P G Oliver

Crosby Lodge Residential Care Homes

Inspection report

2-2a Fitzharris Avenue
Charminster
Bournemouth
Dorset
BH9 1BZ

Tel: 01202517186

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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?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We last inspected Crosby Lodge Care Home in September 2015 where we identified some shortfalls and made a number of recommendations. The home received an overall rating of requires improvement at that inspection.

This inspection took place on 29 April and 4 and 5 May 2016. The inspection was unannounced and carried out in response to information of concern received by the commission. During the inspection we identified serious shortfalls and breaches of the regulations.

Crosby Lodge Care Home is registered to provide personal care for up to 26 people living with dementia or severe and enduring mental health conditions. Nursing care is not provided. There were 16 people living at the home at the time of the inspection.

The home is made up of two separate buildings. These are called 2 and 2a. The two buildings are separated by a freestanding garage in its own driveway that does not belong to the service. This means that the movement of staff and certain activities such as meal distribution can only be achieved by leaving one building, walking a short way along a public road and entering the second building.

The home is currently being managed by the acting proprietor following the death of the proprietor in January 2016. The acting proprietor was supported by two interim consultants they had engaged as a result of serious safeguarding concerns identified by the local authority. The interim consultants had acted swiftly and responsibly to ensure people's basic care needs and safety were met.

There was a registered manager at the home. However, they were not available 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.

One relative told us that the home was, "Perfect", and an agency staff member told us, "This place is the best, it's like family, it's very personal and they are very close to residents". However we identified serious issues that impacted upon people's health, safety and wellbeing.

People were not cared for safely. Prior to the appointment of the interim consultants, risks to people were not assessed and action was not taken to mitigate these risks. In addition, accidents and incidents were not robustly investigated to make sure patterns or trends were recognised to minimise the risks of further incidents. The interim consultants had taken action to ensure people's basic safety needs were met and that people were not at imminent risk of serious harm. However, there remained a number of shortfalls because the interim consultants had not had sufficient time to fully safeguard people. In addition, the premises had significant infection control and environmental issues. Shortfalls in recruitment meant the acting proprietor

could not be sure that the staff recruited were suitable to work with vulnerable people. Medicines were not managed safely so people had not received their medicines as prescribed.

Staff did not have the knowledge and skills to effectively care for or support people. Staff had not been supported through either training or supervision and appraisals to gain these skills.

Staff were not adhering to the principles of the Mental Capacity Act 2005 (MCA). Decisions made for people who lacked mental capacity had not been made in their best interests using the statutory framework, and one person was unlawfully deprived of their liberty at the time of the inspection.

People had not been supported to meet their nutritional needs although following their appointment, the interim consultants had taken action to ensure that there was enough food available for people to eat and that there was a chef in place to prepare meals.

Most of the staff had a caring approach and were genuinely interested in and concerned about the people they supported. However, they sometimes communicated with people, or supported them inappropriately because they had not been supported to develop the right skills.

People's needs were not responded to appropriately. Some people's needs had not been assessed or planned for. Other people had care plans in place which provided staff with inaccurate guidance. Some people had not received the care they required. Other people had not been supported to receive the healthcare they required, including in one circumstance healthcare that was urgently required in response to a fall.

The home was not well led. There was no effective governance and the management in place prior to the appointment of the interim consultants had not supported staff, assessed or monitored the quality or safety of care, or sought feedback from people or their relatives.

The overall rating for this service is inadequate. The death of the proprietor in January 2016 means that there is no registered person for CQC to take action against. The acting proprietor has made a decision to close the home and the last person moved out of the home on 27 May 2016. The home is now closed.

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

People were not kept safe at the home.

Risks to people were not managed to make sure they received the correct care they needed.

The management and administration of medicines was not consistently safe.

Is the service effective?

Inadequate

Staff had not been supported to effectively care for or support people.

People's rights were not effectively protected because staff did not understand or adhere to the Mental Capacity Act 2005.

People had not been supported to meet their nutritional needs.

Is the service caring?

Requires Improvement

The service was caring but needed some improvement. This was because staff did not always respect some people's dignity.

People and their relatives told us staff were kind and caring.

Staff were fond of the people they were caring for.

Is the service responsive?

Inadequate

The service was not responsive.

People's needs were not fully assessed, or planned for.

People did not always receive the support their needed to meet their needs.

People's healthcare needs were not always met.

Is the service well-led?

Inadequate

The service was not well-led.

There were no systems in place to assess and monitor the quality of the service and drive forward improvements.

There were shortfalls in record keeping. Some records were incomplete, contained inappropriate language or were not accurate.

Crosby Lodge Residential Care Homes

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 29 April and 4 and 5 May 2016. Two inspectors visited the service for all three days of the inspection. They were supported by a specialist advisor nurse on two of the days of the inspection.

We met and spoke with twelve people living at the home. Because some people were living with dementia we 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 spoke with three visiting relatives and also spoke with the interim consultants, acting proprietor and nine members of staff.

We looked at eight people's care and support records and care monitoring records in detail, and at monitoring records and specific elements of four other people's care plans. We looked at nine people's medication administration records and documents about how the service was managed. These included three staff recruitment and training records, audits, maintenance records and quality assurance records.

Before our inspection, we reviewed all the information we held about the service. This included the information about incidents the provider had notified us of. We also contacted the local authority safeguarding team and the local commissioners for information.

Inadequate

Is the service safe?

Our findings

People told us they felt safe at the home. Three relatives told us they were confident their relative was cared for safely. However, we identified a number of serious issues that meant people had not been safeguarded from the risk of harm.

The interim consultants had displayed information in communal and office areas about keeping people safe and raising concerns. Staff had received training about how to keep people safe. However, this had not led staff to identify or raise safeguarding concerns about the areas of risk found this inspection with the local authority. People had been placed at risk of harm because the training staff had received was not effective in enabling them to recognise and raise concerns.

Staff took responsibility for managing some people's personal money. We found that the system in place did not protect people's money because one person had less money in place than they should have done. There were no systems in place to monitor and audit the process, which could have identified this shortfall. We asked staff to raise a safeguarding referral about the individual's missing money.

Records showed that accidents and incidents people experienced were often not investigated or followed up. Following their appointment the interim consultants had followed up incidents and accidents, to reduce the risk of them re-occurring.

There had been a failure to address areas of risk. The home's policy on nutrition and hydration stated that routine nutritional screening would be undertaken. There were people living at the home that were underweight or people who had lost significant amounts of weight but these people did not have accurate malnutrition risk assessments. In addition staff had not been supported to understand about people's dietary needs. Some people had lost weight and may have benefitted from being on fortified meals. We asked a staff member about how they would fortify meals for people. They told us they would either puree meals or add thickener to drinks. This was inaccurate and meant that people at nutritional risk were not supported by staff who had an understanding of what they could do to help that person gain weight or nutrients.

One person had experienced significant weight loss over a six month period. However, the risk assessment tool used to establish whether their weight loss was a cause for concern was inaccurate. This meant that this person may not have received the medical support they required. The interim consultants wrote to us following the inspection and confirmed they had referred this person to a dietician. This person had a pressure relieving mattress in place. The setting used was inaccurate which meant this person's skin integrity was placed at risk. The interim consultants wrote to us following the inspection and told us they had checked all mattress settings to make sure people were safe. This person also had bed rails in place, but staff had not completed a bed rails risk assessment. This meant that the person was placed at risk because staff had not considered the risks raised through the use of bed rails or checked that the bed rails were suitable for the specific individual.

Another person was diagnosed with Parkinson's disease which had affected their mobility, however there was no mobility risk assessment in place to support staff to understand the risks posed by this diagnosis and what action they needed to take to mitigate the risk.

Other people who were at risk because of their mental health needs, or who had physical risks for example through poor mobility did not have risk assessments in place. This meant that staff were not supported to understand the risks to people or how they could mitigate them.

One person required monitoring when they were in bed. Their care plan stated that a pressure mat was in use to alert staff when they were leaving their bedroom. We checked them on three occasions during the inspection whilst they were in bed. The pressure mat was not in place on any of our three checks.

The management of the service took inadequate action to improve the safety of the service for people. For example, at the last inspection we identified some of the same issues in terms of out of date risk assessments and failure to assess the risks posed by the use of bed rails. These issues had not been acted upon.

There were risks posed by the poor upkeep of the environment. The provider had not completed a health and safety audit that would have enabled them to identify and act on the health and safety risks within the premises. Some first floor window openings were not restricted to protect people, and there were no risk assessments in place. We asked staff to take immediate action to make sure people were protected and on the second day of the inspection restrictors had been fitted.

Concerns had been shared with us that the home lacked heating and hot water and that people were cold, not having baths or showers, and washing up was completed though the use of hot water from a kettle. The interim consultants confirmed to us that they had acted upon this immediately and that the acting proprietor had engaged a plumber and electrician to rectify the issues. On the first day of the inspection there was hot water available. On the third day of the inspection we checked the water in the kitchen of building 2a and found it was tepid. A care worker told us the boiler had been switched off and they switched it back on. One person living at the home told us, "Sometimes they only put the heating on half strength, the impact of that is that my room is cold".

The premises had not been appropriately maintained. Some bedrooms had hand basins without plugs, and one person's bedroom had missing tiles and exposed plaster around the hand basin. The tap was not securely fixed to the hand basin, and their wardrobe door was broken. Some bedrooms had different coloured paint on the walls. This appeared to be where parts of a wall had been repainted. There was also exposed plaster in one room.

The hand rail of the stairs to building 2a was situated at head height. This meant it could not be used to enable people to more safely navigate the stairs. The toilet on the first floor of building 2a did not have a lock. The toilet in the reception area of building 2a did have a lock but this was placed at the top of the door. This meant that some residents who accessed this toilet would not be able to lock the door and this placed their dignity and privacy at risk. The interim consultants wrote to us following the inspection and told us they had made sure these toilets had locks that were accessible to people who lived at the home.

Throughout the inspection there was wet laundry hung over handrails in communal areas of the home. This prevented people's independence as they could not use the handrails, it released damp water into the home atmosphere as the wet clothing dried and it did not promote people's dignity or privacy as their wet clothing was visible to other people and visitors to the home.

People had evacuation plans to be used in the case of an emergency such as a fire. However for some people these inaccurately identified where their bedroom was located. This meant in an emergency staff, including fire and rescue staff may not have had the correct guidance to evacuate people safely. Shortly before the inspection a fire safety audit had been carried out by the fire and rescue service. They had identified a number of fire safety deficiencies in both the building and staff training. Five of the eleven staff had training that was out of date. We asked a member of staff about their fire training. They said they were not confident in this area and had not been part of a drill for over six months. We brought this to the attention of the interim consultants and the acting proprietor. They arranged fire training for 19 May 2016.

People were placed at risk because of the poor prevention and control of infection. A member of staff told us there were, "General improvements needed everywhere, especially infection control". There was a very small laundry area. The area had a strong faecal malodour. There was a large number of soiled linen and clothing in the laundry. There was nowhere to dispose of personal protective equipment such as soiled gloves. Staff told us they washed their hands in the bathroom next door. This posed an infection control risk because of the potential transfer of infection when moving to another area. The laundry area also contained a mop positioned head down that staff told us was used to mop up bodily fluids such as urine. This mop was visibly dirty. Keeping this mop face down in the warm environment of the laundry posed a risk that bacteria would multiply quickly and there was a risk of cross contamination with clean laundry. Other mops we saw, including the mop used for cleaning the kitchen floor were old, dirty and incorrectly stored. Some were encrusted with debris.

The home has a kitchen in each building. The kitchen in building 2a is small and used for serving meals and making drinks. The kitchen in 2 is the main kitchen used for preparing all meals. This kitchen was split into two halves. On the kitchen side, there were environmental issues such as broken kitchen drawers and scratched laminate surfaces that would have made the area difficult to keep clean. The other half of the kitchen was used to store people's care records and personal products such as hairdryers. Staff freely accessed both areas without use of protective clothing such as an apron. On the third day of the inspection the interim consultants had taken action on this and people's personal care files had been moved to another room where they were safely stored.

Within the kitchen of building 2 part of the trim to the work surface was missing with food particles encrusted within it. The metal strips on the work surface were raised with food encrusted both underneath and at the side. Parts of the lower grout on the walls had old dried food particles. The kitchen cutting boards were heavily scored. The home did not have a dishwasher to ensure these had been washed at a high enough temperature to reduce any risk of cross contamination. There were fridges and freezers stored within the garage that were used to store food. One of the fridges had mould on the door seal.

There was a malodour in the upstairs of building 2. A number of bedrooms in both buildings had poorly fitting flooring. This appeared to be where pieces of furniture had been removed but the flooring had not been replaced. This posed a risk that the flooring could not be effectively cleaned. The interim consultants wrote to us following the inspection to confirm new flooring had been purchased.

We saw that used latex gloves had been disposed of in people's bedroom bins. There was no separate bin in people's room for disposal of personal protective equipment.

We asked about the system for cleaning commodes. A care worker told us they rinsed out commodes in a bath. They said that they disinfected the bath after washing used commodes in it.

In one of the ground floor bathrooms there appeared to be very old, dry hair in the plug hole and some toilet

brushes were old, stained and looked unclean. One bathroom had flaking paint which meant the surface could not be effectively cleaned.

Over a quarter of the staff team had not been supported to update their knowledge of effective infection control through training. This would have enabled them to recognise and address the infection control risks posed by their practice. The home had not completed an infection control audit. Following the inspection the interim consultants confirmed an audit had been carried out. This had identified a number of issues including the need for a deep clean of both properties.

When we asked staff about staffing levels they told us that more staff were required, particularly experienced trained staff. One said the high use of agency staff was difficult because, "They don't know the residents". The acting proprietor and interim consultants told us staff had been working hard and were very tired because that they had lost approximately 50 percent of their staff team in the few weeks preceding the inspection. This meant they were relying on agency staff. We spoke with some agency staff who were on duty during the inspection. They had a basic knowledge of people and their needs.

Staff recruitment procedures were not robust and did not fully protect people living at the home. For one staff member appropriate information had been obtained to ensure they were suitable to work with vulnerable people. However for two further staff members the required checks including a disclosure and barring check and suitable references had not been fully completed before they started employment at the service. This meant there was a risk that people may have been supported by staff that were not suitable or safe to work with vulnerable people.

People were placed at risk of harm because staff did not manage their medicines safely and people did not always receive their medicines as prescribed. Medicines were stored in two locked wheeled cabinets; however one of these was not secured to the wall. We checked the medication administration for nine people and found these noted people's allergies and had a photograph of the person, these records appeared well maintained. However on checking the actual medicines for people we found there were major discrepancies for the number of medicines stated as administered and the number of tablets actually in stock. This included occasions where medicines had been signed for as given but had not been administered. This meant that people had not received their medicines as prescribed. We also found that for some specialist medicines specific records had not been kept accurately. This meant that staff were not able to check that these specialist medicines were kept safely and securely. We found that two people had also not received their medicines because they had not been in stock. For one of the people the missing of their medicine could have had a serious impact on their health and well-being.

In addition, people did not receive their medicines at the correct times. This was important as some people's pain medicine was delayed. This was because at the time of the inspection there was only one care worker on duty who was trained to administer medicines. This meant they were responsible for administering medicines to people in both buildings. This caused a delay to the times of administration for some people. The interim consultants had requested a medicines audit because they were concerned that people were not receiving their medicines as prescribed. This had been carried out and had identified a number of significant issues. The interim consultants were in the process of changing the whole medicines system at the time of the inspection. After the inspection the interim consultants wrote to us and confirmed the medicines management system had been changed.

The serious shortfalls in assessing and managing risk, recruitment of suitable staff, the safe management of medicines and the cleanliness the building were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The shortfalls in the premises were a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

People told us they thought that staff knew how to do their job, and a member of staff told us the home was, "Person centred, staff are very knowledgeable about each person". Relatives said they thought people received good care. One said, "We are pleased", and another told us, "Most of the staff have been good". However, we identified a number of issues that meant people did not receive effective care and support to meet their needs.

The interim consultants and the acting proprietor confirmed that some key staff training was out of date. They were also concerned about the quality of the training staff had previously received. This was borne out though our discussions with, and observations of the staff team. For example, we identified concerns about how some care workers upheld people's dignity. In addition the registered manager had said at the last inspection that they would arrange further dementia training for staff. Training records showed that for 50 percent of the staff team this had not happened.

The training matrix showed significant gaps in training which included health and safety, infection control, emergency life support, fire training, equality and diversity and communication. The interim consultants had already acted upon this and had identified which staff required urgent updates to their training. The home's supervision policy stated care workers would receive supervision four times per year; however, staff had not received adequate support through either supervision or appraisals. The interim consultants and the acting proprietor were unable to locate any supervision or appraisal records. The three staff files we looked at showed that none of the staff had received either supervision or an appraisal. Lack of supervision and appraisal was an area for improvement for the home identified at the last inspection.

The shortfalls in staff skills and knowledge were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had a policy that said it complied with the Mental Capacity Act 2005. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. All the staff had had training in the MCA. One member of staff told us, "It's about giving people a choice and asking them". We also noted that staff sought people's consent verbally most of the time before they helped or supported them.

However, we found significant areas of concern that showed staff were not adhering to the Act. For example, some people who lived at the home lacked mental capacity to make a specific decision. However, only one person living at the home had received a mental capacity assessment. In addition, this person had full capacity and there was no rationale behind the assessment that had been undertaken.

Where people lack mental capacity to make a specific decision, decisions must be made in their best interests in accordance with the MCA. Whilst some people living at the home lacked capacity to make a decision, there was no evidence of any best interests decisions made in accordance with the act.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). These safeguards can only be used when there is no other way of supporting a person safely. The responsibility for applying to authorise a deprivation of liberty rested with the manager. We looked at whether the service was applying the DoLS appropriately.

We found that there was not a system in place to make sure people who were deprived of their liberty were protected. This meant that one person had conditions attached to their authorisation that had not been met. Staff were unaware of these conditions. Following the inspection the interim consultants wrote to us and told us they had taken action to make sure that any conditions attached to a DoLS were adhered to.

One person had been subject to a DoLS that had expired. Although the individual continued to be subject to restrictions amounting to a deprivation of liberty, a further application to the supervisory body had not been made. This meant the individual was unlawfully deprived of their liberty. We raised this with the local authority who are the supervisory body for DoLS. The interim consultants wrote to us and confirmed they had also raised this with the local authority.

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

Concerns had been raised with us that there was little food in the home for people to eat and drink, and that there was a limited budget to provide food and beverages for people. The interim consultants had immediately rectified this. Following advice from the interim consultants the acting proprietor also engaged a chef. This meant that care staff were no longer undertaking cooking the main meal in addition to their other duties.

At the last inspection the manager told us they planned to develop the arrangements for people living with dementia. At this inspection we found that this had not happened. People did not have meaningful meal choices and had not been consulted about what meal options there were on the menu. The interim consultants had identified this as requiring immediate action. They had completed new menus to include two choices for the main meal. Following the inspection the interim consultants wrote to us and told us the new chef had started to engage with people to gain feedback and hear about the sorts of meals people wanted to eat.

We observed the meal preparation for building 2a. A large plastic box that was not insulated was used to place the food in. The box was carried to a supermarket trolley. A care worker pushed the trolley from building 2a to building 2 using the public highway as there is no direct access between the buildings. The food was then removed from the box and served up onto plates. On the third day of the inspection a person asked an inspector to try their food. They said, "Try these green beans, just try them they are not cooked and cold". An inspector tried a green bean and found it was cold. A relative told us the food was improving but that it had been, "Cold, tasteless, bloody awful".

The interim consultants had started to make some changes to people's meal experience. For example, they had ensured there were glasses and jugs available so that people could have access to fluids. However, there appeared to be a set routine for providing people with hot drinks. For example, we observed a care worker offer somebody a cup of tea at 1:45 pm on the first day of the inspection. The tea did not arrive until

2:35 pm when there appeared to be a 'tea round' where everybody was offered a drink.

The interim consultants had started encouraging people to eat meals at a table rather than remaining in their armchair. This showed the interim consultants understood the importance of mealtimes in a residential care setting, both to encourage people's mobility and movement, but also to make the mealtime a distinct and more sociable occasion. This was particularly important at Crosby Lodge as there was limited opportunity for people to meet their social needs.

People's records showed they had been supported with some medical appointments such as with their GP. The interim consultants confirmed to us following the inspection that only one of the 16 people who lived at the home had been supported to access dental care. They also confirmed they had acted on this by arranging training for staff and oral screening for all of the people who lived at the home.

One person who had been admitted to hospital following a fall during the night. Their records showed medical assistance had not been sought for the person until the interim consultants arrived at the home the following day. Their care records noted, '[the person] had a fall last night and they were swearing'. We checked the staff rotas and found the night staff on duty had not received updated training on emergency first aid. By the following morning the person was described as, 'Lethargic and not responding as well as possible'. This person was placed at risk of significant harm because staff had not taken action to protect them following the fall.

Failure to support people to access the healthcare they required this was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the first day of the inspection the first aid kit was incomplete. By the third day of the inspection the first aid kit had been replaced.

Requires Improvement

Is the service caring?

Our findings

People said they liked the care workers and that they were kind. One person said, "Everybody is pretty friendly". However we found that staff had not been provided with the training and support they required to fully carry out their role. For example a quarter of staff had not received training in equality and diversity and six of the eleven care workers had not been supported to understand how to effectively and respectfully communicate with people. In addition, we identified some issues that meant people were not always supported in a way that respected their dignity and privacy.

We observed some positive interactions between care workers and the people they were supporting. Observations showed that care workers had a genuine interest in people and their welfare. However, positive relationships were not fully supported because staff were not given suitable guidance. Our observations identified that staff communicated with or about people inappropriately. This included talking about people to other staff members when they were supporting that person, but without including the individual.

People were not supported to express their views. They were not involved in decisions that impacted upon their lives. One person told us how much this had improved since the interim consultants had been involved in the home. During the inspection we learned that one person was unhappy about a change to the wardrobe in their bedroom. Whilst the intent was positive because the acting proprietor wanted to provide the person with a new wardrobe, they had not involved or asked the individual about this. Instead the person learned about this when they went into their room to find the wardrobe missing, all their personal belongings left out and the debris from the removal on their floor. The interim consultants explained why this was disrespectful to the individual to the acting proprietor who apologised to the person.

People were not provided with explanations about their care or support. For instance, we observed a care worker supporting one person to reposition their feet. They did not explain anything about the support they were completing until the end when they said, "Is that better". The person replied, "Yes".

There had been some concerns about bed linen and pillows that were dirty, stained and old. The interim consultants and the acting proprietor had responded to this by purchasing new pillows. We found that some people's dignity was still not upheld because their bed linen remained old, worn or stained.

Privacy and dignity had not been considered for three people who had bedroom doors with opaque glass. In addition to this some of these people had cognitive issues. This meant they needed extra support to orientate themselves to night and daytime. Their orientation would not have been supported by having these bedroom doors as there would rarely be a distinction between the darkness of night and the light of day during summer months.

Some people's bedrooms were personalised to some degree, however other people's rooms were functional and had not been personalised and did not have a homely feel.

Written records were also not completed in a way that upheld people's dignity. For example one person's daily record noted they were 'p***ing on the floor'.

The lack of respect or dignity afforded to people was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

Relatives told us they thought their family member's needs were responded to. One family member told us the home would be, "Outstanding when [the acting proprietor] has finished". They said they were very pleased because the acting proprietor "Pays attention to what is required".

Some people's needs had been assessed before they were admitted to the service. This was so staff knew about their needs and were confident they could meet them. However other people had not had an assessment of need carried out.

At the last inspection we recommended that assessments and care plans were updated to reflect the needs of those people with mental health conditions, such as indicators of relapse and how their condition affected their lives. At this inspection we found that the guidance contained in people's plans remained generic and at a basic level. The guidance for staff on people's specific mental health condition and how they may wish to be supported was either not contained in the record or very rudimentary.

One person's care records showed they had a diagnosis of diabetes; however there was no guidance for staff on how to safely support this person in meeting this need. We asked a care worker what they needed to be mindful of for this person, for example if they had low blood sugar. The care worker told us, "Well not really although I think [the person] has an EpiPen. I haven't seen it in a long time. It's locked in the controlled drug cupboard". An EpiPen is used when someone has symptoms of a life-threatening allergic reaction, not in connection with diabetes. We asked another member of staff about the management of this person's diabetes and found they had been providing the person with cold cups of tea. They told us, "Well [the person] can't have any hot drinks as [they] has no feeling in [their] mouth. We make sure we use boiled water to cool [their] tea though". They added, "When you are a diabetic you are at risk of burning your mouth so you need to be mindful of that". This lack of knowledge and guidance meant that the individual had not had a hot drink for a three month period.

One person had a diagnosis of Parkinson's disease. Their records did not provide guidance for staff on the illness and what it meant for the individual. This meant there was a risk that staff might not understand how this person needed or wanted to be supported in relation to their diagnosis.

Other records were inaccurate. For example, one person's hospital transfer form (to provide guidance on admission to hospital) stated they mobilised with a walking frame and two care workers. This person did not mobilise with a walking frame and this inaccurate information could have posed a risk to their safety. This individual had a Do Not Attempt Cardiopulmonary Resuscitation form in their file. However their hospital transfer form provided guidance that they should be resuscitated.

Some records provided staff with insufficient information. For example, one person was identified as at risk of choking in their records, however staff were not sure where this information had come from as they were not aware of this risk. They did make sure the person was supervised when eating, but there was no guidance for staff on action they should take in the event that person started to choke.

Where people needed daily checks to maintain their health, records showed these had not always been completed. For example, one person needed daily checks of their skin integrity. In the two weeks of the inspection we saw that checks had not been completed on seven of the 14 days.

At the last inspection we recommended that activities, particularly for people living with dementia were developed to ensure people were meaningfully occupied, and to meet their social needs. At this inspection we found people were still not supported to engage in meaningful activities. The home had a garden to building 2. However access difficulties including a number of steps meant that it was not suitable for some of the people who lived at the home. During the inspection we saw one person went out for a walk and other people chatted with staff or each other. There was a TV in the main lounge that people sat and watched. There were no other activities observed during the three day inspection. An individual told us, "We mainly just socialise, you know, sit and chat". They added, "I would take advantage of going out that would be nice". The acting proprietor told us that a musician visited the home every month. The interim consultants were aware of the lack of activities and had started to act on it. For example, one person enjoyed painting and the interim consultants were organising for their painting equipment to be brought into the home. A family member told us that their relative needed to, "Get out more". We fed this back to the acting proprietor and the interim consultants.

People did not receive the delivery of care that they required. For example, there was very limited evidence that most people were being supported to have a bath or shower. One person's plan said, 'I do enjoy a bath when I get in, it just may take a bit of time'. This persons bathing and showering record showed that they had had three baths in a two month period. Another person's record showed they had only been supported to have strip washes for the five weeks preceding the inspection. A third person's record stated they had not had a bath or shower between December 2015 and April 2016. One person told us they had a bath about once a week. They thought they could have more if they wanted but added, "The bathroom is blooming cold, coldness is my biggest enemy here".

As part of the serious safeguarding concerns being considered by the local authority, district nurses visited the home and completed body maps with people's permission. They found significant areas of concern with unidentified and untreated wounds, and pressure care issues which affected people's skin integrity. The district nurses took appropriate action to address these healthcare needs.

The serious shortfalls in assessing, planning and delivering safe and responsive care were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they had not received any complaints, concerns, comments or compliments since the summer of 2014. There was information on making a complaint available in communal areas.

Inadequate

Is the service well-led?

Our findings

The home was not well-led.

At the last inspection the manager told us that meetings for people who lived at the home and quality assurance surveys would be undertaken. At this inspection we found people or their relatives had not been asked for their viewpoint of the quality of service they received since 2014. This meant there had been not quality assurance surveys and no meetings for people who lived at the home. At the last inspection the manager told us they would start holding staff meetings. This would enable there to be more effective communication, for staff to learn about good practice and for staff to contribute ideas or raise concerns. However this did not happen and this inspection identified that no staff meetings had been held since March 2015.

The interim consultants had made a number of changes to ensure people's needs were responded to promptly with safety in mind. These included identifying people's safety, nutritional and personal care needs. The interim consultants were also developing documentation that supported care workers to understand how people wanted or needed to be supported. They were also identifying staff training and support issues and had a plan in place. They also told us they were spending a large proportion of their time in communal areas to model to staff how to deliver person centred care.

The acting proprietor and manager did not have a development plan until the interim consultants commenced their support. The recommendations made at the last inspection in September 2015 had not been acted on. The interim consultants had swiftly identified and prioritised an action plan that would ensure people were safe. Moving forward their action plan explored how the service could work with individuals to improve their quality of life. The two interim consultants had made a number of changes which both staff and people told us were making a big difference. One person said the interim consultants had, "Made a huge impact" because they responded to the person's requests or concerns. They said this had not happened in the past.

Leadership had not been provided and basic requirements such as effective nutrition and hydration had not been adequately assessed or delivered. The lack of overall oversight had led to significant issues with the building and infection control. Support systems were not in place. Care delivery was provided by staff intuitively and sometimes inaccurately because staff had not been supported to understand their role and responsibility through training, supervision or appraisal.

The acting proprietor and registered manager had not undertaken steps to ensure people received safe, effective, and responsive care. . The quality assurance policy had not been implemented. There were not any accurate audits or reviewing systems in place that fed in to an improvement plan for the home. The findings throughout the inspection showed there was a failure to identify, assess, and mitigate the risks relating to the health, safety and welfare of people and others who may be at risk. In addition, there was a failure to assess, monitor and improve the quality and safety of the services provided.

Record keeping was extremely poor, with gaps in records, negative comments and inaccurate care plan information that provided staff with incorrect guidance.

The serious shortfalls in governance were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.