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Dunedin Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

On the 25 October 2016, we inspected Dunedin Residential Home and found significant failures in the safe care and treatment of people living at the service. Following this inspection, we placed the service in special measures, restricting admissions to home and enforced positive conditions on the provider to submit to us, each month, a report on how the service was improving the areas of concern.

We returned to the service on the 20 and 21 February 2017 to carry out a comprehensive ratings inspection to assess whether the service had improved. Whilst some improvements were made, the service continues to be inadequate in providing safe care and treatment to people. You can see what measures we took at the end of the report.

Dunedin Residential Home is registered with the commission to provide care to up to 21 people over the age of 65, who may or may not be living with dementia. At the time of this inspection, only 11 people were living at the service.

The service is operated as a partnership, with three people registered as making up this partnership, within the report they will be referred to as the provider.

The registered manager had left the service and a new manager was in place. They had yet to register with the commission at the time of 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.

The provider had not routinely maintained the environment and there were significant risks to people's health and safety. The provider did not take action to reduce these risks; they did not introduce action plans and did not specify how or when improvements would be made to make sure people were safe.

Sufficient recruitment checks had not been carried out before staff started work to ensure that they were suitable to work in a care setting. The registered provider had failed to ensure a risk assessment was in place to mitigate risks regarding employing a person with recent criminal convictions or document the reason for their employment. This exposed people who used the service to the risk of being supported by staff who may not be suitable to work with vulnerable adults.

Whilst the monitoring of medicines had improved, when errors had been identified action had not been taken to make sure future practices were safe.

Infection control practices were poor and cleaning staff did not have access to appropriate equipment.

Induction practices for care staff and training of staff had improved and we saw a variety of training opportunities that staff were now being invited to attend.

People's nutritional needs were being met and appropriate referrals had been made to the dietician and speech and language services.

A new staff team had been employed and we saw some caring responses to people. However, there continued to be little engagement with people, particularly for those who were less able to join in with group activities.

Staff did not understand what protected characteristics were. Confidentiality of people's information was poor and staffs understanding of capacity and consent remained poor.

Care plans, did not provide staff with information about how to meet people's health needs. Some systems had been improved and people and their relatives were now asked to give their views about the care they received.

The provider continued to have very poor oversight of the service. They did not have clear governance system or audits in place. Those employed to by the provider to manage some of the issues identified, had not taken appropriate steps to ensure that actions were being implemented effectively.

New managers had been recruited, but the provider did not provide them with an induction and did not support them to carry out their role.

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

The provider had not acted to address significant safety concerns highlighted in fire, health and safety and electrical audits to ensure that the environment was safe.

The provider had not ensured that people employed were recruited safely.

Medicines management still highlighted concerns that had not been addressed by the manager in regards to staff competence.

Care plans did not inform staff how to manage risks to people with physical conditions.

Is the service effective?

Requires Improvement

New staff had not completed an induction that was robust.

Staff had a poor understanding of Mental Capacity and Deprivation of Liberty Safeguards.

People had a good choice of freshly prepared nutritious meals that catered for people's dietary needs and personal preferences.

Is the service caring?

Requires Improvement

The service was not always caring.

The provider did not demonstrate that they cared about people at the service, the environment they lived in and the care they received.

Confidentiality of people's personal information was not always kept secure.

Most staff demonstrated care and caring responses to people.

Is the service responsive?

Requires Improvement

The service was not always responsive

New care plans were in place, but they were not always written in a person centred way and did not contain enough information to enable staff to care for people responsively.

People's needs for social interaction were not met and there were very little activities for people to get involved in if they wanted to.

Complaints had not been used by the provider to improve the service.

Is the service well-led?

Inadequate

The service was not well led.

Deadlines for actions plans regarding service improvement and safety had not always been met. There was no clear plan of priorities being identified.

The providers continued to have poor oversight of the service and the people they had employed to ensure improvements were made.

The providers demonstrated a lack of care and compassion for the people living at their service.

Dunedin Residential Home

Detailed findings

Background to this inspection

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

This inspection took place on the 20 February 2017 and was unannounced. We returned for a second day on the 21 February 2017, announced so that we could meet with the provider and discuss our concerns.

We previously inspected the service on the 25 October 2016 and found significant failings. We placed the service in special measures restricting admissions and enforcing a positive condition to submit monthly quality reports to the commission.

Since the last inspection, the service has been closely scrutinised by the local authority and the Care Quality Commission, resulting in monthly reports from the service and intelligence gathering from the local authority, which we used to help inform this inspection.

Only four members of staff remained from our last inspection in October 2016.The service had a new manager and deputy manager in place, although the new manager was yet to apply to be registered with the Care Quality Commission.

Whilst at the service we spoke to seven people using the service, three relatives, and two friends. We interviewed five staff; pathway tracking five people's care plans and care provided and carried out a number of observations of care staff working with people. We reviewed the information that the manager kept about six members of staff, and policies and procedures that supported the everyday running of the home.

This included a review of any complaints, quality control measures such as audits that the manager and provider carried out to ensure that people were safe and that care provided was effective, caring, and responsive. This included minutes of meeting minutes, action plans for improvement and observations of staff in practice.

Many people at the service were living with dementia and were unable to fully verbalise their experiences of living at the home. In order to gain an understanding of people's experiences of the service we carried out a Short Observational Framework for Inspection (SOFI). This is an observational tool used to collect evidence about the experience of people who use services, especially where people may not be able to fully describe these themselves because of cognitive or other problem.

Inadequate

Is the service safe?

Our findings

People, relatives, and staff told us about institutionalised and abusive practices at the service, which included staff charging people for being escorted to make bank withdrawals. In October 2016 we saw evidence that people were strip washed rather than being offered baths or showers. This was further corroborated by staff and people at the service. Staff told us, "Until the new manager came, people didn't get offered baths or showers it was just a strip wash."

Relatives told us of when they had made complaints and how these were ignored and not documented. People told us they were taken to bed and got up too early. We were told that some people who wandered because of their dementia had not been allowed to leave their chairs. We were told staff spoke rudely to people.

The provider had not improved systems sufficiently to ensure that people were recruited safely to work at the home. During a meeting with the providers and the local authority in October 2016, it had been discovered that the service intended to recruit people who were not appropriate to carry out the role of manager. Following this, the provider told us that any future manager would undergo two interviews during an assessment. Whilst the new manager in place had appropriate experience, they had not undergone these processes and had not been informed at the time of the job offer of the significant concerns about the home.

Some of the new staff were related to each other; checks had not been carried out to make sure, that this could not become a conflict of interest.

Records of interviews were not kept and references from previous employers were not always obtained. People's eligibility to work in the United Kingdom was not routinely checked as part of the recruitment process. Staff did not always have evidence on file to evidence their identity, such as a picture driving licence or passport. Some staff told us that interviews were basic as they knew the provider and knew they were going to get the job.

When basic professional references were given without information about the character and suitability for the role, the provider had not always followed these up to make sure that applicants were appropriate to work at the home.

We found that although staff had DBS (criminal records check) prior to commencing work, that when previous criminal convictions had been disclosed, a risk management plan was not in place to ensure that they had considered the risks. Not all new staff had received safeguarding vulnerable adults training, although they had been working at the home for more than four months. These issues had previously been highlighted as a concern in October 2016.

This was a continued breach of Regulation 19 of the Health and Social Care Act 2008; 2014, Fit and proper persons employed.

The manager and deputy manager had been asked to carry out complete personal emergency evacuation plans (PEEPs) and care plans reviews for people at the service without any prior knowledge of them. The manager said, "I couldn't believe this hadn't been done, and without prior knowledge of people it was difficult. I had to keep going out and checking whether people could walk or not."

Infection control standards remained poor. On the first day of inspection, a note was attached to the front door informing people of an infectious outbreak, but staff told us there had not been an infection outbreak. One member of night staff informed the inspector they did not know about the outbreak, although they were on their fifth consecutive night shift. Consequently, we could not be sure that staff on duty had appropriate handover about people's needs and how to manage risks of cross infection.

The infection control policy was out of date and there was no guidance for staff in the policy to deal with an infectious outbreak. Staff did not understand how to manage a potential outbreak. People suspected to be unwell were not isolated and were using the same toilet areas as those who had been documented as being unwell the previous day.

On the day of the suspected outbreak, we discovered that cleaning staff did not have the appropriate equipment to clean the premises Infection control policy dictates that appropriate coloured equipment should be used in infectious areas to reduce cross contamination. We saw that a blue bucket was used to clean toilet floors. There was only one blue and one green bucket in the whole home. The manager told us that green bucket was used for the kitchen, but this was contrary to what we observed in a Health and Safety report completed in December where a photo showed the blue bucket being used in the kitchen. A staff member told us they had asked the provider for appropriate buckets and equipment numerous times but this had not been provided. We spoke with the provider and noted they immediately went to purchase the correct equipment. Inspectors had to prompt the manager to contact appropriate persons and put in measure to minimise potential risks of cross infection.

In October 2016, we raised concerns about call bells not working. During this inspection, we were informed that some were still not working but staff did not know which ones. This left people at risk if they were in their room and unable to call for help. A proper test and audit of the call bell system had not taken place. We received information from former staff informing us that the problems with the call bells were longstanding.

An electrical installation condition report dated 16 January 2017 stated that, "Works are required to be carried out to bring the installation up to current standard." At the time of inspection, these had still not been carried out or booked in. The provider told us that they had been let down but they were not able to demonstrate any other measures had been taken to address the situation.

In December 2016 an independent Health and safety inspection was carried out. It identified significant issues over security at the home, which had still not been addressed at the time of inspection. For example, doors on various levels did not close properly and posed a risk of people falling down the stairs and for vulnerable people to leave the building without staff seeing them leave or members of the public getting into the building.

Following our inspection, a metal object came away from the fire escape and crashed through the conservatory roof where people sat for meals.. The builder employed by the provider checked the area and informed the manager that the metal had eroded away due to lack of maintenance. A visiting safeguarding officer had to advise the manager cordon of the area and make it safe, as this was not done. Had people been sat in the conservatory when the incident happened the object might have seriously injured someone.

A fire safety assessment completed in December 2016 rated the home as being a substantial fire risk and that urgent action should be taken. The provider had not taken action or put plans in place to make sure that fire risk to people had been reduced. Following the inspection the provider sent us a blank action plan which did not detail timescale or priorities for the completion of the works.

This was a continued breach in Regulation 15 of the Health and Social Care Act 2008; 2014, Premises, and equipment.

New staff had received medicines management training, however night staff remain unable to administer as have not received competency checks following training. This had previously been highlighted as an issue by both the local authority and CQC in October 2016. We discussed this with the provider who felt that night staff did not need to administer medication, however as some of the people at the home had health conditions that were painful, or at times became distressed it would be essential that staff be able to offer PRN (as required medications) if the need arose.

Medicine audits had been introduced following concerns that people medicines were not always being administered safety. The audit had identified that staff had signed for medication but had not given them. The manager did not record this as incidents, nor did they investigate why this had happened or seek advice from the persons GP about whether the missing of medication would have affected people. As all new staff had only just recently completed the medicines training, it was not documented about whether they were competent to continue to administer medications or further training and oversight was needed.

The content of care plans was confused at times with conflicting information. For example, a moving and handling plan, "I don't need any assistance to walk around," but then a risk assessment ticked that the person was unsteady on their feet and needed the assistance of one, and later stated the person walked and mobilised from place to place independently. The action plan to prevent falls for this person was to "ensure [person] is safe to mobilise at all times" but not how staff should do this. We talked to staff and they did not know whether the person should be supported at all times, but told us that they would not let the person leave the living room area without a member of staff, this meant that often the person was encouraged to sit down if they tried to get up and wander away, so that staff could remain in the lounge.

This was a continued breach in Regulation 12: of the Health and Social Care Act 2008; 2014, Safe care and treatment.

Requires Improvement

Is the service effective?

Our findings

The service was not always effective.

Induction processes of new staff were not robust. A new induction record had been developed for the manager to use but this was a series of tick boxes to say that staff had read something or been informed of their duties. The manager and deputy manager had not received appropriate support to effectively and safely carry out their roles.

Both manager and deputy manager reported that they had not completed their induction and that they had been emailed the induction workbooks and told to complete them themselves. As these workbooks were used to monitor that all new staff were competent to carry out their roles it would be difficult to evidence that an appropriate induction had been given for the manager and deputy, as there had been no external oversight of this by the provider or consultant.

Amongst the induction booklets were actions for staff to read certain policies and procedures that related to the safe running of the home and care provided to people and the expectations of staff. Staff had been unable to sign these because the policies were being rewritten and there was no timescale for them to be completed. The consultant overseeing the home's improvements was leading this piece of work and was developing new policies. The manager told us they did not know when they would be completed. This lack of planning and communication meant the manager and staff did not have reference to current procedures or a knowledge of when these would be in place. However, since the inspection, it is important to note that all policies have now been updated.

Manager and deputy manager supervisions only occurred at two monthly intervals, although both were still within the probation period. During the previous inspection, we had found a number of significant failings at manager level that had not been identified by the provider. The lack of regular supervisions during the induction phase of the new management team with a new group of staff in place was not robust. The manager supervisions just documented a list of the manager's and deputy manager's responsibilities but did not review things that had been in place or still needed to be completed.

However, we did see that care staff were now receiving regular supervision from the new manager and their deputy. The quality of these supervisions was good and we saw that they identified how to support carer staff to improve practice and acknowledged their strengths and what they could bring to the team. A supervision record was in place to ensure that staff received regular formal supervision. In addition to this, staff told us that the manager's door was always open and staff found them approachable and felt able to ask for advice as to how to support people living at the home. Staff told us, "The manager is really kind and I feel I can talk to them about any worries or concerns, they are really good."

Following concerns raised during the previous inspection, we did see that training of staff had improved. Training sessions had been developed to tackle a number of previous concerns, such as the care of people who are unwell, and person centred care. In addition to this, more face-to-face training had been planned.

This included note writing, infection control, and end of life care.
The consultant employed at the home was delivering much of the training; however, additional training had been sourced from outside agencies, such as the local hospice for end of life training and support. Most new staff had received all their mandatory training, such as moving and handling people and a new training matrix was in place that identified when staff had been trained and when they were due for training refreshers.

The Care Quality Commission (CQC) monitors the operation of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) which apply to care homes. We found the manager was making appropriate DoLS when the need arose, chased up applications for assessment and sent in the appropriate notifications to the CQC.

The Mental Capacity Act 2005 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.

Care records confirmed that the management team carried out MCA assessments to consider people's ability to make day-to-day decisions. The registered manager demonstrated that they understood the processes to be followed to assess people's capacity.

Staff had undertaken the Mental Capacity Act training as part of their inductions, however their understanding of the principles of mental capacity remained poor, and some did not know what a DoLS was. They did not have a good understanding of capacity, consent, and restrictive practices. For example, we spoke to staff who did not know whether the person was independent or not but erred on the side of caution by saying they were always with them when they moved around.

We observed that the person was at times strongly encouraged to stay seated when they started to get up from their chair. Staff told us this was because the person wandered out of the lounge area out of sight and was at risk of falls. Staff did not consider this a restriction on the person. Although, at other times they were encouraged to dance with staff and walk around the lounge area with staff. This did mean however, that the person was restricted from mobilising independently around the home.

The quality of food at the home had improved and a new cook was in place and had redesigned menus and the way the home brought food. People told us that the food was delicious and that plenty of choice was on offer. During the morning, people had breakfast once they were up and this was prepared individually or in small groups, dependant on what people wanted. People tended to remain seated in the lounge for breakfast with small tables in front of them and we saw people being offered a variety of things, which they enjoyed.

A new blackboard was on display in the lounge area, clearly identifying the choices available and staff would show the food to people to help them make a choice. The conservatory attached to the lounge area had been transformed into a dining area. Staff told us that people had never been encouraged to use the dining room before so initially did not want to get up from their seats, however, with a slow trickle of people sitting at the tables, people started to join in and that now the dining experience was more inclusive and enjoyable.

The cook had introduced thorough cleaning and food auditing procedures to ensure that the kitchen was

clean and storage of food safe. They also had lists of anyone who required specialist diets and drinks, and when people had birthdays so that they could make a cake to celebrate. There was a choice of drinks and people could request a hot or cold drink at any time, not just inside the allocated drinks trolley time.

Residents meeting minutes demonstrated that people were asked what their preferences for food were and that these were considered and planned into the menu. If people changed their minds about what they would like to eat, staff told us that they would be able to request alternative. For those people requiring a softer diet due to swallowing difficulties, food was presented well, with each food source being pureed individually.

Previously we had found that people living at the home had not always received timely advice and support from other health and social care professionals when the need arose.
During this inspection, we did see that this had improved. Reviews of people's needs carried out by the local authority meant that the service had carried out appropriate referrals. We saw evidence of hospital appointments and referrals to district nurse teams, Podiatrists, Diabetic nurses, Dentists and Speech and Language therapists. Staff arranged transport for people and if needed would escort them to their appointments.

Communication systems had been put into place to alert staff to appointments for people had also improved. We saw a communication book and diary to notify staff and inform if transport had been arranged. Although advice was not recorded thoroughly in care plans so that staff could follow best practice. We saw evidence when an appointment had been missed as staff had not recorded it in the diary, and the management team with staff followed this up during handovers in attempt to prevent people from missing future appointments.

Requires Improvement

Is the service caring?

Our findings

The service was not always caring.

The provider had updated a downstairs communal shower room that we had previously identified as dirty and in desperate need of repair, however the commode chair used over the toilet was still heavily stained from use and urine. The provider had seen this room prior to and following completion of the works, but had not done anything about the commode seat.

We highlighted concerns about old, stained, and worn bed linen, duvets, and towels during the inspection in October 2016. Staff told us that whilst new duvet covers had been brought, duvets had not been replaced until December 2016, when the issue was highlighted by the new manager to the provider that the duvets themselves needed to be condemned as they were stained, worn and in a poor state. This lack of immediate action demonstrated a lack of caring and respect for people using the service.

This was a continued breach of Regulation 10 of the Health and Social Care Act, 2008; 2014, Dignity and respect.

There had been a significant turnover of staff since October 2016, and an overlap of previous staff and new staff during this period. Following the last inspection, we had continued to receive concerns about institutionalised, uncaring, and neglectful practices at the home. During this inspection, new staff were able to demonstrate how people at the home had "changed" in the months following new management. We spoke to people and to relatives who confirmed that some people had "come out of there shell," "been less withdrawn and more like their old self," "now always smiling." Staff also told us, "We are getting people up and moving now," "People come to the dining table more", "[Person] talks so much more to us now."

We observed staff speaking to people with respect and offering them choice, "Would you like a hot or cold drink, [option]?" "Would you like me to put on this apron in case you spill any food?" Staff were smiling and pleasant in responses, however, on occasions staff just told people what they were going to do without involving them of offering them a choice. For example, "I am going to put this apron on you so you don't spill food down yourself."
However, we also observed that on occasions some staff were condescending in their approaches to people and that some staff were more engaging and person centred than others. For example, some staff actively sat and engaged with people while other staff just sat quietly next to people without interaction.

We did however see staff use gentle reassuring touch, such as a hand to a person's shoulder or holding people's hand when they offered it to them. A relative told us, "I was so worried about [person] before and raised so many complaints that were always excused away. They used to sit their looking sad and sometimes when staff approached, they flinched away. I have even seen people who wandered tied into their chairs in the past. Since the change in staff and manager [person] is now smiling all the time and happy wandering, and dancing and singing. They never used to do that before."

One person told us that most staff were, "Lovely and very kind," but they had been left feeling like a burden following some negative comments by a member of staff after they had requested assistance. We reported this to the manager who told us they would address this with the member of staff. A relative told us, "The difference in the staff and how they talk to people is much better, [name] is so much happier now. There is a significant change in them."

Care plans had been completed by the new manager and her deputy, however there was no evidence of involvement with people. The manager told us that they had been asked to complete a review of the carers as soon as they started work and had spent ages in the office rewriting things and putting things together. However, the manager told us there were plans to ensure that every person would have personal information about their lives, preferences, and hobbies. Some relatives had been given copies to complete, as their relatives were unable to give to a full account due to living with dementia. The manager was hopeful that this would help to inform staff and create meaningful and caring interactions between people and staff at the service.

There had been a number of safeguarding concerns raised about previous staff and people at the service. We saw that the new manager and the majority of staff were sensitive and caring to people's individual needs and offered support and encouragement to people to express their concerns, particularly when they were having to be interviewed by the police and other health and social care professionals.

Following this, the manager had accessed some advocacy support for a person at the service and this had been helpful, however the poster for the advocacy service was displayed in the manager's office so people and relatives would be unable to see this if they needed that type of support. One person we spoke to wanted but did not know how to access support. We highlighted this to the manager who was able to help the person get the access they needed and move the poster so it was accessible to people and loved ones at the service.

Confidentially of people's information was not secure. Communication books, diaries, and handover records were all kept on the dining table in the conservatory adjoined to the lounge. People's daily records were kept in an unlocked filing cupboard in the corner of the conservatory, and we saw a list of staff telephone names and names accessible for all to see. We addressed this with the manager who informed us that personal information was normally kept in the filing cabinet, however acknowledged our concerns and immediately addressed this issue with staff, removing the personal information from areas where people at the service and anyone visiting could access it.

There was a general lack of confidentiality about care being provided. For example, the dining room, which was not separate from the general lounge, is where handover took place in the morning. Staff handed over in the presence of people in the lounge the care that had been provided, including whether the person had been to the toilet, and if there had been any personal or physical concerns. This did not protect peoples, privacy, and dignity and staff had no insight into why this should not be happening in the present of people at the service.

Requires Improvement

Is the service responsive?

Our findings

In all care plans reviewed we found a variety of on-going health conditions that were mentioned but with no information about how conditions affected the person, for example if they required a special diet due to a stomach ulcer, or if they needed medicines at a particular time due to conditions such as Parkinson's. When mental illness had been identified, the information to inform staff how to support the person was poor. For example, an intervention for depression and low mood was to ensure that the person looked well kempt for when their relatives arrived.

A "Care plan champion" role had been assigned to the deputy manager by the consultant working with the service to drive up improvement. The consultant had carried out one supervision session with the deputy manager and informed them of the excellent standard of the care plans, however the manager and deputy manager when asked, told us the consultant had not read any of the care plans completed by the deputy.

Care plans layouts had the potential for being person centred, however they remained basic and without guidance to staff to help support people in their care. For example, supporting someone with physical health concerns such as diabetes. Interventions told staff to keep blood sugars within a normal range but did not inform staff of what the person's range was, when blood sugars should be taken, where to record it, and what they should look for if the person became unwell. However, most staff had recently undertaken a short session on diabetes care.

Care plan information regarding people's equality and diversity and the protected characteristics such as race, sexual orientation, and disability were poorly considered, and staff had a very limited understanding of these issues. Only two of the staff members had received equality and diversity training. Care plans asked the question about a person's sexual orientation but comments to this were, "Likes to be shaved," "likes to smell nice and brush her own hair.'

We asked how staff would support people with a protected characteristic, such as disability, sexual orientation, religion, but they could not identify what they would do, for example where they would access support. One person was identified as being religious and enjoyed weekly church meetings and staff were to take them. However, we checked records and found that they had not been to church for some time. We asked the manager about this and they spoke to staff who stated that the person had stopped going due to the cold weather. There was no exploration about having anyone from the church visit the person at the home to support this need.

A new activity coordinator had been employed for two and a half hours per day, five days a week. They tried to use this time to engage with as many people as possible, although they had to spend half an hour writing activities in people's notes. The manager told us they often stayed beyond their time to complete these. Due to the limited time, the activity person was not able to carry out interaction for all people at the service. They tried to take people out individually when weather permitted, for example to the shop or beachfront. However, those who were less able to engage did not have the level of engagement that might improve the quality of their lives. The manager told us that staff were going to be spoken to about carrying out activities

with people during supervision, but this had been an action previously identified and not carried through.

We observed that some staff were more engaging than others and could communicate well with people and most staff had received person centred care training. However, limitations of staff time to attend to people's personal needs and the limited time that the activity person had meant that people spent much of their time just sitting in the lounge with the television or music on without meaningful engagement.

This was a continued breach in regulation 9, of the Health and Social Care Act, 2008; 2014, person centred care.

The new manager tried to be responsive to people's changing needs. For example, where a person's mobility had deteriorated, and they found the room they were in uncomfortable. The manager spent time with the person and offered them a bigger room closer to the ground floor. The person was encouraged to choose a colour of paint they liked and the room had a wall painted in the colour in preparation for them to move.

Complaints and comments processes had improved and the new manager had introduced comment slips that were visible to anyone entering the building. They also held regular meetings with people at the home and invited their loved ones to take part. One relative told us, "Under [the manager] new management, things seem to be much better and she listens to me." People had been able to comment on some of the changes in lay out of the service. People had been able to open up to the manager and talk about previous poor care practices. The manager told us that any complaints would be properly investigated and used as a tool for learning for staff.

We also saw evidence of relative and resident meetings with people were taking place so that people could say how they felt. However, when issues were identified, there was not action as to who would follow these up.

Inadequate

Is the service well-led?

Our findings

The service remained inadequately led with very poor oversight from the registered provider.

The provider was a partnership of three people. During the inspection, we were told that one of the partners had been a silent partner for many years but we discovered that they had deregistered from the service several years from companies' house, the government's department of work and pensions who registered business. Neither partner had completed the appropriate notification to the CQC to inform us as required under the Health and Social Care Act, 2008; 2014.

One of the providers visits the home daily and staff told us about the provider having arguments with staff in front of people living at the service. They told us that they had complained and things had improved for a short while.

Much of the maintenance work in the home had previously carried out by one of the providers in order to save money but this had been completed to a low standard. For example, leaks from toilets, which came through to ceilings below. We also saw photographic evidence of poor work carried out by the provider, which had been sent to us from an ex-employee. This poor standard of upkeep was evidenced by the poor overall maintenance of the home.

The manager had to rely on the provider when things needed to be purchased, such as shopping and equipment. We saw evidence sent from previous employees spanning over four years that the provider did not always react to the needs of the service. For example, the manager had to submit shopping lists and did not have the funds to purchase anything independently. The provider often omitted things from the shopping list that were requested, and argued about why they were needed, for example cleaning equipment and extra meat and fish for meals. Consequently, we could not be confident that once oversight of the service from external agencies was removed that the provider would maintain the quality and standard of food provision.

We spoke to the new manager who told us they had been promised some petty cash to hold on the premises. These funds which could be used without authorisation were to purchase things, as they were needed, or for emergencies. In the two months the new manager had been at the service, this money had not materialised.

We were told about one situation by the local authority, and questioned the manager at the home about an unpaid newspaper bill of nearly £600. People at the service had been contributing to the purchase of newspapers; however the actual bill had not been paid. The provider gave the local authority the reassurance that they would pay for this bill, however we found that following this meeting staff had been told to ask people to pay again. The manager told us that they had had to remind the provider that they had promised to pay for this bill.

On the second day of inspection, we met with the provider. When challenged about the lack of progress at

the home in regards to the concerns identified in the previous inspection, the provider refused to acknowledge their own responsibilities. They told us, "I employ people to do that stuff." In spite visiting the home once a month, they had not noticed the serious failings at the service.

One of the providers sometimes slept at the home overnight. While on a tour of the premises with the provider we observed that they did not know people living at the service very well, in spite of staying over on occasion. People did not recognise them and the provider did not speak to the people whilst we were in the same room, they did not show any interest into their general wellbeing. Staff told us this was normal behaviour from the provider.

During the tour with the provider, we showed them the toilets and sinks in people ensuite toilets and in communal bathroom, areas were old and worn with high level of build-up of lime scale. Furniture in people's bedrooms remained old, worn, and stained. Some had handles that were missing and we saw stains on ceilings from old water leaks. In one vacant room, a painted metal toiletry holder was badly rusted and dirty and we saw walls heavily scuffed in places and some rooms with holes and dents in the walls.

We discussed these issues with the provider who did not understand the link between the physical environment in someone's person space/ bedroom, and their feelings of self-worth, dignity, and feeling of being respected, and cared for. We saw evidence from previous employees of reports and quotes for updating and repairing the environment and furniture. However, these were never actioned.

Inspectors asked the provider about their oversight of the service, and the new manager and what was in place to support them. The provider told us they had on-going communication, "You can see all my emails, hundreds of them about this place." He said that as he had employed the manager they should be the one who should be 'managing' the service, "That is what I pay her for and her skills and knowledge."

The new manager informed us that one of the providers had tried to recruit a person on the spot even though they had a criminal past and without carrying out relevant checks and considering the risk to people at the service. The manager had had to "put my foot down" and refuse to employ the person.

There were no identified visions and values to the service and the lack of provider consideration for the wellbeing of people and the environment they resided in had contributed to the poor standard of care provided. At the time of inspection, there had been considerable input from the local authority in trying to support improvements. Whilst there were some improvements in the quality of care, the provider's lack of oversight and commitment to supporting the management team, historical neglect of the maintenance and safety of the environment, and on-going improvements to the safety of the environment at an reasonable and organised pace, meant that we had no confidence that improvement's would continue once the local authority withdrew support.

Previous interim management had broken down due to lack of experience and poor level of support from the provider. In a letter to the CQC, the interim manager informed us of the extreme pressures they had been placed under to try to turn things around, whilst also trying to cover shifts and carry out their regular role. This person had not received any thorough oversight and guidance other than regular phone contact with the consultant employed to drive up standards at the home. They were not informed of their duties to report notification's to the CQC. The provider had not learnt lessons from this in how to support the new manager, and consequently we had no confidence that the new manager would receive the on-going support needed to turn this service around.

Huge demands were being placed on the new manager by the consultant and the providers to keep up with

improvement action plans submitted monthly the local authority and CQC.

The manager, who only joined the service in mid-December 2016, told us, "I couldn't believe that many of the things that needed doing had not been done. I get emails constantly requesting more and more." They told us that they had found issues each day as people and relatives started to share their past experiences of care at the home.

This continued lack of provider commitment and oversight was a continued breach in Regulation 4 of the Health and Social care Act 2008; 2014, Requirements where the service provider is an individual or partnership.

We asked the provider about the action plans for works and they told us, "I have kind of a plan," and the maintenance man is getting on with things." We informed them that we spoke with the maintenance man who told us they did not have a written plan to go by and most things where in their head. There was no prioritising of tasks to improve the health and safety of the environment. The provider told us, "oh yes there is a plan I have a copy of it." Then said, "I hope to god the plan is there." We were not shown an action plan for improvement. The provider told us "All the rooms one by one are getting a white wash." They did not consider the need to make room's person centred, or understand why this was important.

The consultant employed to oversee some of the improvements at the service had not shared timescale's with the manager about when certain things to support the running of the home would be completed. For example, they had not shared a timescale for development of policies and procedures for carrying out the regulated activity. The manager did not know when and which works would be completed.

We saw the health and safety report, electrical report and the fire report which all raised concerns about the environment, however the manager told us that they did not know when works would be completed, as they were not the one doing the actions plans and time scales for improvements.

The various health and safety reports had not been used to develop a time frame for improvements to the environment. The manager told us, "The consultant is sorting that out; I have no idea when this will be done." We fed back to the provider our concerns at the lack of a plan of action to address the most important safety issues highlighted in reports. In response, we received an action plan from the consultant, but there were still no time frames for work to be commissioned and completed.

The new manager was transparent, open, honest, and caring, however, we found that when they had found issues they had not acted promptly and appropriately to deal with them. For example there were issues in medication audits and there had been no review of recruitment files for gaps. The provider hindered the manager's ability to carry out their job role effectively. The manager told us it was "Overwhelming" at times as there was so much to do and each week there was more and more issues. They were so overwhelmed with requests from the provider and the consultant; they found it difficult to prioritise what needed to be done.

Staff who had been underperforming had gone through disciplinary processes to improve performance; however, a number of staff chose to leave instead of going through these processes. On one occasion, the new manager and a member of staff observed a serious safeguarding incident. The member staff refused to go through the disciplinary process and resigned.

The new manager had many years of experience in working as a manager in care homes, however had not had a thorough and robust induction to the service. For example, having to complete their own induction

booklet. They told us that whilst they knew the service had received a negative inspection in October, they had not been informed of the scope of improvements needed.

This was a continued breach in Regulation 17 of the Health and Social Care Act, 2008; 2014, Good Governance.

A new whistle blowing policy had been introduced and displayed for all staff to read and staff were required to say they had understood. The manager told us, "After everything that happened here previously, I wanted to make sure that this was the first policy that we had in place. It is important that staff know their responsibilities to speak up and that they feel safe to do so. I really care about the people here and I want the best for them."

The manager had identified some poor practices when they began working at the service and had worked to change these practices. For example, we saw meeting minutes that demonstrated that the new management team had identified that night staff routinely woke, washed and dressed people prior to day staff arriving on duty. Consequently, we began the inspection very early in the morning to ensure that these practices has ceased. Whilst that there was a few people up early notes documented that this was their choice and people told us they had wanted to get up early. We also saw that people were not supported to remain in bed until they were ready to get up.
Measures put in place included the manager and deputy manager working at varied times of the day, such as starting early morning, and alternating weekends. These had proved effective in changing these practices.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans did not identify and plan for people's individual needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had not acted on all the previous concerns regarding the cleanliness and condition of items used for shared use by people at the service.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service had not acted on safety concerns that they knew about and that had been highlighted following their own internal audits.

The enforcement action we took:

We issued the provider with a Notice of Proposal to cancel their registration in January 2017. The provider has submitted representation to this notice which are currently under review. The evidence from this inspection will be used alongside these representation's in order to make an informed decisions as to whether CQC issue a Notice of Decision to cancel the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had not acted in a timely way to address safety concerns related to the environment that had been highlighted by external professionals. These environmental checks had been arranged by the provider following positive conditions placed on them to do so in October 2016.

The enforcement action we took:

We issued the provider with a Notice of Proposal to cancel their registration in January 2017. The provider has submitted representation to this notice which are currently under review. The evidence from this inspection will be used alongside these representation's in order to make an informed decisions as to whether CQC issue a Notice of Decision to cancel the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had no action plans with timescales for improvements to be made. When new internal audits identified issues the provider and manager had not acted on these audits to address potential issues. The service did not have robust policies and procedures in place to support the overall

governance and running of the home. There was no timescale for these to be completed by and a lack of communication between those responsible to complete it and the manager in place.

The enforcement action we took:

We issued the provider with a Notice of Proposal to cancel their registration in January 2017. The provider has submitted representation to this notice which are currently under review. The evidence from this inspection will be used alongside these representation's in order to make an informed decisions as to whether CQC issue a Notice of Decision to cancel the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not put measures in place following previous recruitment concerns to ensure that people employed at the service were fit and proper persons.

The enforcement action we took:

We issued the provider with a Notice of Proposal to cancel their registration in January 2017. The provider has submitted representation to this notice which are currently under review. The evidence from this inspection will be used alongside these representation's in order to make an informed decisions as to whether CQC issue a Notice of Decision to cancel the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 4 HSCA RA Regulations 2014 Requirements where the service providers is an individual or partnership The provider continued to have a lack of general oversight of the service. they did not have the skills and competence to ensure that the service was safe, effective, caring, responsive and well led. They demonstrated a lack of care and consideration for the needs of people in their care.

The enforcement action we took:

We issued the provider with a Notice of Proposal to cancel their registration in January 2017. The provider has submitted representation to this notice which are currently under review. The evidence from this inspection will be used alongside these representation's in order to make an informed decisions as to whether CQC issue a Notice of Decision to cancel the providers registration.