Old Village Care Limited

The Old Village School Nursing Home

Inspection report

Bedford Road
Marston Moretaine
MK43 0ND
Tel: 01234 768001
Website:

Date of inspection visit: 08 and 10 June 2015
Date of publication: 05/08/2015

Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires improvement
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

This unannounced inspection took place over two days, on 08 and 10 June 2015. The service had been inspected using our ratings methodology on 22 July 2014 and had been rated as 'Good' in all of the five questions that we ask. Is it safe? Is it effective? Is it caring? Is it responsive? Is it well led? However, we had received information that had raised concern about the care that was being provided at the home and we determined that a further comprehensive review of the service was necessary.

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

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Summary of findings

• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration

The Old Village School Nursing Home provides a service for up to 60 people. The home is divided into three units providing personal and nursing care to older people and younger adults; including those with high care needs as a result of neurological conditions and those with end of life care needs. An on-site physiotherapy department provides some people with individual physiotherapy and rehabilitation programmes. At the time of the inspection there were 57 people who lived at the home.

The home had a registered manager. However, the registered manager had been absent from the home for more than a month at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People felt safe at the home and staff had received training on safeguarding of people. However, staff did not always know who to report any concerns to and appropriate referrals had not been made to the safeguarding authority.

Robust recruitment procedures were not always followed when recruiting permanent staff. Checks on the suitability of staff provided by agency services to care for and support people with highly complex needs was not checked. There were insufficient numbers of suitably qualified, competent staff at all times to provide appropriate care and support to people. Duty rotas did not accurately reflect the staff working on the day of the inspection.

There was induction programme provided for new permanent staff at the home, but agency staff were not given an induction. The effectiveness of the training provided was not monitored and there were language barriers between staff and the people they cared for.

Staff were not supported by way of regular supervision with their manager, although annual appraisals had taken place. The interaction between staff and people was caring and friendly, although people had mixed feelings about the care that they received. People's privacy and dignity were not always protected. People did not always receive the care they needed at the time that they needed or wanted it.

Personalised risk assessments were not always sufficiently detailed or accurate. Staff did not always know how to interpret them. Assistive technology designed to reduce the risk of harm to people was not always used when it was in place. People's medicines were not managed, stored or administered safely.

People received sufficient food to maintain their health and well-being, although staff did not always have time to ensure that people had drank sufficient fluids. People's food preferences were not always catered for. People's weight was monitored and referrals made to a dietitian when appropriate but these were not always made in a timely manner. People who received nutrition and hydration by way of percutaneous endoscopic gastrostomy (PEG) tube did not always receive this in the correct volumes or at the correct rate.

People's capacity to make and understand decisions was not always assessed and documented appropriately. Decisions made on people's behalf in their best interests were not always documented.

People were not supported to pursue their interests and hobbies. People and their relatives had been involved in the initial planning of their care, but were not involved in any reviews. Care plans had not been updated when people's needs had changed.

There was a system in place for people to make a complaint should they need to. People and relatives had been asked for their opinion as to the quality of the care provision and were encouraged to make suggestions for improvements.

There was no effective quality monitoring system in place.

During this inspection we identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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.

Appropriate referrals had not been made to the safeguarding authority when concerns of suspected abuse had been brought to the manager's attention.

People's medicines were not managed, stored or administered appropriately.

There were insufficient competent, suitably qualified staff to provide safe care and treatment to people.

Inadequate

Is the service effective?
The service was not effective.

Staff were not supported through regular supervision.

The effectiveness of staff training was not monitored.

The requirements of the Mental Capacity Act 2005 were not always followed.

Inadequate

Is the service caring?
The service was not always caring.

People's privacy and dignity were not always protected.

Staff were friendly and caring.

Requires improvement

Is the service responsive?
The service was not responsive.

People did not receive the care and treatment they needed at the times that they needed or wanted it.

People were not supported to pursue their interests and hobbies.

There was a complaints system in place, but no recent complaints had been recorded.

Inadequate

Is the service well-led?
The service was not well-led.

The registered manager had been absent from the home for over a month.

There was no effective quality monitoring system in place.

Inadequate

The Old Village School Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 08 and 10 June 2015, and it was unannounced. The inspection team was made up of two inspectors, an inspection manager, a specialist advisor, who was a qualified nurse, and an Expert by Experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information available to us about the home, such as notifications. A notification is information about important events which the provider is required to send us by law. We also reviewed information about the home that had been provided by staff and members of the public.

During the inspection we spoke with 11 people who lived at the home, four relatives of people, four nurses and 12 care staff, one cleaner, one of the contracted cooks, the regional manager, the two deputy managers and the providers. We carried out observations of the interactions between staff and the people who lived at the home and we also used the short observational framework for inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We reviewed the care records and risk assessments for six people, checked medicines administration records on the three units and reviewed how complaints were managed. We also looked at eight staff records, the training and supervision schedules for all the staff and staff rotas. We reviewed information on how the quality of the service was monitored and managed.

Inadequate

Is the service safe?

Our findings

People who lived at the home told us that they felt safe. One person told us, "I feel totally safe here. You've got your own room, Yes I definitely feel safer. Safer than when I was in the hospital." Another person told us that they felt safe as they had not had any falls or accidents since living at the home. However, during our inspection we identified issues that meant people may not be always safe at the home.

Staff told us they had received safeguarding training and they were able to talk about various types of abuse. All said they would report bad practice to the management if they witnessed it. However, one member of staff said, "With all the staff changes it is difficult to know who to tell." We were aware that, following an investigation by the local authority, a number of instances of suspected abuse had been identified and reported to the manager, but appropriate action had not always been taken and referrals to the safeguarding team had not been completed.

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

The manager had also failed to notify the CQC of the allegations of abuse that had been brought to their attention.

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

We saw that care records included personalised risk assessments for each person and actions to be taken by staff to reduce the risk of harm to people. These included the risks associated with people being assisted to move around the home, the risk of falling and the risk of them developing pressure related areas on their skin. However these were not detailed enough, such as the size of sling to be used when people were transferred using a hoist, or staff were not fully aware of how to interpret the information, such as people's risk of developing pressure areas, in order to provide the appropriate care.

On the first floor, six people did not have call bells and put them at risk of being unable to summon help if they needed it. The reasons for this were not detailed in any risk assessment. We saw that, for some people, assistive technology had been put in place. However it was not being used when we checked during our inspection. This showed that the actions identified in the risk assessments to reduce the risk of harm to people were not routinely followed.

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

Whilst walking around the home we noted that the door to a sluice room and the door to the laundry were open for periods during which the rooms were unattended. This presented a risk of people entering the rooms and suffering injury.

We saw that there were first aid boxes held with the staff office for use in case of an emergency. The documentation in one box stated that the contents had last been checked in June 2014. The second box held no documentation to confirm when the contents had been checked. Both boxes contained syringes which were inappropriate in a first aid kit.

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

Not all staff were appropriately checked for their suitability to work before commencing employment. For one member of staff, the records we saw showed that their application form and relevant checks had been completed on the day that they started work. The initial response from the Disclosure and Barring Service (DBS), an organisation that checked whether staff were safe to work with vulnerable people, was only received during the member of staff's second day of working at the home.

We also saw that a care worker had changed their role to that of a nurse, having registered with the Nursing and Midwifery Council (NMC) from 24 March 2014. However, they had not signed a contract of employment until 27 April 2015 and their file did not include a job description for their new role.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that there were insufficient staff available to care for them and as a consequence they were getting up later than they wished. One person told us, "They're so short staffed at the moment. They do get short staffed at times but they come and tell me if they are going to be late."

Inadequate

Is the service safe?

Another person said, "They are short of staff."

We found that people had complex nursing needs and the nursing interventions they required were not always completed in a timely way for example; management of food and fluids for people who received these via a percutaneous endoscopic gastrostomy (PEG) tube, pain relief at the times required, day to day medicines management and updating care plans. One nurse told us, "The skill mix here is all wrong. There are too many youngsters." They went on to say, "There is inadequate staffing and there is four to five patients needing frequent suctioning and one trained nurse cannot manage this." Some other staff also told us that there was insufficient staff. The cleaner told us that they too were struggling because of reduced staffing. They were happy to do some additional hours as was needed but that this could not be sustained. The activities coordinator told us that the staffing for activities had been cut by 60% which meant that there was now insufficient time to support people with their interests and hobbies.

Because of the way staff were deployed throughout the home, people were often unattended in communal areas. For example at the end of lunchtime when staff were supporting people in their bedrooms, we saw a person using a knife to eat their soft pudding. The knife had a slightly serrated edge and could have caused a cut. We helped this person to pick up a spoon and removed the knife for their safety.

We were shown duty rotas but found them difficult to read and to determine whether the staffing levels were sufficient to meet people's needs safely. The rotas had been amended considerably due to sickness and other staff changes and did not accurately reflect the staff on duty. For example on each unit, the rotas suggested two of the staff were trained nurses when in fact there was only one nurse on each. We checked the rotas on each unit for 08 June 2015 and found that on one unit the nurse recorded on the rota was different to the one on duty. We were told this was because of sickness and the rota had not been updated by the time we looked at it.

We were told, and the rotas confirmed, that there was a high number of agency staff used by the home. When we asked the provider to explain how they ensured that the nurses and care workers had the skills needed to provide for the complex needs of many of the people who lived at the home, they told us that no checks were made. They took whichever staff was supplied by the agency. Many of the people who lived at the home had very high needs, such as tracheotomy care, and not all nurses who worked for an agency would have the skills needed to meet these effectively.

We concluded that there were insufficient skilled staff to provide the care and support that people needed. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always provided with the medicines as prescribed as stocks were not managed. The systems in place to monitor the supply and administration of medicines could not be audited because of poor recording and it was not possible to check if the stocks of medicines held in the home were accurate. The home held a 332 day supply of one controlled medicine. There were missing staff signatures on medicine administration records (MAR) that confirmed staff had administered the prescribed medicines and there were no robust audit systems established to identify these errors. Staff administering medicines did not always check that the person had taken them.

Many of the MAR sheets did not include a photograph of the person. This was particularly significant because of the high use of agency nurses leading to an increased risk of people being given the wrong medicines. Staff did not routinely record the dose given when a variable dose was prescribed, such as when a person was prescribed a painkiller which could be given as one or two tablets as long as no more than eight were given in 24 hours. Without knowing the exact dose given the person was at risk of being over medicated or denied pain killing treatment if needed. Daily notes in care records indicated that homely remedy creams were applied but these were not recorded on people's MAR sheets.

Staff did not routinely write on the dates when boxes and bottles of medicines were opened even though some medicines, such as eye drops, have to be discarded within a certain time after having been opened. Medicines were not stored safely. Medicines for two people had been left unattended on a table in a communal area and one nurse left an unlocked medicines trolley unattended on one unit. This was brought to the deputy manager's attention who then spoke with the nurse concerned. However, this happened again later in the day and anybody passing the trolley could have accessed the medicines within it.

Inadequate

Is the service safe?

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

We saw that, where doubts as to a member of staff's suitability to continue to work in the role in which they had been employed had been identified, suitable steps had been taken to address them. These had included the suspension of the member of staff, an investigation of the concerns and subsequent disciplinary action.

Inadequate

Is the service effective?

Our findings

People and relatives told us that staff had the skills to care for them. One person told us, "I'm in the right hands here. I knew they'd get my tummy right." A relative said, "[Relative] has been a lot better since they've been here. They are looking after [relative] alright."

There was no induction process in place for agency staff who provided a large number of hours supporting the home. An agency nurse on a unit for people with high care needs told us, "I have never had any induction on this unit and at times I have to find out myself who is diabetic and who is not."

We spoke with one care worker who confirmed that they had received training on safe moving of people in March 2015. However, during our inspection we observed them working with another care worker to assist a person to move from their bed to a wheelchair using a hoist. They were unsure of how to use the hoist and their colleague had to remind them what to do. This showed that the training they had received had not been effective.

We asked one member of staff if they had regular supervision meetings with their manager. They were unable to answer and said, "I'm find it hard to understand." When we explained what supervision was, that is an opportunity to discuss their performance and training needs as well as any other issues they had, they were still unable to understand and told us that the management had allowed them to work as many hours as they needed to. A nurse told us that they received supervision, "… on a daily basis." One care worker told us, "We have supervision and can talk about issues but they don't always happen and you don't know who your supervisor is going to be, so it is difficult to follow up on things." The staff files we looked at showed that staff had received supervision only sporadically, with one file indicating that there was a gap of over 27 months between the dates of supervision meetings. There was evidence in staff records that showed appraisals had taken place during 2014, at which staff had been able to talk about their training and developmental needs.

A nurse told us that everyone living at the home could communicate verbally but they would use non-verbal methods to communicate if this was needed, such as visual aids. However, during our inspection we noted that some people could not understand when staff tried to communicate with them verbally. We saw a care worker asking someone who could not communicate about their meal choices, but no visual aids were used to explain the choices available to them. One care worker we spoke with was unable to fully understand the questions we asked of them. When asked about emergency procedures they told us, "I call the nurse, but I'm still trying to learn, but it's hard due to language barrier." We ended our interview with them due to their lack of understanding of English. As the majority of people who lived at the home spoke only English, the care worker's ability to communicate with and understand the needs of the people they cared for was restricted and could result in people not getting the right care.

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

There were mixed opinions about the food that people were given. One person told us, "The food is very good." However, another person said, "I don't like some of the food here. Some of the food puts me off."

Each day people were offered a choice of a meat or a vegetarian option. However, on two of the three units, people were expected to make their meal choices on a weekly basis and many people were unable to remember what they had chosen to eat when their meals were served. We saw that people did not always enjoy their meal. One person who had opted for the vegetarian meal of stuffed peppers told us, "The pepper is not cooked." We observed that the pepper was very hard.

We saw that staff supported some people to eat their meals. However, not everybody who required this received it and we saw one person eating their meal with their fingers before being given a spoon to eat it with. One person who had been assisted to eat their meal complained that the care worker who had assisted them got up a couple of times to check on other people and as a consequence their meal was cold when they ate it. We also noted that some people had their meals placed on tables over their chairs and they had to stretch to reach their food. The atmosphere in one dining room was busy with care staff moving through the room to take meals to people who were eating in their rooms. At the same time the cleaner was manoeuvring equipment and bags across the room. This did not enhance the eating experience for people.

Inadequate

Is the service effective?

The care workers, instead of the kitchen staff, had recently been given the responsibility to ensure that people had drinks throughout the day in order to prevent dehydration because of the risk of some people choking. One member of the care staff told us that this added to their pressure, They said, "We give drinks but if we are busy it is difficult [to find time to do so]." This meant that some people had to wait to have a drink until a member of the care staff was available to get it for them.

We noted that people's weight was monitored and referrals were made to the GP or dietitian as necessary. However, this was not always done in a timely manner. We noted that one person's weight had dropped and a note was put on their record on 4 June 2015 to contact the dietitian. However, this had not been done by 10 June 2015..

People who received food and fluid via percutaneous endoscopic gastrostomy (PEG) tube did not receive their food at the correct rate and regularly received too little fluid which was not given at the times that their care plan specified. One person was recorded as receiving only 200 mls of fluid one day instead of the 1100mls that they should have had. PEG feed supplement was stored on the window sill in one bedroom. The instruction on the food supplement stated it should be stored in a cool dry place and it may therefore have been damaged by being stored inappropriately.

The failings to ensure people had sufficient food and fluids was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had received training on the requirements of the Mental Capacity Act 2005, and the associated Deprivation of Liberty Safeguards. Some people's capacity to make and understand the implication of decisions about their care were assessed and documented within their care records. However, other care records showed that cursory decisions had been made as to people's capacity to make decisions. We noted that in one record there was a statement, "[Name] does not show mental capacity to make decisions." There was no assessment to evidence this statement within their care records or any record of decisions that had been made to provide care in their best interests.

For some people who lacked capacity to make key decisions about their life and support there were no assessments in place to indicate who had the authority to make these decisions on their behalf. Key decisions were not appropriately recorded within the correct legal framework with forms being signed by individuals who did not have the legal authority to do so. We raised this with the regional manager and the provider on 08 June who acknowledged that further work was needed to address this. We saw that best interest decisions had been made on behalf of some people following meetings with relatives and healthcare professionals and were documented within their care plans. Authorisations of deprivation of liberty were in place for some people who lived in the home.

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

Staff told us that they received induction training when they started work at the home. One care worker told us, "Yes, I had five days induction shadowing." Another care worker told us that they had received training on safeguarding and moving and handling working at the home in February 2015. We were shown the new induction training plan and records that had been recently introduced. Three care workers were currently working their way through the plan.

Staff had on-going training, which included medicine management, moving people and nutrition. During our inspection staff were receiving training in Dignity In Care. We saw that agency staff had been used to cover for staff who were attending this training session. One member of staff told us, "We get good training here to help us do our work." Another member of staff said, "The moving people training was good because the trainer used our equipment and our rooms and made it real for us."

People told us that they were offered choices as to their day to day lives, such as what clothes they wore. One person told us, "They get something out of the wardrobe and I say "Yes that's okay." We saw that care records included signed documentation to evidence people's agreement with the care to be provided. We observed that staff talked with people and asked for their consent before providing any care or support to them.

We spoke with the cook who told us that care workers provided the information about people's specific dietary needs and of any changes to people's diets. The cook told us that they checked the notes and ensured that the meals for people with allergies were prepared separately. Low

Inadequate

Is the service effective?

sugar cake mixes were used to make cakes and desserts for people living with diabetes. They told us of one person who requested a cheese omelette every day, which was provided for them.

We saw that people were assisted to maintain their health and well-being. Care records showed that referrals to other healthcare professionals, such as the GP, district nurse and dieticians were made on people's behalf when required.

Requires improvement

Is the service caring?

Our findings

People had mixed feelings about the care they received. One person told us, "The care here is nil, management is to blame." However, another person told us that the staff, "…are very good." A relative told us, "I think it's generally very good. We wouldn't consider moving [relative] to another home." One person told us, "The girls here are brilliant."

We observed the interaction between staff and people who lived at the home and found this to be friendly and caring. A member of the care staff said, "We know our patients well so we get on with the work."

People told us that they had been involved in planning the care they needed in discussion with the manager and sometimes their relatives had been involved. One person told us, "I have physio here. It's fantastic."

People told us that their privacy and dignity were protected. One relative told us that their relative always looked clean and well-dressed when they visited. However, one person told us that they were distressed as their finger nails were very dirty and they could not manage to clean them on their own. We observed that staff knocked on people's doors before entering their rooms but the doors of the majority of rooms were left open whilst people were in their beds, which afforded them little privacy. However, we saw that doors were closed when people were being supported with their personal care . On some units, screens were used when people were supported to move using a hoist but this was not always done on one unit. Although staff made sure that the person was covered properly, screens were not used which allowed other people in the lounge to watch, which gave the person little dignity.

Staff told us how they maintained the confidentiality of the people who lived at the home. One member of staff told us, "I do not give any information to anyone, maybe just family members if it's okay." Another member of staff said confidentiality was to, "Keep vital information and convey it to those who are supposed to know it, making sure that anyone receiving the information is legally supposed to have it, and if not then it is not given."

People told us that their friends and relatives could visit them at any time. One person told us, "They can come any time they like here. They just ring up and it's alright."

People were given the information they required in a format they understood. We saw that in the entrance hall there was a notice board that contained information for people and visitors about the home and local contacts, such as for the safeguarding authority. People were also provided with a Service User Guide which detailed the services provided at the home, including the additional services such as hairdressing, reflexology, physiotherapy, aromatherapy and chiropody. It detailed the core values of the service and introduced the staff at the home.

Inadequate

Is the service responsive?

Our findings

People told us that they did not receive the care and support they needed at the times that they wanted it. One person told us that they were getting up later in the morning than they wanted to with times varying from 10.30 am to mid-day. We noted that when we entered one of the units an alert that someone had pressed their call bell was sounding. We noted that it took more than 20 minutes for the call bell to be answered. There were no care staff visible on the unit. The person was very uncomfortable throughout this time and needed to be moved. The care worker explained to the person that they would have to wait longer for support with their personal care as the unit was short of staff, but they made the person more comfortable in the meantime. On another unit we observed that it took in excess of five minutes for a call bell to be responded to.

People told us that they were not supported to maintain their hobbies and interests. One person told us, "I just sit here. You're sitting in the lounge looking at people and that's all. I think they should have more activity like music or someone singing. There's not enough." Another person said, "I'd rather go out. They haven't got time really to listen to music. You just have to make the best of it."

We spoke with the activity coordinator who told us that they provided group activities in the morning and worked one to one with people in the afternoon. They told us that there used to be two full time activity coordinators and one who worked part time, but now there was just one to provide support to the 57 people who lived in the home across the three units. People were not able to be supported to go out from the home because of this. On the day of our inspection we saw that the coordinator had organised a film show for people on one unit. People who were able to attend from other units had been invited to join in. However, many people were cared for in their beds so were unable to attend the show.

Minutes of a meeting held by the activity coordinator in May 2015 with people who lived at the home showed that suggestions made by people for themes for a garden party to be held in July this year had been dismissed by the activity coordinator either on the grounds that the theme had been done before or that the suggestion would prove too costly. People were also told that there would be fewer stalls at the garden party than in previous years as it was too expensive for staff to be employed to run them. Similar requests by people for outings had been met with a response that group outings were too expensive, based on costings obtained a few years ago.

We carried out an observation in one lounge for 30 minutes. During this time, staff spoke to only one of the three people in the lounge for only a minute or so. Staff told us they were too busy to sit and talk with people. One member of staff told us, "We talk to people when we give care but we have little time to sit and talk. If there were more staff we could do that."

Records in one care plan indicated that the person would benefit from pain relief given 30 minutes prior to personal care being provided. However the medicines administration record showed that the medicine was given four times a day, but not in line with when personal care was provided.

A nurse told us, "We don't have time to do everything so we have to prioritise. For example, I would do a dressing rather than updating a care plan." An updated care plan had been introduced in May 2015 and existing care records were being transferred to the new style. The new care plans were individualised to reflect people's needs and included clear instructions for staff on how best to support people with specific needs. However care plans had not been reviewed regularly and we saw that some had not been reviewed for more than three months. The care plan for one person who had moved from another home contained a photograph of them that had been taken at a previous home. Another care record had not been updated following a person's discharge from hospital a week earlier to reflect a revised medicine regime and the person had continued to have medicines administered after they had been stopped by the hospital.

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

People and their relatives told us that they had been involved in deciding what care they were to receive and how this was to be given. They had been visited by the manager who had assessed whether the provider could provide the care they needed before they moved into the home. The care plans followed a standard template which included information on their personal history, their individual preferences and their interests. One relative told us that they were aware of their relative's care plan but

Inadequate

Is the service responsive?

were not aware of any reviews of this. Another relative said that they had sat down with a member of staff and gone through their relative's care plans. We saw that the regional manager had recently introduced 'snap shot' care plans that staff could easily refer to for 'at a glance' basic information on the care and support that each person needed.

People told us that they were aware of how to make a complaint but had not done so. One person told us, "I'm quite happy dealing with the lower people because they will get you what you want." They went on to say, "If you want to make a complaint you write to the boss. They have new staff but they are here every day on site. I would just write them a little note to ask them to put things right." Another person told us that they had made any complaint but they would tell the care staff if they were not happy about something. A relative told us, "I have no problem with the staff here at all."

There was an up to date complaints policy in place and a notice about the complaints system was on display in the entrance of the home. A recent questionnaire given to people who lived at the home showed that all of the 26 people who responded were aware of the complaints system. There were no records of complaints received available for us to check whether the complaints system was effective.

Inadequate

Is the service well-led?

Our findings

The registered manager, who is also the provider's nominated individual and responsible for the day to day operation of the service, had been absent for over 28 days at the time of our inspection. The home was being run by the provider's regional manager with the support of two recently appointed deputy managers. One deputy manager had clinical responsibilities, as well as, supervising the staff. It was noted that during their informal interview, they had told the provider that they would need support in developing the auditing side of the role. This had not yet been provided.

The visions and values of the provider where not communicated to staff by the registered manager who operated in isolation from the rest of the provider's services. The lack of supervision and day to day management meant that staff were not supported or listened to. We saw that meetings in which staff could be involved in the development of the home had been re-introduced in May 2015 following a break of nine months. Separate meetings had been held on each unit during the month of May 2015. The minutes of these showed that all areas of the service provided had been discussed, including staffing, communication, recent safeguarding incidents, rotas, training and equipment. The minutes reflected that staff had been scared to document when there had been a problem. The minutes of the staff meeting held on one unit indicated that malpractice had been embedded on the unit and when concerns had been raised these had been ignored by the registered manager.

We saw that people and relatives had completed satisfaction surveys in which they had been asked to contribute suggestions about ways in which the home could be developed and the service improved. We noted that the action plan following the relatives' survey had indicated that action had been taken to reduce the draught from the access doors to the garden. However, on the day of our inspection the doors to the garden were open and a cold draught could be felt down corridors and in people's bedrooms. One person who was in bed in their room complained that they were cold and was covered with a blanket. This showed that, if action had been taken to implement suggestions made by relatives, the effectiveness of that action was not monitored.

Staff were not always clear about their roles and responsibilities. One member of staff told us, "We are pulled in all directions and sometimes don't know what we should be doing." Some staff were also unclear as to whether there was a whistleblowing policy in place. Whistleblowing is a way in which staff can report misconduct or concerns within their workplace. One member of staff, when asked if the service had a policy, said, "Possibly we have."

The clinical commissioning group had provided significant input into the home to lever improvements and a pharmacist had visited to support changes in the medication system. However we found that these improvements had either not been sustained or in some cases had been ignored. The regional manager told us that following recent visits they were introducing a new internal auditing system as the one that had been in place was ineffective. This was not yet fully in place.

Representatives of the provider spent considerable time at this service however the regional manager told us that systems in place in other homes run by the provider group had not been introduced into this home by the registered manager. There was no recent documentary evidence of checks on the quality of care having been made and the provider was unable to account as to the reasons why this had been the case. We saw from staff files that observations of how care had been delivered had been carried out as part of the supervision process, but as supervisions had not been taking place on a regular basis, these checks had also not been completed.

It was evident from the information collected and observations during the inspection process that out dated and unacceptable practices by some staff were deep rooted and were part of the accepted day to day practice. Governance systems had not identified these issues and had not addressed the issues being raised by external professionals, staff and importantly people using the service.

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

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People did not receive the care they needed at the time they needed it Regulation 9(1) and the care and treatment provided was not always appropriate Regulation 9(2) and were not reviewed regularly Regulation 9(3)(a)

The enforcement action we took:
The service was placed into special measures. Special Measures provides of a framework within which CQC uses its enforcement powers in response to "Inadequate" care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The provider did not always act in accordance with the Mental Capacity Act 2005 with regard to consent to care and treatment where people did not have the capacity to make or understand decisions for themselves. Regulation 11(3)

The enforcement action we took:
The service was placed into special measures. Special Measures provides of a framework within which CQC uses its enforcement powers in response to "Inadequate" care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Actions identified to mitigate risks were not always followed Regulation 12(2)(b).

The enforcement action we took:
The service was placed into special measures. Special Measures provides of a framework within which CQC uses its enforcement powers in response to "Inadequate" care.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People's medicines were not available at all times Regulation 12(2)(f) People's medicines were not managed properly and safely Regulation 12(2)(g)

The enforcement action we took:
We have taken enforcement action and will report on it when the action is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Incidents of suspected abuse were not always investigated and referred to the safeguarding authority Regulation 13 (3)

The enforcement action we took:
The service was placed into special measures. Special Measures provides of a framework within which CQC uses its enforcement powers in response to "Inadequate" care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs There was insufficient hydration provided to people who received foods and fluid via a percutaneous endoscopic gastrostomy (PEG) tube Regulation 14(4)(b) and the provider failed to meet the reasonable requirements arising from service user's preferences Regulation 14(4)(c)

The enforcement action we took:
The service was placed into special measures. Special Measures provides of a framework within which CQC uses its enforcement powers in response to "Inadequate" care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

This section is primarily information for the provider

Enforcement actions

The access to areas which presented a risk to people was not appropriate Regulation 15(1)(b) and equipment used in relation to emergencies was not properly maintained. Regulation 15(1)(e).

The enforcement action we took:
The service was placed into special measures. Special Measures provides of a framework within which CQC uses its enforcement powers in response to "Inadequate" care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance There was no effective system in place to assess, monitor and improve the quality of the service provided Regulation 17(1) and (2)(a)

The enforcement action we took:
The service was placed into special measures. Special Measures provides of a framework within which CQC uses its enforcement powers in response to "Inadequate" care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing There were insufficient numbers of suitably qualified, competent staff to meet the needs of people. Regulation 18(1) Training was not monitored for effectiveness and supervision meetings were not held regularly to support staff. Regulation 18(2)(a)

The enforcement action we took:
The service was placed into special measures. Special Measures provides of a framework within which CQC uses its enforcement powers in response to "Inadequate" care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

This section is primarily information for the provider

Enforcement actions

The required checks of person's suitability to be employed to work with vulnerable people had not been completed before they started work at the home. Regulation 19(1)(a)

The enforcement action we took:
The service was placed into special measures. Special Measures provides of a framework within which CQC uses its enforcement powers in response to "Inadequate" care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered manager had failed to notify CQC of allegations of abuse in relation to a service user. Regulation (18)(2)(e)

The enforcement action we took:
We have taken enforcement action and will report on it when the action is complete.