Minster Care Management Limited

Ashgrove Care Home - Humberstone

Inspection report

Whitehall Farm
North Sea Lane
Cleethorpes
Lincolnshire
DN35 0PS
Tel: 01757 248586
Website: www.minstercaregroup.co.uk

Date of inspection visit: 16 & 18 December 2015
Date of publication: 30/03/2016

Ratings

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

Overall summary

This inspection was undertaken on 16 & 18 December 2015, and was unannounced. The service was last inspected on 15 May 2015 and was found to be in breach of regulation 12 in relation to infection control. We undertook this inspection to follow up on this breach; we also wanted to fully evaluate the service that people were receiving because we had received information of concern that the service may not be managed effectively.

We were aware that the Clinical Commissioning Group [CCG] had placed a suspension on admissions to this service. At this inspection we found the registered provider was still in breach of regulation 12 in regard to infection control and medication. We found other shortfalls in the service which are described throughout all sections of this report.

Summary of findings

Ashgrove Care Home is registered with the Care Quality Commission [CQC] to provide accommodation for up to 45 older people some of whom are living with dementia. Accomodation is provided on the ground floor. The service has private grounds and a separate secure garden. Local amenities and a bus route are accessible. Onsite parking is available. An extension to the service has been completed but has not been registered for use with the Care Quality Commission.

At the time of our inspection the home had a registered manager.A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have the legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found the registered provider was in breach of eight regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to, person centred care, need for consent and working within the requirements of the Mental Capacity Act [MCA] 2005, safe care and treatment, safeguarding people from abuse, cleanliness, infection control and medicine management, staffing levels, staff skills and training, meeting nutritional and hydration needs, complaints, and assessing and monitoring the quality of service provision, We also found a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 for non-notification of incidents. The majority of these breaches were assessed by CQC as high, and posed a possible or probable on-going risk to people's health and wellbeing.

Care records we inspected were difficult to follow; information was not present about people's full and current care needs and risks to their health and wellbeing. We were not able to determine if people were receiving the care they required. People's care plans and risk assessments were not updated as people's needs changed. People who needed to be supported to change their position regularly to prevent pressure sores did not have this undertaken in a timely way by staff. This placed people at risk of harm.

The staff did not have the knowledge and skills to support people to consent or follow legal processes to make decisions in their best interests. People living at the home were subject to restrictive

practice which had not been identified or managed in line with the Mental Capacity Act [MCA] 2005 and The Deprivation of Liberty Safeguards [DoLS.] Consent had not been gained from people or their legal representatives in relation to covert medicine administration and do not attempt cardiac pulmonary resuscitate orders [DNACPR]. This did not protect people's rights.

People's preferences for their care and support were not provided. There was a lack of stimulation and activities suitable for people living with dementia.

There had been a failure to protect people from harm and to recognise and report to the Care Quality Commission when people had been put at risk or had been subject to harmful situations. There are currently six safeguarding concerns being investigated in regard to people living at this service.

There was a continued breach of regulation in regard to infection control throughout the service. We had to ask for a number of issues to be addressed during our inspection. Safe systems were not in place regarding the ordering, storing, administration, stock control and return of medicines. People did not receive their medicines safely the systems were inadequate and placed people at risk of harm.

We found that there were not enough staff available to meet the needs or maintain the safety of people living at the service in a timely or safe way. Staff training was not up to date for all staff which meant that some people were being looked after by staff who did not have the relevant up to date skills and knowledge to care for people safely.

People who required their nutrition and fluid intake to be monitored by staff to ensure their health and wellbeing was maintained did not have this undertaken in an effective way by staff. Timely and action was not taken by staff to ensure all departments and relevant health care professionals were aware of people's needs. Advice given

Summary of findings

by health care professionals was not always followed by staff. Where people had lost weight this had not been acted upon robustly. This meant that people were at risk of not receiving adequate nutrition.

The systems in place to deal with complaints were hard to review and it was not clear if the complaints raised had been effectively investigated or responded to in line with the registered providers policy.

The registered manager and registered provider had failed to monitor the quality of the service provided to people and had failed to provide a safe, effective service which met people's needs

The quality assurance systems in place were ineffective and inadequate. Audits were not undertaken in a timely way, action plans were not implemented to ensure issues found were corrected. Where audits had occurred their findings were inconsistent with the shortfalls we found during our inspection. The registered provider did not have clinical leads in pace or training departments to help improve the quality of the service provided.

Due to the concerns found by North east Lincolnshire Clinical Commissioning Group (NELCCG) at their quality monitoring visits, our findings at the inspection and concerns about the management of the service. After the inspection the registered manager resigned from her post, the registered provider has two area managers running this service. The North East Lincolnshire Clinical Commissioning Group have staff monitoring the service at times when the area managers are not on site to ensure people's safety and welfare.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. People were not protected from abuse. People had been put at risk or had been subject to harmful situations.

People were not protected against the risks associated with medicines, infection control. The management team did not monito the safety of the service effectively.

Staffing levels were inadequate to meet people's needs.

Staff were not aware of people's full and current care needs relevant care was not provided to protect people's health and wellbeing.

The recruitment processes for volunteers had not been followed this posed a risk to people living at the service.

Is the service effective?

Inadequate

The service was not effective. Staff training was not up to date which meant people were cared for by staff who's knowledge and skills were out of date and not in line with best practice.

People's mental capacity was not affectively assessed or monitored. Consent was not gained from people or their legal representative to ensure people's rights were protected.

People's nutritional needs were not monitored effectively. Action was not taken in a timely way to ensure people received adequate nutrition.

Health care professionals were not always contacted by staff for help and advice in a timely way. If they were contacted their advice was not always acted upon by staff. This effected people's health and wellbeing.

Is the service caring?

Inadequate

Staff were not caring. People we spoke with told us they did not always feel cared for by the staff.

Staff were not observant, they did not interact with people and they did not have time to spend with people.

People were not always treated with dignity and respect.

Is the service responsive?

Inadequate

The service was not responsive. People's views and experiences were not taken into account in the way the service was provided and delivered in relation to their care.

The complaints procedure was ineffective and not followed. It was unclear if complaints received had been acted upon appropriately.

Is the service well-led?

Inadequate

The service was not well led.

Summary of findings

Effective systems or processes were not in place to ensure that the service provided was safe, effective, caring, responsive or well led.

The service lacked leadership and management which meant the staff team were ineffective in providing safe and appropriate care.

Care records did not evidence people's care needs were met. Auditing and quality monitoring of the service was inadequate. When issues were found they were not acted upon to enhance the quality of the service provided.

Notifications had not been made to the Care Quality Commission for all safeguarding incidents.

Ashgrove Care Home - Humberstone

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 registered 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 16 and 18 December 2015 and was unannounced. It was carried out on 16 December 2015 by one adult social care inspector, a Contracts Officer, from Procurement and Compliance, North East Lincolnshire Clinical Commissioning Group [CCG] and a Pharmacy inspector. On 18 December 2015 two adult social care inspectors attended the service with the Contracts Officer from the CCG.

We reviewed the information we held about the service prior to our inspection. We looked at the notifications we had received and reviewed all the intelligence the Care Quality Commission [CQC] held about this service, which helped inform us about the level of risk that may be present. We planned the inspection using this information. We had been informed by the CCG that they had concerns about this service. These concerns were raised during their assessment of the quality of the service provided to people. The CCG had a suspension in place to prevent new admissions to Ashgrove Care Home.

During our inspection we undertook a tour of the building. We used observation to see how people were cared for whilst they were in the communal areas of the service. We were shown around the home. We saw how staff interacted with people. We observed breakfast and lunch being served in two dining rooms and observed how staff administered medicines. We inspected 11 medicine administration records [MAR] and medication storage. We inspected six people's care records, this included care plans and risk assessments. Records which demonstrated how the service was run were seen, these included policies and procedures, audits undertaken and quality assurance surveys, training records, staff rotas, cleaning schedules and maintenance checks. Staff files included recruitment information, supervision and appraisal records. We spoke with three people living at the service and with three relatives. We spoke with the registered manager, two area managers, the nominated individual and with seven care staff. We also spoke with three visiting health care professionals.

We looked at how the service used the Mental Capacity Act 2005 and Deprivation of Liberty code of practice to ensure that when people were deprived of their liberty or assessed as lacking capacity to make their own decisions, actions were taken in line with the legislation. We found significant concerns regarding this at the service.

Some people who lived at the service were living with dementia which meant they could not tell us their experiences. We used a number of different methods to help us understand the experiences of the people who used the service including the Short Observational Framework for Inspection [SOFI]. SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

People we spoke with did not tell us that they felt safe living at the service. We received comments from people that the service was short of staff and this meant they had to wait for help and support. One person said, "I like to be up and dressed about 9.30, getting dressed about 11.00 is par for the course, yesterday [17 December 2015] it was 11.30. You are in their [the staffs] hands, I'm flexible but would like to be up earlier. If someone [staff] has not turned up for work there may be a hiccup but the norm of getting up 10.30 to 11.30 it's not great." Another person said, "I'm always up late. I like the girls, [staff] it's just the waiting. I don't like getting up after 10.00 or 11.30. I prefer to get up early." Another person we spoke with told us they were not getting their medicines as prescribed, we found this was the case and asked the registered manager to address this. This placed this person's health and wellbeing at risk of harm.

We spoke with three relatives who all raised concerns about their relations medicines, the concerns raised about staff not giving prescribed medicines to people were substantiated. The relatives told us they felt there were not enough staff to look after people and deliver a safe service. One said, "Sometimes there's not enough staff."

Staff we spoke with told us they had received training about how to protect people from abuse. However, we found that people were not safeguarded from abuse. Since our inspection on 15 May 2015, the Care Quality Commission [CQC] has received notification of eight safeguarding incidents. These included concerns were a person living with dementia may have been chemically sedated when not displaying agitated behaviour and two people having to attending hospital which may have occurred due them possibly receiving inadequate care and support or through omission of prescribed medicines. We await the outcome of some of these incidents and will report upon these then.

The North East Lincolnshire safeguarding team have also received information from the registered manager regarding 22 'low level safeguarding incidents' that have occurred and have involved people living at the service. This information was not provided to CQC. These issues range from people being neglected because they have not been given their breakfast by staff, up to issues where people have physically abused each other or a visiting relative has potentially abused their relation living at the service. In some cases people were restrained by staff, details of how this restraint was undertaken by staff were not provided. It may be that if further details had been provided to the local authority safeguarding team they may have instigated investigations of some of the 'low level' safeguarding issues that were raised. CQC were not informed of notifiable incidents of abuse.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Also a breach of Regulation 18 of the Care Quality Commission (Registration Regulations 2009) regarding the non –notification of incidents.

We found that people did not receive person-centred or safe care which was individual to their needs and preferences. People were not being supported to get up in a morning when they preferred too and did not receive timely care and support. For example, we noted two people who needed regular pressure area care to prevent pressure damage occurring to their skin did not receive this at the required intervals and this placed them at risk of developing damage to their skin. We observed a person slipping out of their chair in their room; we had to ask staff to attend to them quickly to make sure they did not fall. We observed a member of the ancillary staff assisting a person to eat and drink, they had not been provided with training in how to safely assist people to eat and drink. We asked the registered manager if any ancillary staff were provided with training in regard to this, they confirmed ancillary staff were not trained to undertake this. We asked the registered manager and area manager to cease this practice immediately.

During our last inspection on 15 May 2015 we found the registered provider was in breach of regulation 12, safe care and treatment because suitable systems were not in place regarding the prevention, detection and to control the spread of infection. During this inspection we found compliance had not been achieved. We saw a member of staff place a commode chair, which had been used by a service user in the commode store room without it being cleaned. We spoke with the member of staff who said, "I had been asked to clean the commodes after a person used them before bringing the commode back to the room [commode storage area]. I knew I should have cleaned the commode before I returned it to the storage room. I just forgot. Human error." We asked another member of staff

about the cleaning of commodes and they said, "I've never been asked to clean commodes before they are placed back into the communal commode storage room. This has been mentioned today [16 December 2015] I am able to do this now." Random checks of commode chairs in this store room revealed they were not clean, we found bodily fluids on the commode seats. We asked the registered manager to have all the commodes cleaned during our inspection.

We saw that the hoist slings in use for people were hung on the back wall of the commode storage room. They had to be lifted over the commodes to be placed on hooks. The slings were not labelled for each individual's use and some slings were touching the commodes. The hoist slings were not stored separately to prevent cross infection. We asked the registered manager for the audits relating to the cleaning of the hoists and slings. We were told these were not in place. Adequate infection prevention and control measures were not in place.

We observed the bathrooms and shower rooms. We found a dirty tissue on the floor in one bathroom, the bin had no lid and the hoist bath seat's was dirty underneath the seat. The shower seat in the shower room was also dirty and rusty. We asked the registered manager to address this during our inspection.

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

The service had been inspected by the local authority environmental health officer; a two star rating had been awarded for food hygiene. We inspected the kitchen. We found it was dirty and required a deep clean of all surfaces, the floors were dirty and cobwebs were present over the extractor fan in the kitchen. The waste disposal unit under the sink and the shelves behind the microwave were dirty. Three trays under the kitchen counter were water damaged. The tray stacking unit which had been prepared with trays ready for lunch was situated outside the kitchen in a corridor covered in building dust, next to dirty trolleys and items to be thrown out. We spoke with the registered manager and asked for the trolley with the trays on it to be stripped and cleaned. These shortfalls meant that food safety was not maintained due to a lack of cleanliness. Kitchen cleaning records had been completed with no gaps present. We were unsure if cleaning had taken place or if staff signed that cleaning had taken place when it had not been undertaken. We also saw that at lunchtime the bain marie trolley used to serve lunch from had dusty plates and dishes upon it which staff were going to serve people their food on. We asked for the trolley to be cleaned and the crockery to be washed before lunch was served.

We found two freezers in a room where building work was being undertaken. This did not ensure food safety was maintained. The freezers were covered in dust. We spoke with the registered manager about this and asked that the freezers be cleaned and be moved to another room where no building work was occurring. We were so concerned we contacted the Local Authorities Environmental Health Officer [EHO] on 17 December 2015 about the issues we had found. They attended the service on 18 December 2015 for our second day of inspection. They noted that even though the kitchen had a deep clean on 17 December 2015, under the counter in the corner of the kitchen a medicine pot and food debris remained. They found that a freezer was seriously iced up and required defrosting. Further inspection of the service will be undertaken by the EHO at a later date.

We found an iron had been switched on and left unattended in the laundry by staff, we had found this during our last inspection. The registered manager had put a sign up in the laundry which said, 'Fire hazard- never leave the iron on and unattended.' This guidance had not been adhered to by staff. Chemicals for the kitchen [Rinse aid -10 containers] were stored in the clean area of the laundry; these items were moved at our request to ensure they were stored securely and in a more hygienic area of the service where people who used the service could not gain access to them.

At our last inspection we had made a recommendation that the registered provider follow current guidance in relation to medicines. During this inspection we found that medicines were stored securely in a locked treatment room and access was restricted to authorised staff. However, we found the treatment room for storing medicine was dirty. Controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were appropriate arrangements in place for the management of controlled drugs, including their destruction.

Medicines which required cold storage were kept in a fridge within the medicines store room. Maximum and minimum temperatures had not been recorded correctly as recommended in national guidance. Temperatures for the

Is the service safe?

medicine storage room had not been recorded on four occasions in June and July and three times in September. The medicine fridge temperatures had not been recorded five times in May, six times in June, five times in July, twice in August and once in September. The fridge temperature for the storage of medicine had fallen outside the normal range on seven occasions in November, but no action had been taken. This meant there was a risk medicines kept in the fridge would not be safe to use as they had not been stored in line with the manufacturer's guidance. We also found a sample of faeces stored in the fridge with medicines which was dated 29 September 2015. This demonstrated unsafe practice.

We looked at 11 medication administration records [MAR] during the visit and spoke with senior carers who were responsible for administering medicines. Medicines were not always given, as prescribed. We found that one person who was prescribed a liquid medicine was given double the dose because the MAR had been incorrectly re-written by care staff. The dose that was given on the day of our visit was different to what was prescribed and also different to what was written on the incorrect MAR. A further two residents were prescribed a once-weekly medicine which had not been given during one week in December. In addition, one person had not been given six of their medicines over a three day period, which included pain killers. The reason recorded was that the patient was being barrier nursed, so the staff had decided not to administer any medicines. Failing to give the person their prescribed medicines could have contributed to their illness and left them in pain.

We found a lack of information to guide staff how to safely administer when required medicines. The recording of whether one or two tablets were given when variable doses of pain killers had been prescribed was not always documented.

Medicines records were not always clearly completed to show the treatment people had received. We found a number of gaps in ten of the 11 records we reviewed with no reason recorded why medicines had not been given. This meant it could not be confirmed whether people had been given their medicines as prescribed. In one case a medicine for Parkinson's disease had been signed as though it had been given, on several occasions, but we found the tablets were still in the medicines trolley. We found three bottles of expired medicine in one of the trolleys. One bottle which had expired on 13 November 2015 was in use and had been given to a person using the service on a daily basis since 30 November 2015. Out of date medicines may not have the same effect the prescriber intended. We also found eye drops which had been open for greater than 28 days which poses a risk of infection. We found bottles of liquid medicine which were not marked with the date of opening. Stock control remained a concern throughout the visit and we found excessive quantities of medicines had accumulated in the medicines room. For example, we found 14 tubes of cream for one person and nine large tubs for another, none of which had been opened.

The recording of stock levels on MARs was inaccurate or incomplete in all of the records that we looked at. For example, one record stated 56 tablets were in stock, but we found 122 in the cupboard. Another record stated 41 capsules should be in stock, but we found 150. This meant that we could not identify if people had received their medicines as prescribed. When we discussed this with the manager, we were told they were aware that staff had been signing for medicines which had not been given, particularly antibiotics; no corrective action had been taken. We found three unopened inhalers for one person from March, June and August. When we checked their records only eight doses had not been signed for in the last six months. We checked records for another person who was prescribed an inhaler and found that 22 doses had been signed for, but the counter on the inhaler showed only four doses had been taken.

The administration of inhalers and eye drops was of great concern; we saw one person who had not received their glaucoma eye drops on 51 occasions over a three month period. The reason documented on the MAR was that the patient had refused or that the drops were not required despite a hand written note on one MAR stating that they should be given every day. When we spoke with the manager we were told that the medicines policy stated that the GP should be informed if any medicine is refused on three occasions. They also confirmed that no attempt had been made to contact the person's GP. We found that another person had not received their regular inhaler at all between 14 September 2015 and 08 November 2015 with the same reasons recorded. No attempt had been made to discuss this with their GP.

Inadequate

Is the service safe?

This is a breach of Regulation 12(1), (2) (f) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our last inspection we had recommended that the registered provider review the staffing levels provided at the service. This review had occurred and staffing levels had been increased by one member of staff throughout the day. However, during our inspection we observed that staffing levels at the service did not provide people with timely care and support. We saw staff had to ask people to wait for assistance to get up or go to the toilet. Staff we spoke with all confirmed more staff were needed. A member of staff said, "It's challenging here. I do enjoy it. Trying to keep on top of all my checks and give residents time. There is not enough staff we need more staff across the board. Very rarely get quality time with people. It's stressful. They went on to say, "When we are getting people up it is busy and stressful. If we had extra staff in the morning it would go better. Breakfast and drugs go on until 11.00 approximately or a bit longer. We would like more staff to give a better quality of care." We observed that the safety of people was not protected by the staffing levels provided.

We had been contacted prior to this inspection by Healthwatch [A national consumer champion in health and social care,] who had undertaken a visit to this service on 9 November 2015. They immediately raised concerns regarding the cleanliness of the service and poor staffing levels. On the day of their visit two staff had not attended for their shift due to sickness and the deputy manager had not taken full or appropriate action to cover the shift with other staff. This placed people at risk of not having their needs met. Staff sickness and absence was being monitored by the management team but it was not always possible to get staff to come in to cover absences.

During our last inspection we recommend that the registered provider gained further advice and guidance about the nurse call system to help to protect maintain people's comfort and safety. We found the nurse call system had been replaced.

We saw that people's care records contained risk assessments which informed the staff about potential risks to people's wellbeing. However, we saw these were not updated to reflect people's current needs. For example, we saw a person was at an increased risk of fall's but their care records and risk assessments did not reflect this. We also was people at risk of losing weight did not have relevant risk assessments in place. Care records were inadequate and did not inform the staff how to maintain their safety.

We inspected staff recruitment files. These contained application forms, references from previous employers and disclosure and barring service [DBS] checks. We saw that gaps in potential staffs' employment history were looked into and their past experience and qualifications were recorded. The identity of staff was checked and this recruitment process helped to protect people from staff who may not be suitable to work with vulnerable adults. However this was not the case for the volunteer working at the service who had not had a police check undertaken. The registered provider had failed to ensure themselves of the volunteer's suitability to work with vulnerable people. This did not ensure people's safety.

We saw that maintenance and safety checks of the property were undertaken. Records confirmed these checks were up to date.The registered manager confirmed after our last inspection staffing levels had increased by one member of staff during the day. They told us they were currently recruiting more staff because when staff phoned in sick they were not always able to cover the shifts at short notice which meant people's care and support was affected. We spoke with the registered manager about the current staffing levels provided and the concerns that had been raised with us by people we had spoken with, relatives and staff. The people we spoke with at the service told us there were not enough staff. Relatives reiterated this, one said, "Sometimes there's not enough staff." Staff said to us;"Staffing levels are maintained but we need more staff one or two in the morning because people are getting up late the morning and getting breakfast late in the morning. [Breakfast finished 11am today]. We have staff for tea time, buzzers going and some people need two care staff if two people need two staff, it's not very safe for people. We cannot rush people. No one has come to harm. I feel guilty I don't have time to sit and chat with people. I need to answer buzzers and look after people. If we have more staff we would have more time with residents they would get better care." "There is not enough staff we need more staff across the board we very rarely get quality time with people. It is stressful when we are getting people up it is busy and stressful. If we had the extra staff in a morning to get people up and answer buzzers, it would go better. Breakfast is on until 11.00 or a bit longer. We have days

Inadequate

Is the service safe?

when staff ring in sick. We try and get this covered, if we can't we just have to manage. We make it as safe as we can, would like more staff to give a better quality of care." The registered manager informed us there were enough staff provided, however, it was an issue of the staff's work ethic. We concluded that the staffing levels provided were not adequate to meet people's needs.

This is a breach of Regulation 18 [1] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

During our inspection we found that there was one volunteer working at the service. They were assisting the activities co-ordinator but they had not had a police check undertaken by the Disclosure and Barring Service [DBS]. Effective supervision was not provided to the volunteer, the registered manager ad not undertaken effective recruitment processes in regard to the volunteer to ensure this person was safe to work with vulnerable people.

Other staff we spoke with confirmed they filled in application forms and had to attend an interview, provide references and undertake a police check [DBS] before they were offered a position working at the service. They confirmed that a period of induction took place which included 'shadowing' a more senior carer so new staff were shown how to support people before working on their own.

Inadequate

Is the service effective?

Our findings

There were not enough staff to support people in line with their preferences. Staff did not have time to encouraging people to choose how they wished to spend their time. People we spoke with said they did not always feel supported by staff. We found that staff did not always ensure people had consented to their care and treatment.

We received the following comments from people we spoke with: "[Staff] Slow at getting us up, staff have their favourites. I got breakfast at 8.15 and got dressed at 11.00. My visitor came last Saturday at 11.05 I wasn't dressed. I'm not a fussy person but I like to be up and dressed about 9.30." "If someone [staff] has not turned up for work there may be a hiccup, but the norm of getting up 10.30 to 11.30 it's not great. No medicine yet 11.40. It [medicines] has become more of a problem there has been a bit of an issue with them [medicines] before."

We spoke with relatives and received the following comments: "Medicines are most important. These should be right if the home is going to improve. If new staff are doing medicines they have to have the right training. Regarding the food- like a change of menu. No trained cook. I buy a lot of food and bring it in. Sunday it's the same old trifle, no gateaux, Sunday buffet lunch is the same as tea in the week. Home baking is not great, a high tea with Kipling cakes for a change would be nice," and "Staff are under pressure. They could do to increase staffing at weekends- they could do with an extra member of staff."

We saw during our inspection that staff were very busy and that they did not have time to speak

with people. We spoke with seven members of staff about the staffing levels provided all raised

concerns they could not support people effectively.

We found that staff had received limited training. From discussion with staff and looking at the training information we found that some staff had not received training in essential areas: This included: health and safety, moving and handling, fire safety, safeguarding, dementia, mental capacity and depravation of liberty, mental capacity act, first aid and medicine administration. The training provided to staff in medicine administration and infection control had not been ineffective. Staff had not learnt from specific training to assist them to care for people at the service. We saw an area manager's report stated; "Staff had undertaken dementia training but felt they did not understand the concept and did not have the skills." The lack of provision of effective training to staff meant people received inadequate care and support from staff who were not appropriately skilled or trained.

We saw that supervision for staff was being undertaken but that this required to be reviewed so that all staff had undertaken this. The registered manager was diarising supervision. Supervision helps clarify the training and developments needs of staff and allows performance issues to be addressed. We saw staff appraisals were being planned but had not yet been completed.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

The Mental Capacity Act 2005 [MCA] provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The Care Quality Commission is required by law to monitor the use of Deprivation of Liberty Safeguards (DoLS). DoLS are applied for when people who use the service lack capacity and the care they require to keep them safe amounts to continuous supervision and control. There were three people who used the service who had a DoLS authorised by the supervisory body. DoLS were in place to ensure people received the care and treatment they needed and there was no less restrictive way of achieving this. The registered manager had not notified CQC of the outcome of the DoLS applications which they are legally obligated to do. We found staff had an inadequate understanding of DoLS and least restrictive practice. Therefore people's rights were not protected.

The registered manager and staff had a poor understanding of the principles of the Mental Capacity Act 2005 [MCA] and were not able to describe how they supported people to make their own decisions. Staff lacked the skills and knowledge needed to complete mental capacity assessments comprehensively. We saw some capacity assessments had been were undertaken using on

generic assessments and that people had been determined not to have capacity, where this was the case there were no best interest meetings held to ensure people's rights were protected. For example, we found that one person's GP had written a letter giving direction to staff to administer their medicine covertly in food. This instruction was being followed by staff who had not involved any other agency such as the local authority or family/advocate to ask for a best interest meeting to be held. Another two people had 'do not attempt cardio pulmonary resuscitation records [DNACPR] in place for life. There were no best interest meeting undertaken to support these decisions. For another person issues were recorded regarding washing, dressing, changing continence pads and being cared for by male care staff. We found no best interest meeting had been undertaken relating to person's lack of capacity to give their consent to their care and treatment or in regard to their views about being cared for by male staff.

We found generally relatives were consulted with or made decisions on behalf of people who lacked capacity. However, we found evidence that people's relatives did not have power of attorney for health and welfare in place; therefore they were being allowed to make decisions about care and treatment unlawfully.

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

People at the service did not have their nutritional needs met. Information about people's preferred foods and drinks, food allergies, likes and dislikes was not always recorded. We observed people having breakfast, lunch and tea. Menus were not displayed and staff did not show people the food being served to help people decide what they would like to eat. Snacks and drinks were provided mid-morning and mid-afternoon and supper was provided. Adapted cutlery was in use to help people maintain their independence. Some people on occasions had missed breakfast because staff had not realised it had not been provided to them. People who were at risk of losing weight did not have their dietary needs monitored effectively to make sure their nutritional needs were met. For example, one person had lost 5.05 kg over four months, the GP had been informed of this but no referral had been made to a dietician. People's nutritional needs were not met.

We observed that mealtimes were not social occasions and staff left people to eat alone which did not protect people who may be at risk of choking.

This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Meeting nutritional and hydration needs.

We saw the building was spacious in areas which allowed staff who needed to use equipment such as hoists or wheelchairs to do so. Special equipment such as hospital beds and pressure relieving mattresses were provided to individuals who had been assessed as requiring this support. However, some equipment such as pressure mats which had been stated as being required for people to help to effectively maintain their safety were found not to be present. We spoke with the registered manager and deputy manager about this they could not tell us when or why this had occurred.

Pictorial signage assisted people to find toilets and bathrooms. However, this was basic and could have been enhanced to help support people who were living with dementia to find their way around. People's bedrooms were personalised and some contained items which may have helped people reminisce about loved ones and their life.

Inadequate

Is the service caring?

Our findings

People we spoke with said that they had to wait for care and support. One person told us the staff were generally caring but there were not enough of them.

We saw at peak times of the day staff were very busy and they had to ask people to wait for assistance, telling them they would come back to attend to them as soon as possible. This caused some people to be anxious. Staff did not make sure people were cared for safely and protected from harm. For example, we heard a person shouting and went to see what was wrong. We found the person in their room slipping off their chair; we immediately alerted staff who assisted them to sit safely in their chair. We observed staff undertook this with a caring attitude, but then had to leave the person to attend to other people.

We observed that people were left in communal areas of the service without appropriate stimulation. People went to sleep sitting in chairs because there was no interaction by the staff with them. Friendly banter did not occur and there was a lack of a homely atmosphere within the service. The staff we spoke with told us they needed more staff to be able to spend time to support and care for people. They told us they were busy and stressed and gave examples that people were getting up late for breakfast and then it was close to lunchtime.

We found the quality of care provided by staff to people was inadequate. For example; people were not kept safe from harm and abuse, staff did promote and ensure people were helped to get up when they wished too, staff did not keep care records up to date to reflect people's full and current needs. This meant people did not receive the care they required. We found some people had been deprived of their liberty unlawfully. Staff did not ensure that people's nutritional needs were not adequately met.

Staff had either not had or had not learnt skills effectively from training that had been provided to them. They failed to inform the management team that they did not have the knowledge to care for people in a safe way. Staff did not adopt effective infection control whilst working in the service. Staff responsible for giving people their medicine carried this out in an inadequate way with no regard to maintaining people's heath or wellbeing. All of these shortfalls demonstrated a lack of a caring ethos by staff within the service.

We saw that staff lacked understanding about the needs of people living with dementia. We observed that if people became agitated staff struggled to divert people's attention or effectively support people during this time. Staff appeared stressed and they were seen to concentrate on getting tasks done rather than showing individualised care and compassion for people. Staff did not have time to talk to people unless they were undertaking a care task. When the task was completed staff left the person to undertake other duties. Time was not spent with people improve or maintain their life skills or independence.

We observed that staff from all departments walked through the communal lunge without speaking with people who were sitting there. We undertook a Short Observational Framework Assessment [SOFI] on 16 December 2015 in the lounge from 11.40 until 12.30. We observed twenty staff from all departments walked through the lounge past people who were sitting there to get to other areas of the service, they made no attempts to interaction with people as they walked through the lounge. During this time the only interaction made was from a member of staff giving people their medicine, who spoke during this interaction. Staff did not speak with people at every opportunity they could. This did not promote effective communication or engagement and showed us there was a poor culture within the home that did not promote the health and well-being of the people who used the service.

We observed that in the registered managers office there were piles of documents all over the floor and on the desk and office furniture, nothing was easy to find. This demonstrated a lack of appropriate storage of personal and sensitive information.

Inadequate

Is the service responsive?

Our findings

People we spoke with told us that they felt staff did not always respond to their needs. We observed that staff were busy and often had to ask people to wait until they had finished supporting others before returning to assist people.

People we spoke with and their relatives told us they would raise complaints. During our inspection one person complained to us that they were not getting their medicine as prescribed. The person said, "I have been short changed on my medicine. I have no doubt about that." We looked into this and discussed it along with the registered manager and it was found this complaint was substantiated. The person's GP was contacted regarding this issue to gain advice and to discuss corrective action.

The majority of people in the service were living with dementia. People's care records gave brief information about people's life and family histories, for some people this was not detailed which meant that staff may not be able to reminisce with people in a meaningful way, or provide social activities that were of interest to people.

We inspected six people's care records. We found people's individual preferences for their care were not recorded. The documentation was difficult to follow and not specific to people's individual needs.

We found concerns in the way people's care and welfare was managed. We found the care records difficult to follow, relevant information such as up to date risk assessments and care plans were not present and we were not able to determine if people were receiving the care they required from reading their care records. This meant there was insufficient record keeping in place. There was no evidence of any involvement from people or their relatives in the design of their care plans or in care reviews. We found that all six people's care plans had not been reviewed in a timely way. Reviews that had been undertaken sporadically and did not provide sufficient detail to demonstrate if people's health or wellbeing had been maintained improved or had deteriorated. We found that the information present in people's care records did not provide guidance for staff of any outcomes that had been achieved and did not identify actions or key areas for further development.

Care plans and risk assessments were not updated as people's needs changed. For example, a person had a fall on 14 December 2015 whilst getting out of bed, they mobilise with a frame. They had gone to hospital for treatment of cuts and abrasions. An accident form was completed, but their mobility care plan was not updated at all and staff had not considered any preventative measures they may put in place to help prevent further falls. The use of a sensor mat, to alert staff if the person got up unaided had not been considered to help to maintain the person's safety.

We saw another example where a person had a care plan in place for having a urine infection, This stated they were to take antibiotics twice a day and a retest of the person's urine was to be carried out in three days' time by staff. No evidence was present to confirm a retest of their urine had taken place. The registered manager confirmed that this had not been completed. This demonstrates that staff did not respond appropriately to the person's needs.

We found that people's care records were not reflective of the aids and adaptations that were required to assist people. For example one person required a sensor mat to be in place to alert staff if the person got up unaided. The care documentation said this was in place; however, this had been removed from the person's room. They also required pictorial cards to aid their communication. [These help people communicate their needs by using pictures.] These were not present. This meant the person not provided with the equipment to be able to respond to staff to help make their needs known.

We found that people's personal evacuation plans were not changed as people's needs changed. This meant that these documents would be ineffective at informing the emergency services about people's current needs.

People's care records were not updated following emergencies. For example, we saw that when the emergency services had been called to attend to a person who was unwell there was no recorded outcome from the emergency services visit, no review of the person's care condition or care records was undertaken by staff. This meant that it was unclear what had taken place and if the person's wellbeing was protected.

We found that people's needs in relation to the prevention of pressure damage was poorly assessed, planned and reviewed. We found that people had not received

consistent support as required by staff in relation to pressure area care For example, people who had been assessed as requiring a change to their position within two or four hours did not have this undertaken in a timely way by staff. We saw that people were not always sat on their pressure relieving equipment, such as cushions for their chairs. Staff did not respond appropriately to ensure people were protected from the risk of pressure damage to their skin.

We observed that people's moving and handling records were not clear, for example we saw one person a hand written note in their care records saying that two staff were to undertake transfers, this did not provide detailed information about the equipment needed such as the type of sling or hoist to be used to maintain the person's safety.

We found people's needs about maintaining continence was not clear. We saw that one person had a brief entry in their care records which simply stated – 'now is incontinent.' No further information was recorded therefor we were unaware if an assessment by a continence advisor had taken place or if products to aid continence were in use for this person.

These shortfalls demonstrate a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection, we spoke with three health care professionals and received mixed feedback. One health care professional said staff did not always ask health care professionals to assess people as their needs changed in order to maintain people's wellbeing. They told us they had concerns about care records not reflecting people's current needs. They also said that staff did not alert them to issues or gain timely advice to help maintain people's wellbeing. They said, "It is generally not good here, issues regarding recommendations are not being followed. Records are not matching, for example staff using codes that people are aggressive, yet daily records say the person has been fine."

The community mental health team was providing support in behavioural management for one person because they demonstrated behaviours which challenged the service and others. We found that the person's care records did not reflect correctly the person's behaviour, for example there were times when the person had been given medicines to help calm them but their care records reflected they were calm and settled. Relevant guidance given by health care professionals involved in their care had not been followed. Staff had not responded appropriately to the person's needs.

We saw that there was an activities co-ordinator employed by the service and a programme of activities was displayed. We saw that on some days people were not provided with any activities. We observed there was a lack of stimulation and engagement with people by the staff who were too busy to spend time with people. On the second day of our inspection we did see a Christmas party and a birthday party was undertaken.

On the first day of our inspection we observed people sat in the lounge, round the edge of the room before lunch with pop music playing. Some people were asleep, there were no 'rummage boxes' or items for people living with dementia to use to reminisce provided in the communal areas of the service. People generally lacked stimulation.

On the inspection on 18 December 2015 we found the main lounge had been relocated to the dining area within the service. This appeared to provide a more homely lounge environment for people to be able to interact with each other. We also saw a Christmas and birthday party were being held. This meant that people had a better opportunity to gain social interaction with each other.

We saw that people were able to choose what they wanted to and how they wanted to spend their time. However, staff were busy and not available immediately to support people. We observed that staff acted upon what was said to them but that people had to wait whilst staff attended to other people, before returning to assist them.

There was a complaints policy in place, however, we were unsure from looking at the information received regarding complaints provided by the registered manager if all issues raised had been appropriately investigated and responded too. Complaints were not responded to in line with the registered providers policy. The information contained in the complaints had not been used to develop or improve the service.

This is a breach of Regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

Quality monitoring at the service was ineffective. We found checks on how the service was operating were not being completed and they lacked detail. The risk of harm to people was not being assessed, managed or kept under review. Staffing levels were inadequate to meet people's needs and the staff were not managed effectively.

The Clinical Commissioning Group [CCG] held a meeting on 18 November 2015 to which we were invited along with the registered provider. The registered provider told us they were seeking to support the registered manager to help them to develop their performance to the required standard to enable them to continue to run the service. Support had been provided by an area manager up to three days per week. However, during our inspection we found that the support provided to the registered manager had not been effective. The registered provider had not adequately ensured the service was managed effectively. We found a number of breaches in regulation which demonstrated people receive inadequate care and support.

The registered manager was present throughout the two days of the inspection. They were suspended on 18 December 2015, pending an investigation by the registered provider into the lack of effective management at the service.

During our inspection we found the staff lacked leadership and effective management. Staff did not know key information about people's care needs or their legal responsibilities in terms of the Mental Capacity Act 2005. Effective systems were not in place to ensure people's needs were assessed, monitored and reviewed. People's care records were not detailed enough or kept up to date. Systems were not in place to make sure monitoring charts for pressure relief and nutrition were completed in a timely way. The management team had not addressed these shortfalls. People were not receiving the care and support they required.

We saw there were ineffective auditing systems in place. Monthly audits had not been undertaken as required by the registered provider. No audits were undertaken in November and December 2015. We inspected the audits undertaken prior to that; a sluice audit dated 28 October 2015, treatment room audit dated 27 October 2015, the supplying pharmacy medicine audit dated 31 July 2015, Kitchen cleaning schedules from May 2015 and a one page weekly random check of medicines undertaken by the registered manager. We also reviewed the infection prevention and control audit dated 29 October 2015. We found the auditing that had taken place was ineffective. The shortfalls we found in the service relating to infection control, kitchen cleanliness, food hygiene, medicine administration and recording and poor care records and cleanliness of the service were present and could have been easily identified and addressed if effective auditing and governance had been in place.

The registered manager had undertaken a 'drugs trolley check' on 30 July 2015 where eight service user's medicines were inspected. They had found that two people did not have the date of opening recorded on their medicine bottles. No other monitoring of the medicine system was provided to us by the registered manager during our inspection.

A catering audit was undertaken by the registered manager on 29 October 2015. A score of 90 percent was recorded. Issues were noted that the food probe had not been calibrated, the freezer door seal was not in good repair and the store room was not clean. There was no corrective action recorded as having been undertaken regarding these issues. This demonstrates inadequate management and a failure by management to take action about known risks.

The registered manager and registered provider failed to ensure that staff received appropriate and effective training in areas necessary to protect people's health safety and wellbeing. Training for staff was not up to date, which meant that staff delivered care to people when they were not trained or safe to do so.

We found that when senior management found concerns, action was not taken, for example; the area managers home visit report dated 27 November 2015 stated: Pressure area care, 'despite training staff appear to have little insight into the implementation of pressure area care routines. They consistently failed to move residents on a two or four hourly basis. Disciplinary action had been taken with some staff for shortfalls that had placed people's health and safety at risk.

We reviewed the quality assurance surveys which had been completed by people at the service. The registered

Is the service well-led?

manager told us that the quality assurance surveys had not been sent out to everyone at the service. We were shown three surveys, no action had been taken to review the information received.

We inspected the external audits that had been undertaken; for example, the Community Matron for infection control had undertook an audit on 17 June 2015, a score of 90 percent was achieved which was rated 'good'. We saw evidence that the registered manager had carried out an infection control audit on 29 September 2015 which scored 87 percent. No serious issues were found. However, on 10 November 2015 another review of infection control was undertaken by the Community Matron scored 78 percent, 'inadequate'. Action was not undertaken by the registered manger to address the issues found and to address the lack of training provided to staff in this area.

These examples are breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider confirmed with us that there were no clinical leads in place within the company responsible for ensuring that key essential areas of the service were provided at an agreed standard. For example; for training, infection control, mental capacity or DoLS. There was also no system in place to ensure accidents, incidents and safeguarding issues were reviewed to identify any patterns or trends which may help prevent further issues from occurring. This demonstrates inadequate management and governance of the service.

We requested an analysis of safeguarding issues to be undertaken and sent in to CQC so that we could see if we had been notified of all safeguarding issues. We have been informed there had been 21 'low level' safeguarding issues raised with the safeguarding team which CQC had not been notified about. The Nominated Individual was asked if safeguarding concerns, incidents and accidents were analysed to reveal any patterns and trends which may help prevent further issues from occurring. We were informed this analysis did not take place at the service or at board level. This demonstrates inadequate governance from the registered provider.

This was a breach of Regulation 18 of the Care Quality Commission (Registration Regulations 2009) regarding the non–notification of incidents.

During our inspection we found that effective systems were not in place to ensure the service provided was safe, effective, caring, responsive or well led.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **People living in the service were not receiving person centred care. Care records were inadequate to ensure people had their needs met.**

The enforcement action we took:
We have judged that this has a moderate impact on people who use the service. This is being followed up and we will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The registered provider did not have suitable arrangements in place for people to consent to their care or follow legal requirements when people could not give their consent.**

The enforcement action we took:
We have judged that this has a major impact on people who use the service. This is being followed up and we will report on any action when it is complete.

Regulated activity	Regulation
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Care and treatment was not provided in a safe way. The registered provider had not taken steps to properly assess the risks to the health and safety of people living at the service. Safe systems to support effective infection prevention and control and food hygiene were not in place. Safe systems were not in place in relation to medicine management.**

The enforcement action we took:
We have judged that this has a major impact on people who use the service. This is being followed up and we will report on any action when it is complete.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The registered provider did not have adequate arrangements in place to protect people from harm or abuse.**

The enforcement action we took:
We have judged that this has a major impact on people who use the service. This is being followed up and we will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs People's nutritional needs were not appropriately monitored or met.

The enforcement action we took:
We have judged that this has a moderate impact on people who use the service. This is being followed up and we will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **The register provider's policy for dealing with complaints was not followed. There were inadequate systems in place to ensure complaints were dealt with appropriately and that the service learnt from the issues raised.**

The enforcement action we took:
We have judged that this has a minor impact on people who use the service. This is being followed up and we will report on any action when it is complete.

Regulated activity	Regulation
	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

Effective quality monitoring and auditing systems were not in place to ensure the service provided was safe, effective, caring, responsive or well led.

The enforcement action we took:
We have judged that this has a major impact on people who use the service. This is being followed up and we will report on any action when it is complete.

Regulated activity

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Staffing levels were not provided to meet people's needs. Staff were not provided with effective training to ensure they had the skills they required to meet people's needs.

The enforcement action we took:
We have judged that this has a major impact on people who use the service. This is being followed up and we will report on any action when it is complete.

Regulated activity

Regulation

Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents

There was a failure by the registered provider and registered manager to provide notification to CQC of safeguarding incidents.

The enforcement action we took:
This is being followed up and we will report on any action when it is complete.