are information about specific events that the service is legally required to send us.

We spoke with seven people living at the service, two relatives and nine staff members, this included senior staff, two members of the provider's senior management team and the registered manager. We also spoke with three health/social care professionals. We reviewed eleven people's care and support records and three staff files. We also looked at records relating to the management of the service such as incident and accident records, meeting minutes, recruitment and training records, policies, audits and complaints.

Some people at the service may not be able to tell us about their experiences. We used a number of different methods such as undertaking observations to help us understand people's experiences of the home. As part of our observations we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the needs of people who could not speak with us.

Inadequate

Is the service safe?

Our findings

Risks to people were not managed to ensure they received safe care. People's needs had not always been assessed. Assessments had not always been updated when their needs changed. For example, one person had diabetes and their risk assessment advised staff there was a risk of low or high blood sugars. There was no information to guide staff on what this meant, how to identify potential concerns or what action to take. People's risks due to compromised mobility were not always assessed and plans were not in place to support them to move around safely. We found four people did not have a moving and handling assessment in place. This meant staff had no clear guidance to follow on how to support these people safely. One person's daily records dated 24 June 2018 stated, "[Name] not walking very well, keeps falling backwards. Had to be put in wheelchair." This person's last falls assessment was in September 2017. Staff had signed the care plan as reviewed on 24 June 2018 but there was no mention of falls risk. Another person had a risk assessment that identified potential infection control risks. Their risk assessment, undated, did not guide staff to support the person to wash their hands before eating as a way of reducing these infection risks.

None of the people's care records we reviewed contained a continence care plan. This meant the provider could not be sure people received the support they needed with continence needs.

We looked at four people's records who had 'repose' air mattresses. These mattresses are supplied for people who are at risk of pressure damage to their skin. The district nurse told us these mattresses should be checked weekly and that a care plan should be in place. None of the four people had an assessment or care plan in place to advise staff about the use of the mattresses or to advise them to check they were inflated. We looked at four air mattresses, all four were deflated. We brought one mattress to the attention of the registered manager at the time. . She confirmed it should be inflated, and said all mattresses were checked monthly. The last audit had been completed on 12 June 2018, seven weeks previously. The audit did not identify all the 'repose mattresses' that were in use, did not identify if they needed inflation, or if this had been carried out. At the end of the inspection we fed back the need for these mattresses to be inflated and asked the registered manager if they had taken action about the deflated mattresses. The registered manager replied, "No, there is a pump somewhere."

Where people were at risk of damage to their skin integrity there were no risk assessments or support plans in place to ensure people received adequate support to reduce the risk of pressure ulcers. There was a sheet entitled, "Pressure cushion advice sheet." This listed people who needed to sit on one of these cushions. We checked, along with the registered manager, if people in the lounge who needed these cushions had them. Of the nine people we saw only two were seated on these cushions. The registered manager took no immediate action to remedy this.

The 'handover sheet' given to agency staff did not indicate which people should be seated on a pressure relieving cushion. We saw in some people's records that the district nurses had noted people were not always sat on pressure cushions. This put people at increased risk of developing pressure ulcers. Following the inspection we received an updated copy of this 'handover sheet'. However, the information still did not

contain complete information about people's pressure area support needs.

People were at risk of not receiving safe care and treatment, due to ineffective management of skin care and topical creams,. People's prescribed creams for skin care were not managed safely. One person told us, "I'm very itchy all over, I've got some cream from the doctor, they (staff) sometimes put it on, but not every day." People's topical medicines administration records (TMAR) were kept in a file in the office. Although the agency 'handover sheet' stated some were kept in people's rooms.

TMARs had information about the prescribed cream to be applied, the frequency of application, and a body map to show staff where to apply it. We looked at seven TMARs for people and found there were incomplete records to confirm whether the person had been administered their cream as prescribed. For example, one person had a TMAR that stated Cavilon cream was to be applied 'After personal care'. The TMAR for 24 June 2018 to 21 July 2018 was signed on only five of these days and only once on each day. This meant the provider could not be sure that staff had applied the cream regularly as prescribed. This person was also prescribed Epimax cream for 'Dry areas, legs and arms', there was no body map, their TMAR was in their daily records where staff did not have access to it whilst delivering care and applying the cream. Their TMAR had been signed to confirm the cream had been applied on only five occasions over the monthly period. The district nurse had noted on their professional visit record of 28 May 2018, "Re-iterated need to cream legs every day." This person was at risk of skin problems and required their cream applying to protect their legs.

A second person was prescribed Epimax twice daily. Their daily records contained a TMAR dated from 1 January 2018 to 6 June 2018, this was on one sheet which was designed for daily recording over a month period. Over this six-monthly period staff had signed to confirm application of cream on only nine occasions. On only one occasion was the cream confirmed as applied twice. A third person's records stated, "Apply proshield cream", however they did not have a TMAR in their daily records.

We saw creams in people's rooms that were not stored correctly. Some were unnamed so it could not be identified if this was the person's prescribed cream. Others did not have a date of opening so it could not be checked if this cream was being used in line with the manufacturer's instructions.

Staff were unclear when describing how to identify potential skin problems or pressure damage. One member of staff told us they would alert the team leader, "If legs were red and rashy and skin was flaky." Another member of staff told us, "Creams were needed if someone was in pain or had dry skin." None of the staff we spoke with identified red skin or continence as a risk to people's skin integrity. Staff told us cream charts were signed at the end of their shift. We asked the agency member of staff what information they had received about the application of creams. They told us they had administered the creams found in people's bedrooms when supporting them with personal care. They had not recorded this as they had been told this was done at the end of the shift.

On 06 August 2018 we received an action plan from the provider which stated all TMARs and charts were now in people's rooms. We returned to the service on 07 August 2018 and found that nobody had the records in their room. We asked the registered manager about these charts and they brought a file form their office which contained all the records. This meant that staff, and particularly agency staff unfamiliar with the service, did not have information about where and how often people required their prescribed creams. Everybody had a new chart started on 06 August 2018. We reviewed these charts and found these had not been completed to evidence people's creams had been applied at the frequency required. The administration of creams could not be accurately monitored.

People were not protected from the risk of infection. The premises were dirty and in the communal lounge

there was a strong odour. Chairs and furniture in the lounge were worn, stained, dirty and had a strong odour. We had raised the issue of the strong odour on 23 July 2018, however, no action was taken until after our visit on 30 July 2018. On 07 August 2018 we found the odour had reduced but was still present. However, furniture had now been steam cleaned and stains removed.

Bathrooms and toilets were not always clean and there was poor practice by staff in the management of soiled waste. For example, we observed one member of staff carrying a dirty incontinence pad into the sluice, the bin foot pedal was not working so they lifted the lid and deposited the waste then left the room. They still had the same gloves on, which should have been disposed of to prevent cross contamination. On another occasion we saw a member of staff pick up a used incontinence pad with their bare hands, commenting, "I'll wash my hands". On the 30 July 2018 we entered the communal toilets on the ground floor and observed a soiled incontinence pad draped over the grab bar. We alerted a member of staff who said, "I don't come on shift yet" and walked off. The incontinence pad was not moved for a further 20 minutes.

On entering the communal toilets on another occasion, we found faeces on the toilet seat and floor. We found no system in place to regularly check toilets were clean and free from the risk of cross infection. We observed a soiled incontinence pad deposited in a bin without a lid, this was emitting a strong odour.

Waste was not always managed safely in line with good practice. There was a clinical waste bin and a general waste bin in the sluice on the first floor. Both these bins should have been foot operated, however both foot pedals were broken and staff had to manually lift the lid. This placed staff and people living at the service at risk of cross infection as these surfaces were a potential source of infection. On the 07 August 2018 the clinical waste bin with the broken lid had not yet been replaced. We observed a member of staff manually lift the lid and put a bag of clinical waste in. This made the bin overfull so they pushed the waste down with their hand. Clinical waste bins should not be filled to more than two-thirds to enable sealing of waste bags. A short while later we saw bagged clinical waste left in the corridor. This waste should have been immediately moved to a suitable disposal container.

We identified further infection control risks in the communal bathrooms. One bathroom had a basket of toiletries which meant there was a risk of cross infection if they were used for more than one person. Another bathroom had a soiled incontinence pad on the floor and laundry on the radiator. Bathroom floors were stained and did not look clean.

People were at risk from dirty equipment. For example, one person used a stand-aid, the equipment was stained and dirty. It had not been cleaned for some time. Three people's bedrooms had a very strong odour on 30 July 2018 and one person's sensor mat was stained and sticky. We checked their room after it had been cleaned but the mat had not been cleaned. At our inspection of 07 August 2018 two people's rooms still had a strong odour and the sensor mat still had stains.

We identified a broken electrical double socket in one person's bedroom. The bottom part of the socket was missing with metal and wiring visible. There was a risk of harm to the person should they touch this or attempt to plug something into the socket. The person told us their bed had been moved because of this and they could no longer sit in the window to look at the birds.

Accident and incident forms had not been consistently completed. We found examples where records of accidents and incidents had not been kept. When accident and incident forms had been completed for May, June and July 2018 there was no management review of the incidents. This meant actions taken to reduce the risk or reoccurrence had not been documented or had not taken place. Some incident and accidents we reviewed indicated records were not kept to demonstrate how people had been monitored and checked

following an incident or accident. For example, one person had fallen and hit their head and there was no further information recorded.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had mixed views on the staffing levels and support provided from staff when they summoned assistance.

People said there was not always a timely response to call bells, and that staff often 'cancelled' the bell but did not attend to their needs at that time. This meant they had to ring repeatedly. One person said, "They (staff) come as quickly as they can. Sometimes they come in and turn off the bell and say, 'You don't have to keep ringing!' I'm not sure if I'm doing something wrong and perhaps I'm not supposed to ring, but they turn it off and don't come back. So, I have to ring it again". A second person told us, "Sometimes they are short staffed and they can't help it if it takes a bit longer, perhaps more than half an hour". Another person told us, "They are short of staff and they (staff) don't stay here long, so we get a lot of agency staff. It doesn't really affect me that much because I can speak for myself and explain what I need, but I think it must be difficult for some people living here".

There were not enough suitably trained and competent staff to support people. At our last comprehensive inspection there were three full time day care assistant roles and an activity co-ordinator post vacant. We had been told at our inspection in March 2018 two new staff were starting shortly. However, at this inspection there were still three full time day care assistant roles vacant and three full time night staff vacancies. In addition, the activity post was still vacant. During our inspection on 30 July 2018 we found there were two senior members of care staff, four members of the care team and one member of night staff available to cover shifts. The shortfalls of permanent staff were being covered by existing staff and agency staff.

We spoke with seven members of the permanent staff team and one member of agency staff. One member of staff told us, "Staffing is inadequate." Some staff were working many additional hours, for example one member of staff had only three days off in a three-week period. This included one day off following two night shifts. We found some staff were regularly working long hours from 49 hours to 72 hours. This posed a risk to the well-being of staff and people they were caring for.

Staff told us that there were not enough staff at night. One staff member said "[Name] spends the night wandering around and can't be left alone. It's difficult for the other person to do all the two hourly checks and everything else." We were also told by staff, "It's not very often that there are enough staff on duty, we need more staff in the morning, because of getting up and breakfasts."

The registered manager told us that they used the Indicator of Relative Need (IoRNS) dependency tool to calculate the number of staff per shift based on the needs of people living at the service. This tool was reviewed each month. The Head of Care completed the input of people's needs. The Registered Manager explained they sat in on handovers and looked at records to determine people's needs then discussed what to put into the tool with the Head of Care. However, we found people's records were inaccurate and not reflective of people's needs so the registered manager could not be assured the information used to complete the tool was correct.

People were at risk due to agency staff being unfamiliar with people needs and the lack of accurate information available to them. There was no up to date information made available to agency staff about

people's risks of moving and handling support needs. Information about people given to agency staff consisted of a list of tasks and moving and handling consisted of, "Uses Zimmer frame", or, "Uses Zimmer frame/Standing hoist". There was no further detail such as if the person was a falls risk or how much support they needed to mobilise such as verbal guidance and encouragement." This list of 'tasks' was not up to date. One person needed assistance from staff with eating but this information was not included to ensure care staff were familiar with how to support the person. The person was also at risk of falls and walked with a frame.. Another person now needed to move around the service in a wheelchair but this information was not included on the 'handover sheet'.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Systems to identify and investigate potential safeguarding concerns were ineffective. At the last inspection it was identified that there were no systems to escalate or investigate potential safeguarding concerns. At this inspection improvements had not been made. The body map form had been amended to detail the actions taken in response to bruising or skin tears found. However, these were not consistently completed to demonstrate the actions taken. In addition, where incident and accident forms or daily records indicated risks to the person's safety staff had not followed the system in place to raise concerns, investigate or to take action to keep the person safe. During the inspection we found the registered manager had identified a safeguarding concern but had failed to take adequate action to ensure the person's safety.

Staff we spoke with did not always understand whistleblowing, and what do if they were worried about potential abuse. Two members of staff told us it was, "When staff are causing trouble", and, "When you tell someone higher up, cos I seen it on the telly. You could lose your job."

We identified incidents of potential harm or abuse that had not been reported promptly to the local authority safeguarding team or notified to the Commission as required.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a recruitment policy and procedure in place. Checks had been undertaken such as obtaining photographic documentation of new staff members, reference checks and enhanced Disclosure and Barring Service (DBS) check. A DBS check helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether are barred from working with certain groups of people. Where DBS checks had shown further information was required. The service had conducted a risk assessment to determine the staff members suitability for the role.

We found information contained with recruitment files that would require clarification. For example, for one person two references had been obtained. However, the dates of employment did not match what was on the staff members application form. This had not been identified. The second reference was unclear if this related to past employment or if this was a character reference. The provider's policy stated, 'Two written references are requested covering a minimum of three years. One reference must be from a current or recent employer. References are not accepted from families or friends.' We found the recruitment checklist to ensure all parts of the employment process had not been completed for one staff member and partially completed for another.

Inadequate

Is the service effective?

Our findings

People were not always provided with care from staff that gained consent before carrying out support. People told us, "I'm really not sure that they do. Sometimes they ask and sometimes I think they just do things without asking", and, "They don't always ask for consent, for example the cleaner just comes in and starts cleaning". Another person said, "The staff are doing their best, it would be mean to say anything against them".

Consent to care and treatment was not always sought in line with legislation and guidance. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We saw that information about people's capacity was not always correct. For example, one person had been assessed, whilst in hospital, as lacking capacity to consent to care and treatment. The service had stated in the person's care plan that they had full capacity. We spoke with the person's social worker who confirmed the person did not have capacity. This meant that the staff may not have made decisions in the person's best interests as required to do by the MCA.

There was a keypad to open the front door and the code was not given to anybody who lived there. Staff told us people could not go out alone as 'They might fall'. There was no evidence that people with capacity had consented to this or where people lacked capacity they had been assessed and a best interest decision considered.

Care records showed that some people had not signed to consent to care and treatment. The provider's audit had identified this for one person in March 2018 and that their mental capacity assessment had not been signed. Neither of these actions had been completed.

People and their relatives were not always involved in decisions about people's care. One relative told us, "In the early days staff took me to one side to talk about things, my (sibling) is local and discusses care more, but I wonder how much we'd know if we didn't come in. I
don't get the feeling that there are regular reviews, we were more involved in decision making at home than we are here."

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

Staff were not clear about consent and DoLS. One member of staff described seeking people's consent by,

"Encouraging them." Whilst a second staff member told us they, "Didn't think people could go out without a carer or a relative." A third member of staff said, "If someone refuses to get changed if they are incontinent you have to make it clear, to them if they're wet and need changing – but do it quietly if in the lounge." Staff also told us the MCA was about people making safe decisions. Staff told us that most of the people living at the service were on DOLS, however, records showed only eight people were under a DOLS.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not always consult health care professionals about people's needs. For example one person's daily records on 11 June 2018 stated, "Left lower leg, including foot quite enlarged/swollen" and noted it was quite red, the team leader was informed. On the 16 June 2018 the persons records noted, "His socks were very tight on him due to his feet swelling." There was no record that staff had informed the district nurse or GP. There was no information in their care plan about this.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a risk that people would not have their needs met with regards to eating and drinking. Some people had lost weight. One person's care plan review on 16 April 2018 stated, "[Name's] weight is very concerning as she does not eat at normal times." The person's records showed they had lost five kilograms in the last year. The screening tool for nutritional risk (MUST) had not been completed since December 2017. Their records stated, the MUST was to be completed monthly.

This meant the provider could not be sure that the person was effectively assessed for nutritional risk and received appropriate support to eat enough. On our visit of 07 August 2018 this person had the remains of their breakfast still in their bedroom at 15.00. They told us they had not been offered lunch. We alerted a member of staff who went into their room and we heard them asking, "Why didn't you tell us?".

At our inspection in March 2018 we found information regarding people's nutritional needs was not always sufficient. We made a recommendation that the service considered current recognised guidance on supporting people with their nutritional needs. However, we found this improvement had not been made.

People were not always supported to have enough to eat and drink. We observed one member of staff refuse to bring a person a cup of tea, telling them they would have to wait for the tea trolley. We observed another person left, on both days of our visit, to sleep through lunch. On our first visit soup was left on a side table, by the time the person woke up and ate it the soup was cold. On our second visit we observed a person served their dinner in a cereal bowl which was put onto their lap. The bowl was not on a tray, there were no condiments made available. Throughout the first two days of our inspection we did not see any drinks made available to people outside of mealtimes and the tea trolley which was taken around once in the morning and once in the afternoon. There were no jugs of water or juice available to people in communal areas. On the first day of our visit the temperature was high but people were not offered additional drinks to prevent dehydration. On the third day of our inspection staff were offering people in the lounge drinks during the afternoon.

There were no snacks freely accessible to people in the communal areas. There was a 'shop' which stated its' daily opening times as 9.30am-2.30pm, Monday to Friday. It remained closed and padlocked during all the inspection visits.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were positive about the food, "The food is very good, that's one good thing here. There's enough choice and I can eat in my room. It's hot when it comes and I'm always hungry and eat very well. I'm not sure if you can get meals outside of meal times as I haven't tried. I've got a jug
here and they change that for me every morning."

We carried out an observation of people's lunchtime experience. Staff had laid the tables in advance with tablemats, cutlery and glasses. There were no tablecloths, condiments, sauces or napkins and people were not offered clothes protection. Staff serving the meal at lunchtime were not observed to carry out hand hygiene themselves, or to offer hand hygiene to people before serving the food. Adapted cutlery was available for a person who needed it and staff washed this between courses.

People were offered a choice of drinks including water, and three flavours of squash. The one staff member assisting people with lunch was attentive, offering choice of each course individually at the table. They took time to explain the options to those who needed more help to choose and obtained custom choices from the kitchen for those who requested a particular combination of sandwich filling and type of bread. People were not offered a hot drink at the end of the meal.

Staff did not have the skills and knowledge to deliver effective care. Some of the permanent staff working at the service did not know the needs of people with diabetes. Staff we spoke with were unsure how to support people with diabetes. One member of staff said they did not know which people had diabetes but, "Team leaders check people's sugar levels, and people had to have diabetic food, no sugar, plain biscuits and insulin daily." Another member of staff told us five people had diabetes and that their needs included food and injections. None of the staff were aware of the importance of monitoring people's feet, for example, when they had diabetes or the need to report any concerns to the district nurse.

At a previous inspection in September 2016 we found staff had not received training in supporting people with diabetes care. Information to guide staff was limited in how people should be effectively supported with diabetes care. Whilst this had improved at the inspection in March 2018 this improvement had not been sustained.

Some staff were unable to describe how to support people living with dementia. We were told about one person who was deaf, but would not wear hearing aids and was living with dementia. We asked a staff member how they communicated with them. The staff member told us they could lip read. Another member of staff said nobody at the service was deaf and that the way to support people living with dementia was, "To speak kindly and explain what is happening." A third member of staff told us the way to communicate with people with dementia was, "To get to know people as an individual." None of the staff were able to describe basic techniques such as bending down to the person's eye level, making eye contact, speaking slowly and clearly and giving people time. We observed poor communication skills from some members of staff which included physically manoeuvring people without speaking to them and standing over somebody saying, "Up, get up". We asked about this and were told that the person was living with dementia and understood gestures more easily. The daily orientation board in the dining room was not up to date. It was not showing a day or date, and inaccurately showed the weather as bright and cold This was not reflective of good communication practice.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's individual needs were not met by the adaptation and design of the service. People we spoke with told us they could not have a shower. One person said, "I am asked if I'd like a bath, but it's such a palaver and I've tried it and didn't like it. I'd really like a shower but they haven't got any and so I have a good wash every day, but I miss a shower as I was used to having one at home". A second person told us, "I get help to have a wash but I would like to have a shower. They haven't got any. When you get up they do ask you if you want a bath sometimes."

There was no seating area or chairs in the long bedroom corridors where people could rest if they needed to. All bedroom doors looked the same and had nothing to distinguish them from each other apart from a number and the occupant's name on a small label. Not everybody had their name on the door. People living with dementia could find it difficult to identify their own room and become disorientated and confused. Doors had small empty picture frames next to them, the registered manager told us these were intended to be used as memory boxes. This meant that items meaningful to the occupant could be displayed to help them recognise their room. None of these boxes was in use. Some people had continence issues. The bedrooms of these people had not been adapted, for example, impermeable flooring which could be easily cleaned to reduce odour. People had carpet and the rooms emitted strong odours.

The communal toilets on the ground floor, whilst having a picture sign and easily identifiable seats, were not designed to promote people's privacy and dignity. The toilets were in a row of three with doors opening outwards behind a door to the corridor. Some people, due to their dementia, did not always close the door. However, as the door to the corridor may be closed staff could not always make sure people had closed the door. On two occasions we observed toilets in use side by side with doors open.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service caring?

Our findings

At the last inspection we found people's dignity was not always upheld. Communication styles were not always altered to take account of people's different support needs. Care records were inconsistently completed and lacked detail in some areas of people's care. There was no activity coordinator in post and people said they lacked stimulation. At this inspection we found that the service had deteriorated.

We found that people spent most of their day in a lounge with a very strong unpleasant odour seated on dirty stained chairs with little or no stimulation.

People told us, "The staff are ok, they do listen to you if you don't want them to do something that way, they do give you a choice. They let me independent, yes they're good at that …leaving you to it!" Another person said, "The staff are kind, this (staff member) is very kind and helps me. We pray for my (family member) which gives me comfort. Some of them are a bit rough in the way they speak." A third person told us, "The staff are alright, most of them are kind and we have a laugh, there are always some people you don't get on with so well in every walk of life".

People did not experience kind and compassionate care. Care at the service was institutional and task-focussed. People were supported by some permanent staff in a brusque and offhand manner at times. On the first day of our inspection we observed a member of staff supporting a gentleman into the lounge. They had their hands on the person's arms pushing and turning them. There was no verbal communication to guide or reassure the person. We observed another member of staff guiding people into the lounge. They stood some way in front of each person and used minimal verbal interaction, they did not walk alongside or with people.

One member of staff told us their job was, "Helping people to maintain independence, making sure they are fed and watered on a regular basis."

The service operated a key worker system but this was not effective. Key working is where a member of staff gets to know somebody and makes sure their care plan reflects their needs, as well as spending time with the person providing emotional and psychological support. Staff comments included, "It's about keeping their rooms tidy, and making sure the bed is clean and tidy", and, "I'm a keyworker to four – I can give them a bath once a week, I can manage that. I can give [name] a shave once every two days. " Another comment about providing care for people was, "We have to make sure they're fed and watered on a regular basis."

The staff had not noticed when a person's needs were not being met in respect of their bed. The person told us, "My bed is a bit too high and sometimes I sleep in the chair because I can't get in or out of it on my own". Their family member told us, that the bed had been brought from home and they did not realise there was a problem, but that they would be happy to have it replaced with an adjustable bed.

People had limited access to a bath and there was no walk-in shower available at the service. We looked at bath records for one person who had gaps of up to three months between baths (RD). Another person was

recorded as having baths monthly (JB). One member of staff told us, "I can only do four baths a week".

We saw that people were left sat in the lounge for long periods of time. We observed people to be asleep or withdrawn. Staff on duty made no effort to engage with people. During the first two days of inspection we did not hear any laughter from the people living at the service. They appeared withdrawn and depressed. On the third day we saw some staff who were engaging people appropriately and encouraging conversation.

During the three days we were at the service we did not see anybody supported to sit outside. On occasion the doors to the decking area were open but people did not go out there. We noted that, although there was a ramp on the outside of the door, the step up to go through the door was a trip risk. This had been marked with 'hazard tape' which was now worn and faded.

Staff giving the handover from the night shift to the day shift referred to some people by room number rather than name. People's daily records were labelled with their room number rather than their name which was institutionalised practice. Some staff were unable to tell us what person-centred care consisted of. One member of staff told us, "It's when they give themselves personal care. "

People gave mixed feedback on how staff respected their rights. One person said, "They (staff) don't always knock on the door, if you're in bed they just come in, it doesn't really bother me." Whilst a second person told us, "They usually knock on the door and call out before they come in."

People's dignity and privacy was not always respected. The communal lounge did not lend itself to dignity and respect or people's well-being. There was a very strong unpleasant smell and people were seated on worn, dirty chairs covered in stains. During 'tea round' we observed people were not offered plates but left to put biscuits on dirty chair arms or side tables, which were not always clean.

We observed part of the medicines round with a senior member of staff. One person was still in bed and had an uncovered commode containing urine beside them. The member of staff ignored this and proceeded to administer the person's medicines. They then left the room without emptying the commode. This compromised the person's dignity.

On the second day of our inspection we observed one person's underwear left on the floor outside their bedroom door. This was not moved by staff, although at the time we first saw it a member of staff was entering their room, and after two hours we advised a member of the senior management team who took action. Later in the day we observed another person's trousers and underwear left in the corner of the communal toilets on the ground floor. We went back to check if this had been moved but found another item had been added to the pile of clothing

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

Inadequate

Is the service responsive?

Our findings

People did not receive personalised care that was responsive to their needs. There was poor communication within the staff team and advice from professionals was not always added to people's care plans. The system in place to induct agency staff, which the service used on every shift, was inadequate. Agency staff were shown fire exits and handed a printed sheet entitled, "Agency sheet". This contained a list of people living at the service and tasks to be completed. For example, one person's information (RP) stated, "Assistance of one to two with personal care. Doesn't wear pads so must be assisted to the toilet regularly. Must be supervised upstairs". The person also needed support with eating but the sheet had not been updated to reflect this. There was no information on this sheet about people's preferences. A second person's information stated, "Creams and cream charts in room." This person did not have a cream chart.

Care records did not accurately reflect people's needs and were organised in a way that made it difficult to locate people's care plans. The service used high numbers of agency staff but there was no brief portrait of people to give agency staff a guide to people's care needs and preferences. People had a front sheet in their daily records entitled, "All about me" which is an information sheet designed to give information to hospital staff should a person be admitted. . The sheet had not been completed for everyone. One person had another person's form in the front of their records. We looked at their 'All about me" which we found on the next page. This had not been updated to reflect their current needs. It stated, "I walk with one carer, no aids". However, we observed this person to have poor mobility and used a walking frame. Another person only had a partially completed transfer to hospital form. This form lacked important information about their mental health which meant they would not get the support they needed in hospital.

People's care plans did not guide staff on how to support people emotionally. We looked at care plans for two people with mental health needs. One person's plan stated, "[Name] has a history of depression and anxiety but overall is a happy person." There was no guidance for staff on how to identify depression or anxiety for this person or how to support them.

We looked at care records for two other people with diagnosed mental illness. There was no guidance for staff on what the signs and symptoms of these illnesses were. There was no information to guide staff on how to support people or when to seek support from mental health professionals.

Care plans did not accurately reflect people's support needs or what they were able to do for themselves. People's care plans had not always been updated. For example, one person who moved into the service in February 2018 had only a, 'short term care plan' which had not been developed once staff got to know the person. We discussed this with the person's social worker who confirmed it did not accurately reflect the person's needs.

People's care plans had been written to include their preferences, however, they were not updated when people's needs changed so staff could not be sure of their preferences. People's needs were not always included in these plans.

Staff did not always read people's care plans so would have been unaware of any changes. Staff told us, "I haven't read all the care plans, there isn't really time," another member of staff said they, "Were able to read care plans during lunch breaks or in-between jobs." A third member of staff commented, "It is quite difficult to read care plans, a later shift is easier to manage this."

People did not have access to activities at the service. The Activities Co-ordinator post remained vacant and during the inspection we did not see any recreational or social activities being offered to people. On the second day we noted a religious service took place. People sat in the lounge where the TV was on or sometimes music played. At one point a Christmas song was played and we had to ask staff to turn this off as it could be confusing for people with living dementia.

People told us, "There are no activities. I don't go into the lounge they're all asleep and there's no-one to talk to and nothing really going on. My (family member) takes me elsewhere for the day where they have things going on, otherwise I'm in my room watching TV. I'm lazy and it's enough for me", and, "They keep saying come upstairs, and I do go to meals so I can meet people here and get to know them but I wondered what was going on as they kept saying it, so
went to the sitting room and there was nothing happening at all, it was the same as being here and I'd rather be in my room with the television programme of my choice". A third person said, "I was sitting here wondering what to do and how miserable I was going to be this afternoon, waiting for family and hoping someone would come."

The majority of the care records we looked at did not have information about people's preferred preferences for care should they become unwell. One person, however, had their preferred preferences for care documented as, "Family would like [Name] to be fed and watered for as long as needed". These comments had not been written in a person-centred way which took into account the person's emotional well-being and comfort.

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

People told us, "I only have girls looking after me, helping me with my wash, they always keep me covered up, I wouldn't want a man washing me." People said they had not had to make a formal complaint. One person said, "The manager is very pleasant and listens, but I get the feeling it's a place where things get noted but nothing really happens about them".

People had limited access to the outdoors. One person told us, "I don't really go outside, sometimes when my (family member) comes we go out. We went to the rugby once, that was good, I enjoyed it, and we won!" Another person said, "I don't go out there (outside decking area), I've never been a sun worshipper so I'm not bothered about it but I can't get out there on my own anyway". A third person told us, "I don't sit outside I can't get out there. We don't really go out."

Inadequate

Is the service well-led?

Our findings

The service had been rated Requires Improvement since 2014. Improvements identified on the provider's action plans had either not been implemented or not been sustained. The provider had audit systems and management oversight of the service was in place. However these processes were not effective.

People expressed some general opinions of the service which suggested they had low expectations and were making the best of living at the service or had no choice. Comments included, "The home is alright. It's ok, it's not wonderful but I'm fine here and I can manage", and, "I can't say that I like it here. It's apparently where I have to be, the doctor said I had to come here which I was upset about. As you get to know them (staff), I can't say anything is bad. I just don't want to be here". A third person commented, "I've got no choice and I'm pretty happy here…it's not too bad really".

Governance processes within the service were ineffective. There were no effective systems in operation to assess and monitor the quality of the service. Following an inspection in March 2018 the provider submitted an action plan. None of the actions in this action plan had been started and the quality and safety of the service had deteriorated since the inspection in March 2018.

Some care plans had not been audited since April 2017 and shortfalls identified through the provider audits had not been rectified or followed up. Care plans and risk assessments were not updated with changes to service users' needs. A member of staff had recently been appointed to review the care records and produce a prioritised list of initial actions. It was agreed that information would be sent to us following the inspection but this was not been received. There was no system in place to ensure agency staff had access to up to date accurate information about people's care needs, although this was updated after our inspection it remained incomplete

Mattress audits did not identify deflated air mattresses needed to protect service users from pressure damage so that action could be taken. During our inspection of 30 July 2018, we alerted the registered manager to a deflated air mattress. She confirmed it needed to be inflated but no further action was taken. We asked her at the end of our inspection if We identified a further three mattresses in use which were deflated. There was no effective system in place to monitor whether air mattresses were inflated. There was no system in place to ensure people were sat on the required pressure-relieving cushions and action was not taken to rectify this.

There was no oversight of safeguarding processes within the service to protect people. There was a failure to take appropriate action following concerns raised by the police and the safeguarding team about staff conduct. There was no coherent collation and investigation of incidents such as falls, injuries and incidents of aggression. There was no system in place to assess competency of staff and identify shortfalls in their practice. Institutional practices had not been identified and rectified.

There was no effective system to monitor the cleanliness and maintenance of the home. Cleaning audits had not identified the stained and dirty furniture or dirty equipment. There were no effective checks to

ensure toilets remained clean and safe for service users. There were ineffective infection control audits with no action taken to make improvements.

Neither the provider nor registered manager had not identified poor medicines practice. The current medicines audit did not check on topical creams to ensure they were applied in line with service user's assessed needs and recorded accurately. On 06 August 2018 we received an action plan from the provider which stated that relevant charts were now in people's rooms. This was not correct. The charts had been placed in a separate file but were still not kept in people's rooms.

Daily records were in a state of disorder and uninformative; they were jumbled and not in consecutive order. This had not been identified or rectified. This presented a risk service users' health and care needs may not be met and important information was not easily accessible.

There was a quality improvement plan in place but the majority of the shortfalls detailed in this report had not been identified by the provider through robust governance and oversight. There was no oversight of the action plan following the last inspection and the provider had not taken action regarding the lack of any implementation of this plan. The service had deteriorated significantly since our previous inspection. The provider had not identified many of the serious shortfalls we found at the service and had failed to ensure shortfalls they were aware of were rectified.

Two people were able to tell us about the resident's meetings, but neither expressed that they felt engaged in the running of the home, "There are meetings …I wouldn't say anything about things I'd like changed as beggars can't be choosers.", and, "I don't bother to go, it's ok here, I'm alright so I wouldn't say anything". Neither of the relatives we spoke with knew about any feedback questionnaires, although one said that their sibling may possibly have completed one. There was a 'You Said / We Did' board on display in the communal area corridor. This was filled with photographs of people living at the service and displayed no information about improvements requested or made.

In September 2016 we found systems to investigate and explain unexplained injuries were inconsistently managed. This meant there was a risk potential safeguarding concerns may not get identified and reported as appropriate. We found in the March 2018 inspection that this had not been rectified. At this inspection we identified that the provider had still failed to make improvements.

We also found at the two previous inspections that identified shortfalls in medicines and care plan audits had not been rectified. At this inspection we found that action had still not been taken.

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

The service was not displaying their rating assessment on the premises. The report on display in the entrance area and on the noticeboard was from September 2016, not the most recent inspection of March 2018.

This was a breach of Regulation 20(A) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Some staff worked excessive hours which meant they would potentially be too tired to carry out their duties effectively. This was not being monitored or managed effectively by the provider.

We attended one handover from the night staff to the day staff. Information was brief with little information shared about people's current needs. An agency member of staff was starting a shift. They had visited once before, but had never been accompanied round the building or had a fire tour. On this occasion, the registered manager took them round the building, but did not introduce them to either staff or residents.

No information was given about which residents were subject to the MCA or DoLS. The night staff described the behaviour of one person which was unsettled and needed constant staff supervision. There was no discussion about how staff could best support this person or keep them and others safe.

The registered manager had not always notified us of important events at the service such as injuries to people and safeguarding referrals to the local authority.

This was a breach of the Care Quality Commission (Registration) Regulations 2009 (Part 4) Regulation 18: Notification of other incidents.

Staff told us they enjoyed working at the service. Comments included, "There's a great atmosphere at work, the staff work well as a team and I believe the residents are happy. The manager is approachable and is hands on , she gets things done. And, "The atmosphere is very good, we carers get on , there's no bickering. Another member of staff said, "There is a good atmosphere at the home, the carers get on well and the team leaders have a good rapport."

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive person centred care. Sufficient information about people's individual needs was not always available. Care at the service was institutional.

The enforcement action we took:

Cancellation of registered manager.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The overwhelming smell in the lounge and the dirty and worn furniture did not respect or promote service users' dignity. There was no sense this was service users' home and their comfort or needs were considered. The service was institutionalised and task driven. Service users were supported by permanent staff in a brusque and offhand manner at times. Care records were labelled with service users' room number rather than name evidencing more institutionalised practice. Comments in one service user's end of life plan were disrespectful.

The enforcement action we took:

Cancellation of registered manager.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People were not allowed to leave the service.

	Staff did not understand DoLS. The front door was locked and people who had capacity and were not on a DOLS were not given the code.

The enforcement action we took:

Cancellation of registered manager.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Service users did not have up to date risk assessments and risk management plans. Service users with behaviour that challenged did not have plans in place to guide staff how to support them safely and protect other service users. Service user's care records had not been updated when their needs changed placing them at risk of harm or unsafe and inappropriate care. Agency staff did not have access to adequate information to provide safe, person-centred care to service users.Handover to agency staff was insufficient and no information was communicated about service users risks or preferences. Service users were not consistently administered topical creams as prescribed to meet their assessed needs. Service users were not protected from the risk of infection. Procedures to protect service users from skin pressure damage were not followed

The enforcement action we took:

Cancellation of registered manager.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and

	improper treatment Systems were not operated effectively to protect service users from abuse.

The enforcement action we took:
Cancellation of registered manager.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People did not always have access to nutrition and hydration.

The enforcement action we took:
Cancellation of registered manager.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises were not clean. There was a very strong odour of urine in the communal lounge and in some bedrooms. Bathrooms and toilets were not always clean. Furniture in the communal lounge was worn, dirty and odorous. Equipment such as stand aids and sensor mats were not clean presenting a cross infection risk.

The enforcement action we took:
Cancellation of registered manager.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to oversee the quality of the service were not operated effectively. Records were missing and inaccurate.

The enforcement action we took:
Cancellation of registered manager.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider had not displayed the most recent review of ratings on the premises.

The enforcement action we took:

Cancellation of registered manager.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Systems in place to oversee the quality of the service were not operated effectively. Records were missing and inaccurate.

The enforcement action we took:

Cancellation of registered manager.