Qu'Appelle Residential Care Home Limited

Qu'Appelle Care Home

Inspection report

Harrington Street
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Lincolnshire
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service:
Qu'Appelle Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. The home is registered to provide accommodation for up to 36 people, including people living with dementia. There were 31 people living in the home on the first day of our inspection. The registered provider also offers day care support in the same building as the care home although this type of service is not regulated by CQC.

People's experience of using the service:
• People were not receiving safe, effective, caring, responsive or well-led care.
• We found ten breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because of shortfalls in organisational governance; a failure to appoint a person with the necessary skills and experience to manage the home; a failure to properly assess and mitigate risks to people's safety; a failure to ensure sufficient staffing to meet people's needs and keep them safe; a failure to ensure people's nutritional and hydration needs were properly met and monitored; a failure to ensure staff had the skills and knowledge to support people safely and effectively; a failure to obtain proper consent to care and treatment; a failure to consistently treat people with care and compassion and promote their privacy, dignity and respect; a failure to support people in a consistently person-centred way and to meet their needs for mental and physical stimulation and a failure to properly display the rating of our previous inspection of the home. We also found one breach of the Care Quality Commission (Registration) Regulations 2009 due to a failure to notify us of significant issues involving the people living in the home.
• In other areas, the registered provider was also failing to provide people with the service they were entitled to expect. The provider's approach to safeguarding was ineffective; there was no evidence of effective organisational learning; internal communication required improvement; complaints were not managed in a systematic way; staff morale was low and people's feedback on the running of the home was not listened to.
• In a small number of areas, the registered provider was meeting people's needs. End of life care was provided in close consultation with specialist agencies; people were supported to access to a range of local healthcare services; there were some links between the home and the local community and some refurbishment of the home had taken place since our last inspection. To their credit, staff at all levels were admirably candid in providing feedback on their experience of working in the home.

Rating at last inspection:
Good (Published August 2017)

Why we inspected:
This inspection was scheduled in response to concerns shared with CQC by the local authority safeguarding and contract monitoring teams following their recent visits to the home. At this inspection we found service quality had deteriorated sharply. As result, the rating of the home is now Inadequate and the home is

therefore in 'Special Measures'.

Enforcement:
We are currently taking action against the registered provider to ensure that they make the necessary improvements to become compliant with legal requirements. Full information about the CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up:
We will continue to monitor intelligence we receive about the home until we return to visit as per our re-inspection programme. If any concerning information is received we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our Safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our Effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our Caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our Responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our Well-Led findings below.

Qu'Appelle Care Home

Detailed findings

Background to this inspection

The 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 checked 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.

Inspection team:
Two inspectors, a specialist adviser whose specialism is nursing 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.

Service and service type:
Qu'Appelle Care Home is registered to provide accommodation and support to up to 36 people, including older people and people living with dementia.

The home did not have a registered manager. A registered manager is a person who has registered with CQC to manage the service. Like registered providers ('the provider') they are 'registered persons' who are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
The first day of our inspection was unannounced. The second day was arranged in agreement with the manager.

What we did:
In planning our inspection, we reviewed information we had received about the service since the last inspection. This included any notifications (events which happened in the service that the provider is required to tell us about). We also reviewed feedback we had received from the local authority safeguarding and contracting teams. On this occasion, we had not asked the provider to send us a Provider Information return (PIR) in advance of our inspection. A PIR is a form that asks the provider to give some key information about the service. This includes what the service does well and improvements they plan to make. However,

during our inspection we offered the provider the opportunity to share information they felt was relevant.

During our inspection we spoke with six people and two visiting family members or friends to ask about their experience of the care provided. We also spoke with the manager, the assistant manager, the kitchen manager, two care staff and one local healthcare professional.

We reviewed a range of written records including seven people's care plans, four staff recruitment files and information relating to the administration of medicines and the auditing and monitoring of service provision.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

People were not safe and were at risk of avoidable harm. Some regulations were not met.

Staffing

•Staffing levels were insufficient to meet people's needs and keep them safe. The provider had identified the required number of care staff as being six on the early shift; five on the late shift and three on the night shift. On the first day of our inspection we reviewed actual staffing numbers on 21 days in the period 18 February – 17 March 2019 and found there were 13 occasions when there had been only two staff on the night shift. This meant there were only two care staff members in the building after 8.45pm to support and supervise 31 people. As there were at least 12 people who required 2:1 support, this meant there were occasions when up to 30 service users were unsupported or supervised. One person said, "At night if I need someone …. someone usually comes. But not always, and then I wonder what am I going to do?" Additionally, on almost half of the 21 night shifts we reviewed, the provider had failed to ensure a senior care assistant or team leader was deployed. This meant people could not receive 'as required' pain relief medicines after 8.45pm, as there was no staff member in the building with the requisite training to administer medicines.
•We also identified numerous occasions in the period 18 February – 17 March 2019 when there had been less than six staff on the early shift and less than five staff on the late shift. Commenting on the staffing levels in the home, one staff member told us, "It's not safe for us and it's not safe for [the residents]. When we are short-staffed we only do … the basics. We don't have time to pay attention." Another staff member said, "The weekends are a nightmare. We are lucky if there are four staff on [the late shift]. We've done the afternoon with three." The assistant manager told us, "There are times when … staffing levels are not safe."
•People told us of the negative impact the staffing shortages had on their health and well-being. For example, one person said, "The home could do with more staff as they seem very short and I have to wait for help." A staff member told us, "Call bells are ringing longer than they should be. Sometimes … when people are waiting to go to the toilet … we get there too late and they've already [passed faeces or urine]." Another staff member said, "We are always making them wait … to go to the toilet. We don't have enough carers." People also told us that the staffing shortages meant they could not always get up or go to bed at a time of their choosing and that they received insufficient baths or showers. We looked at the provider's 'bath days' rota and some people's daily care records for the six weeks preceding our inspection. For some people there was no record of any bath or shower in the six-week period. For others, only one bath or shower had been recorded. One person told us, "I don't think I can have a bath or a shower here." A staff member commented, "[We have] no time to [give people] a bath or shower as often as I would like."
•The staffing shortfalls also resulted in some people not being repositioned in bed in accordance with the requirements of their care plan. For example, one person had been assessed as requiring three hourly turns, day and night. However, in the period 16 – 18 March 2019 we found two instances when their 'position recording sheet' indicated they had not been repositioned for over six hours, increasing the risk of damage to their skin. Commenting on this issue, the assistant manager told us, "[Repositioning] is very irregular …

currently. Because there is not enough staff. It does alarm me."
•□The provider's failure to ensure sufficient staffing to meet people's needs and to keep them safe was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Using medicines safely; Preventing and controlling infection; Recruitment

•□The provider had failed to assess and mitigate a wide range of potential risks to people's safety and welfare.
•□We identified significant shortfalls in the care planning system which meant potential risks to people's safety had not been properly assessed and reviewed. For example, one person had been admitted to the home almost six weeks before our inspection but no care plan or individual risk assessments had been completed. Staff were reliant on information obtained before admission, increasing the risk that the care provided might not meet the person's current needs. When we looked at other people's care records we found many care plans had not been reviewed since September 2018. As a result, much of the information was out of date and did not reflect people's current support requirements. Similarly, where individual risk assessments had been completed, these had not been updated nor action taken to reflect changes in people's circumstances. For example, one person had been assessed as being at low risk of falls. The last falls risk assessment had been completed in December 2018. Since then the person had been found on the floor on at least two occasions, having apparently fallen. However, there was no evidence that action had been taken to reduce this risk. Similarly, another person was being cared for in bed but their monthly skin integrity risk assessment had not been completed since September 2018, increasing the risk of damage to their skin.
•□We identified numerous safety hazards in the building. We found an unlocked storage cupboard on a communal corridor which could have been accessed by the people living in the home, some of whom were living with dementia. Inside we found several potential safety hazards including disposable razors and denture cleaning tablets marked 'harmful if swallowed'. In an unlocked communal bathroom, we found a shelf with baskets containing people's personal toiletries and medicines. These included a tube of skin cream marked 'for external use only'; a tube of maximum strength ibuprofen; steroid cream and more denture cleaning tablets – all of which could have caused harm if swallowed.
•□We found another unlocked cupboard containing an electrical fuse box. The cover of the fuse box was also unlocked, creating a potential risk to anyone accessing the cupboard. A heavy fire extinguisher in the conservatory had become detached from its bracket and was standing loose on the floor, creating the risk of injury should someone knock it over or attempt to pick it up. A gate had been installed at the bottom of the main staircase to prevent people having unsupervised access to the stairs. However, the lock was faulty meaning the gate was unlocked at times. Additionally, the lock on the gate at the top of the staircase could be bypassed and we observed one person open the gate and attempt to access the stairs independently. In one communal bathroom, the call bell could not be reached from the shower, making it harder for someone to summon assistance in an emergency.
•□We also identified shortfalls in the provider's management of people's medicines. Medicines were administered by senior carer assistants and team leaders but no recent assessments had been completed to ensure they were competent to undertake this task safely and effectively. On the first day of our inspection, we found a tin of fluid thickening powder in the main lounge which had been left unattended by the staff member conducting the morning medicines round. When we alerted senior staff to this issue, they confirmed they were unaware of the NHS patient safety alert issued in February 2015 following the death of a person in a care home which instructed 'all providers of NHS funded care where thickening agents are prescribed, dispensed or administered' to ensure arrangements were in place to ensure appropriate storage of thickening powder by 19 March 2015.

•□We reviewed people's medicine administration records (MARs) and found one person had missed a dose of a prescription medicine on 18 March 2019, as they had slept late that day. Their MAR stated that they did not have their morning dose until almost lunchtime and that the lunchtime dose was omitted. There was no evidence to indicate staff had sought advice from the GP or pharmacy about whether the lunchtime dose should be given or omitted, creating a potential risk of harm. Commenting on the poor medicines administration practice of some staff, one person told us, "They don't stay with me to make sure I take them. They are under a lot of pressure."
•□The provider had failed ensure a systematic and effective approach to preventing and controlling the spread of infection. In one communal toilet we found a used incontinence pad in a domestic style bin clearly labelled 'No soiled pads in this bin please'. On two separate occasions we found unsealed clinical waste in open bags on a housekeeping trolley. The paintwork on skirting boards in some communal corridors was worn and chipped making it harder to clean effectively. Throughout the home, push panels on doors were dirty, increasing the risk of cross contamination. One of the buttons in the lift had been covered up with two medicine pots and duct tape. The tape was frayed and dirty, creating a further risk of cross-contamination. We found bed bumpers and mattress protectors which were still in use lying on the floor of one communal bathroom. In another communal bathroom, access to the hand basin was blocked by wheelchairs and other equipment, increasing the risk of poor hand hygiene by anyone using the room. We reviewed the provider's 'daily cleaning' schedule for the kitchen and found this had only been recorded as having been completed on eight out of twenty one days in the period 1 – 21 March 2019.
•□We also found that the provider's staff recruitment procedures were not consistently safe. For example, when we reviewed the file of one staff member we found no evidence that references had been obtained prior to them commencing their employment. Similarly, for another member of staff there was no evidence that the person had the necessary DBS clearance to work with vulnerable adults. These shortfalls increased the risk of unsuitable staff being employed to work in the home.
•□Taken together, the provider's failure to properly assess and mitigate risks to people's safety was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

•□There was no evidence to indicate the provider had effective systems to promote organisational learning from significant events. For example, as described above, in one unlocked communal bathroom we found baskets containing people's personal toiletries and medicines, some of which would have been harmful if swallowed. Staff told us these items had been moved to the bathroom following an incident in which a person had swallowed bubble bath in their bedroom. However, the action taken to move the items had actually increased the risk to other people living in the home.

Systems and processes to safeguard people from the risk of abuse

•□The provider's approach to safeguarding was ineffective, creating further potential risks to people's safety and welfare. For example, when we reviewed the provider's 'training matrix' we found that over half the staff employed in the home had no record of having received safeguarding training. Additionally, the 'service user guide' given to people when they first moved into the home had no information on how to raise a safeguarding alert with relevant organisations, should this ever be necessary. Three members of staff had been identified as 'safeguarding leads' but the assistant manager acknowledged this was "more of a token role".

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

Supporting people to eat and drink enough with choice in a balanced diet

•□The provider had failed to ensure people's nutritional and hydration needs were properly met and monitored, creating an increased risk to their health. For example, on the first day of our inspection, one person was admitted to hospital on an emergency basis. We reviewed this person's food and fluid recording sheet and found that in the 53 hours preceding the decision to call for emergency assistance, staff had recorded fluid intake of no more than 400ml and some sips of tea. In the 27 hours preceding the decision to call for emergency assistance, staff had also recorded on eight consecutive occasions that the person's incontinence pad had been dry of urine. There was no indication that this information had been escalated to senior staff, or that any other intervention had been considered prior to the decision to seek emergency assistance. The person spent five nights in hospital being treated for an infection, something that might have been avoided had staff acted more promptly and professionally in response to the sharp drops in their fluid intake and passing of urine.
•□Another person had lost over 9% of their body weight in the 12 months to December 2018 and, as a result, staff were monitoring their food and fluid intake on a recording sheet. On the first day of our inspection, we found there was only one entry on the recording sheet for that day, stating the person had had a full cup of tea at lunchtime. At 4pm (the time we reviewed the food and fluid recording sheet) there was no evidence to indicate that the person had had anything else to drink, or anything at all to eat.
•□Additionally, people told us that the staffing shortages described in the Safe section of this report meant they were sometimes unable to get out of bed until shortly before lunchtime. As result, people sometimes missed breakfast, creating an increased risk to their health through a lack of proper nutrition. For example, one person said, "About two weeks ago there was no one to get me up and I had to stay in bed until lunchtime. During that time, no one brought me anything to eat or drink." Similarly, a staff member told us, "We get days when the poor … residents come down for lunch, having missed breakfast. There's just never enough staff." In confirmation of this feedback, when we reviewed people's food and fluid recording sheets and 'food diaries' for the period 13 – 21 March 2019 we identified at least five occasions when there was no record of a person having had breakfast.
•□The provider's failure to ensure people's nutritional and hydration needs were properly met and monitored was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience; Assessing people's needs and choices; delivering care in line with standards, guidance and the law

•□The provider maintained a record of each staff member's mandatory training requirements. However, when we reviewed this training matrix we found significant gaps, increasing the risk that staff did not have the necessary skills and knowledge to care for people safely and effectively. For example, one member of the care team had commenced their employment in August 2018 but was yet to complete infection control, fire safety, first aid, health and safety and safeguarding training. As described in the Safe section of this report, the training matrix indicated over half the staff team had not received safeguarding training. Similarly, 50% of staff had not received infection control training and 56% had not received health and safety training. Additionally, two senior care assistants had not undertaken moving and handling training in the previous three years and one senior care assistant had not received medication training for over four years. Most worryingly of all, three care assistants who had started in August 2018 were yet to complete their moving and handling training. Sharing their concerns about the lack of training in the home, one staff member said, "I have had no training since I came, no courses. There should be more training, especially for the new starters. They need to know more."
•□Any mandatory training courses that were provided to staff were only available as online 'e-learning'. Staff we spoke with told that this approach was not always effective in providing them with the practical skills they required. For example, one staff member said, "I had online moving and handling training. It was absolute rubbish. Moving and handling needs someone to come in to [provide practical instruction]." Similarly, the assistant manager commented, "It's not ideal, how can you practice [moving and handling] online? It started last year. I think it was in relation to cost."
•□The provider had also failed to ensure staff received regular one-to-one supervision, depriving staff of opportunities to reflect on their practice and identify any areas for further learning. Senior staff told us that the provider's policy required this to be provided every three months but the assistant manager confirmed that this was not being achieved and that "about half the care staff" had had no recent supervision.
•□Similarly, senior staff acknowledged that staff had little access to books, magazines and other information sources to help them keep up to date with changes to good practice and legislative requirements. The assistant manager told us, "We need to be not so isolated." Reflecting this comment, no one from the home had participated in the monthly information sharing events organised by the local authority's infection control team, meaning an opportunity to ensure the provider was up to date with best practice in this area had been missed. In this and other areas, staff were left to conduct their own independent research, increasing the chances of inconsistent and inappropriate practice. One staff member said, "If I want to know anything, I just Google it."
•□Reflecting these shortfalls in the provision of training, supervision and good practice guidance, throughout our inspection we identified areas in which staff lacked some of the skills and knowledge required to care for people safely and effectively. For example, as described elsewhere in this report, staff did not always store clinical waste in line with good infection control practice. Nor did they appear to have understood the potential implications of the low levels of hydration, nutrition and urinary output they had recorded on some people's food and fluid charts. Similarly, staff did not appear to have appreciated the importance of seeking medical advice prior to making the decision not to administer a dose of one person's prescription medicine.
•□The provider's failure to ensure staff had the skills and knowledge to support people safely and effectively was a breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance

•□As part of our inspection we checked whether the provider was working within the principles of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as

possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

•□Staff at all levels in the home demonstrated only a limited understanding of the MCA. The assistant manager acknowledged, "I need training on the MCA. The manager, [myself] and the team [all] need to be updated." Reflecting this lack of current knowledge, we found shortfalls in the provider's approach to best interests decision-making which meant people's rights under the MCA were not fully protected. For example, on the second day of our inspection we noted that one person had refused to take two of their prescription medicines for the previous nine days, a decision which may have had a detrimental effect on their health. Although staff knew the person lacked capacity to make an informed choice in this matter, they not taken action to formally determine if it was in the person's best interests to continue not to take their medicines. When we reviewed another person's care record we found a correctly documented decision confirming that it was in their best interests to receive personal care, even when they indicated they did not want it. However, staff told us that in providing this person with personal care they sometimes used a form of restraint, something the manager told us she was unaware of. There was no record to indicate who had made this decision or that other less restrictive options had been considered. Similarly, for other people who had lost capacity to make the decision for themselves, we found that there was no documented best interests decision in place to support the use of bedrails.

•□ The provider's failure to obtain proper consent to care and treatment was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff providing consistent, effective, timely care within and across organisations

•□Staff expressed their dissatisfaction with the internal communication systems in the home and the impact this had on their ability to provide safe, effective care. For example, one staff member told us, "Communication is slipping." Care assistants were particularly critical of a recent decision to restrict shift handover meetings to senior care assistants. Although the senior care assistants were supposed to brief the care assistants on the content of the handover meeting, staff told us this did not always happen. One staff member said, "We don't get to know what's going on. The seniors don't always tell us. We need to know before we start getting people up." In one distressing illustration of the provider's failure to ensure effective internal communication, several budgies had recently been found dead in the aviary in the garden as they had not received food or water for several days. Commenting on this incident, the assistant manager said, "[The person] responsible for the birds went on holiday and [feeding them] got overlooked. Communication could be improved. It's a shortfall."

Supporting people to live healthier lives, access healthcare services and support

•□People's healthcare needs were monitored and supported through the involvement of a range of professionals including GPs, district nurses and therapists. Commenting positively on the approach of staff in this area, one person told us, "The staff are very good at getting the doctor to see me." A local healthcare professional said, "I have a good relationship [with staff]." However, as described elsewhere in this report, staff were not always sufficiently proactive in seeking external medical advice and assistance, increasing the risks to people's health.

Adapting service, design, decoration to meet people's needs

•□Since our last inspection, several bedrooms and the reception area had been redecorated. In response to feedback from our inspector, the assistant manager agreed to lower the position of information on the

noticeboards in reception to enable people to view the content more easily. Looking ahead, the manager told us she hoped to create a sensory room to provide additional stimulation for people living with dementia.

Inadequate

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls and some regulations were not met.

Ensuring people are well treated and supported; Supporting people to express their views and be involved in making decisions about their care

•□People told us that, although individual members of staff were kind, the provider's failure to provide sufficient staffing meant staff did not have time to care for them in a consistently person-centred way. For example, one person commented, "The carers are lovely, there is just not enough of them." Similarly, a relative said, "The carers are really approachable and friendly but there is not enough staff, as they always seem busy and stretched." Describing a typical day at work, a staff member told us, "We get them up, then it's lunchtime. We feed and water them and then it's home time." Another member of staff said, "We are always in a rush."
•□Throughout our inspection we saw we saw evidence of this impersonal, task-centred approach. For example, at lunchtime on the first day of our inspection we observed staff rushing from one person to another to support them to eat. As a result, there were delays in providing some people with the eating support they required. Expressing their dissatisfaction with the lunchtime arrangements, one person told us, "We have to wait ages between our main course and pudding and sometimes it is cold when we get it."
•□As described in the Safe and Effective sections of this report, the provider's failure to deploy sufficient staff meant people were not always treated in a caring and compassionate way. For example, the people who had missed breakfast due to delays in supporting them to get out of bed; the people who had defecated and urinated where they sat due to delays in responding to call bells and the person who had had almost nothing to drink for 53 hours and had been admitted to hospital on an emergency basis. Talking about the quality of the service they provided to the people in their care, one staff member said, "I don't feel good about it. I feel guilty." Another member of staff told us, "I wouldn't want one of my relatives to live here at the moment."

Respecting and promoting people's privacy, dignity and independence

•□Staff told us that they understood the importance of supporting people in ways that helped maintain their dignity and respect. However, during our inspection we found that this was not reflected consistently in their practice. For example, when talking to our inspection team, some staff described people in a very undignified and impersonal way as "feeds" (people who needed support to eat). This was despite staff being aware that they should not be using this term. For example, immediately after telling one of our inspectors about the support received by the "feeds", one member of staff said, "I say feeds, you know what I mean."
•□Staff also told us that they understood the importance of supporting people in ways that respected their privacy. However, we found this too was not reflected consistently in their practice. For example, on one

occasion we saw someone lying partially uncovered on their bed with their underpants visible to anyone passing the room. Additionally, people's care plans were stored in the treatment room which opened onto the main corridor of the home. This room was frequently left unlocked and unattended which meant people's private, confidential information could have been accessed by people and visitors passing in the corridor.

Taken together, the provider's failure to consistently treat people with care and compassion; to protect their right to privacy and to promote their dignity and respect was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2008.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

Services were not planned or delivered in ways that met people's needs. Some regulations were not met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

•□As described throughout this report, during our inspection we identified many ways in which staffing shortages resulted in people receiving rushed, task-centred care which did not meet their individual needs and preferences. People also told us that the lack of staff meant they were not always able to exercise proper and choice and control over their lives. For example, one person said, "I like to go to bed at 8pm but a lot of the time that isn't possible as there are not enough staff. It can be 10pm sometimes, before anyone gets to help me." Another person told us, "I have a shower weekly on a certain day. But sometimes they are that short of staff I don't manage to have it on that day." Talking to a member of our inspection team at lunchtime on the first day of our inspection, another person said, "You just get [the vegetables] you are given. I would have liked some carrots like [name]. But I have just been given cabbage." During our inspection we noted it was staff who chose the channel on the television in the main lounge and the music that was playing in the reception area. Commenting on this issue, one person said, "They just switch the television on and leave it. No one even asks if there is anything we would like to watch." Acknowledging that people were not receiving the personalised support they were entitled to expect, one staff member told us, "We would like to be more person-centred than we are. I try not to let it bug me but it does."
•□As described in the Safe section of this report, we identified significant shortfalls in the provider's care planning system which meant staff did not have access to up to date information about people's individual needs and preferences. One person had been living in the home for over a month without a care plan and where care plans were in place, many had not been reviewed since September 2018. Sadly, when we looked at some people's care files we found the 'My Life Story' was almost completely blank, depriving staff of important information about the person's life before they moved into the home.
•□Staff openly acknowledged they did not read people's care plans. For example, one staff member told us, "I want to know everything about my residents. But I don't have time to read the care plans." Another member of staff said, "I'd like to find out a bit more about [the people I care for]. But there's no time." As a result, we found the guidance set out in people's care plans was not always reflected in the care people received. For example, the goals set out in one person's 'eating and drinking' care plan were, 'to provide a good intake of fluids' and 'monitor food and drink intake and report any changes'. This was the person, as described in the Effective section of this report, who had had almost nothing to drink for almost two days before staff sought medical advice. Similarly, people who were being cared for in bed were not always repositioned in accordance with the frequency set out in their care plan.
•□People told us that they had little opportunity to contribute to the ongoing development and review of their care plan. For example, one person said, "When I first came in about two years ago, they talked to me about what I could do and what I needed help with. But nothing since." A relative told us, "[Name] has been here a number of years and I haven't seen … or been asked about a care plan. If there is one, it hasn't been discussed with me."

•□The staffing shortages in the home and the need to prioritise physical care tasks, left care staff with little time to provide people with emotional support or to respond to their need for physical and mental stimulation. One person told us, "Eighteen months ago the carers would have had time to sit and chat, but not anymore." The assistant manager told us, "Care staff don't have time for interaction."
•□The provider employed an activities coordinator to take the lead in this area but their hours had recently been reduced to only 16 hours a week, supplemented with some additional volunteer support. The activities coordinator had developed a weekly activities programme which was on display in the home. However, during our inspection it became clear that many of the activities listed on the programme did not actually take place. For example, on the first day of our inspection the activities organiser was out of the home supporting someone to attend a hospital appointment. As a result, the only activity we observed taking place was a volunteer supporting two people to do some painting. On the second day of our inspection, the activities organiser was off and therefore neither of the advertised activities (armchair exercises and a sing along) took place. Although the provider booked professional singers and other entertainers to visit the home, these were relatively infrequent events and throughout both days of our inspection we saw people sitting for long periods of time without any stimulation. Others walked repetitively round the home. Expressing their frustration, one person told us, "It sends you out of your mind being here, because there is nothing going on." Similarly, a staff member said, "People are bored." The assistant manager told us, "I don't think [16 hours a week for the activity coordinator] is enough. It's got to have an impact [on people's well-being]."
•□Taken together, the provider's failure to support people in a consistently person-centred way and to meet their needs for mental and physical stimulation was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2008.
•□Senior staff were unaware of the national Accessible Information Standard (AIS) which provides best practice guidance in communicating with people in ways that meet their individual needs and preferences. However, the manager told us she would research the AIS and incorporate into the provider's approach in the future. In the meantime, the provider had some understanding of the importance of communicating with people in ways that met their needs and preferences. For example, picture cards were available for staff to use to assist in communicating with a regular respite guest who was hard of hearing.

End of life care and support
•□Staff worked alongside specialist agencies such as Macmillan and Marie Curie whenever this was required to support people who were receiving end of life care. Discussing the support provided to people's families, the manager told us that relatives had the opportunity to stay overnight in the home, to enable them to spend as much time as possible with their loved one as they neared the end of their life.

Improving care quality in response to complaints or concerns

•□People told us that they were satisfied with the provider's response to any issues or concerns they had raised. For example, one person told us, "I complained once as another [person] was in my room. The manager has now given me a key which has sorted the problem out." However, the manager acknowledged she did not maintain a log of any formal complaints which had been received. This meant we were unable to ascertain whether complaints had been handled correctly in accordance with the provider's policy. Additionally, the provider had lost an opportunity to review complaints in a systematic way to identify common themes and learning for the future.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

•In preparing for our inspection, we reviewed the notifications (events which happened in the home that the provider is required to tell us about). However, as part of our inspection we identified that we had not been informed of one serious injury to a service user; seven Deprivation of Liberty Safeguards (DoLS) authorisations and two allegations of abuse of service users which had been considered by the local authority under its adult safeguarding procedures.
•The provider's multiple failure to submit notifications was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.
•Under Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, providers are required to ensure the rating of their most recent CQC inspection is displayed 'conspicuously in a place which is accessible to service users'. On the first day of our inspection we found a black and white photocopy of the home's current rating at the top of a noticeboard in reception, about two metres from the ground. This made it inaccessible to most of the people living in the home, particularly those who used a wheelchair. This was a breach of Regulation 20A.
•During our inspection we identified very significant shortfalls in the provider's approach to the auditing, monitoring and improvement of service provision. Acknowledging the inadequacy of the provider's approach in this area, the assistant manager told us, "[We have] very few audit systems currently." As described elsewhere in this report, people's care plans and risk assessments had not been reviewed and updated for several months, creating risks to people's health and welfare. Similarly, the monthly manager's monthly 'quality assurance' audit had not been undertaken since December 2018 and the manager was unaware if any action had been taken in response to an external health and safety audit undertaken in March 2018. Commenting on this audit action plan which had identified some of the same issues of concern we found on our inspection some eight months later, the manager told us, "I gave it to the handyman … I presumed he would have got on with it." An action plan that had been completed by the manager in January 2019 following an audit of the kitchen stated that a cleaning schedule was to be put in place to address identified shortfalls in the cleanliness of the kitchen. However, as described in the Safe section of this report, we identified numerous occasions on which there was no record of the daily kitchen cleaning schedule having been completed. The manager told us, "I presumed it happened every single day."
•As a result of these failures in organisational governance, the very significant shortfalls in areas including individual risk assessment and care planning; nutrition and hydration; infection control; safety of the premises and the management of medicines described elsewhere in this report had not been picked up or addressed, increasing the risks to service users' safety and well-being. Additionally, as detailed in the Safe

section of this report senior staff were aware that care staffing levels were unsafe, but no effective action had been taken to increase them.

•□The provider's failure to effectively assess, monitor and improve the quality of the service and to take action to address and mitigate a range of risks to people's health, safety and well-being was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•□At the time of our inspection, the manager had been in post for about 12 months. In November 2018 she had applied to become the registered manager and was waiting for her application to be assessed by CQC. An assistant manager was also in post, although she was only contracted to work 16 hours each week.

•□The manager appeared well-liked by most people connected to the home. For example, one staff member told us, "I love her. She is so understanding." A relative commented, "The manager is very approachable." However, almost everyone we spoke with told us they thought the manager lacked the skills to manage the home effectively. For example, one person said, "The previous manager was very organised and [the home] ran well. Things have really changed for the worse." Similarly, a staff member told us, "The home is not running well [and has] got worse since around Christmas. [The manager] just wants to keep everyone happy by saying 'yes' to them. A manager can't keep everyone happy." Another member of staff said, "[The manager] is too soft. She will never say 'no'. She is too nice for a manager. People take advantage of it." Confirming that she had had no previous experience of managing a care home, the manager told us, "I am pretty much learning on the job." Reflecting this comment, at times during our inspection the manager demonstrated a worrying lack of knowledge in certain areas. For instance, acknowledging her failure to notify us of the serious injury sustained by one of the people living in the home, the manager said, "I thought it was just deaths [I had to notify]. I didn't realise it was a serious injury [as well]." Similarly, the manager was unsure of the role of a Lasting Power of Attorney and did not know how many people living in the home were subject to a DoLS authorisation.

•□People also expressed concerns about the visibility and accessibility of the manager. For example, one person's relative said, "The previous manager was very hands on, visible and had a presence. But there is not so much of that now." A staff member commented, "I don't see a lot of [the manager]. She is probably here three days a week." Talking of the manager and her mother (who was one of the owners of the home), the same staff member said, "They give the impression that they don't give a monkey's. If they did, they would be here more often and would have sorted out the staffing." Staff also told us that it was difficult to contact the manager when she was not in the home. Her telephone contact details in the provider's 'business continuity plan' were out of date and asked what they did in an emergency situation, one senior care assistant said, "That's a good question! I usually try and overcome it myself."

•□As a result of the manager's lack of experience and knowledge of how to manage a care home effectively, it was unclear who was in operational control of the home and how important decisions were made. For example, one staff member said, "[The assistant manager] is really the manager. She has more experience." Another member of staff told us, "[The manager's mother] likes to interfere with things … and micromanage." Commenting on the ineffective, unsafe leadership arrangements in the home, the assistant manager said, "It's very confused. The staff don't know who to go to. There are very unclear structures of who is responsible for [certain] areas. Which makes it very disorganised, which leads to risk." In confirmation of this comment, we found the manager was unaware that staff were using a form of restraint when supporting one person with their personal care. Similarly, the assistant manager told us that it was sometimes difficult to obtain agency staff to cover shifts at short notice to maintain safe staffing levels, as this had to be personally authorised by the manager's mother, who was often unobtainable. Additionally, as described in the Effective section of this report, the manager had recently decided to restrict attendance at shift handover meetings to senior care assistants, to ensure the care assistants remained available to support the people living in the home. However, the manager acknowledged her decision had not been respected and that some senior care assistants were still allowing care assistants to attend the meetings.

•□The provider's failure to appoint a person with the necessary competence, skills and experience to

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

Engaging and involving people using the service, the public and staff; Working in partnership with others; Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

- As described in the Effective section of this report, staff were critical of the internal communication systems in the home. One staff member said, "Communication is a bit lax." There had been no staff meetings organised in the months preceding our inspection and the staff Christmas party had been poorly attended. Commenting on this event, the assistant manager told us, "The majority of staff didn't come. It was not planned sufficiently in advance." Describing the atmosphere within the staff team, one staff member told us, "Morale is quite low."
- As described in the Responsive section of this report, people were not involved in planning and reviewing their care. One person told us, "Since I came here no one has asked me what I need or how I like things." The provider used a questionnaire to seek people's views on the quality of the service they received. However, acknowledging the provider's failure to address the feedback received in the most recent survey conducted in June 2018, the manager told us, "Even then [people] felt staffing was an issue."
- More positively, there were some links between the home and the local community. For example, a small team of volunteers was available to assist the activities coordinator and local school children visited on occasion.
- To their credit, most of the staff we spoke with were candid in their feedback on their experience of working in the home. In particular, the assistant manager displayed a commendably open and non-defensive approach, despite the many issues of concern we identified during our inspection. At one point she told us, "I can't be something I'm not."