# Appleby Rest Homes Limited

# Appleby Lodge

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Inadequate |

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|---|---|
| 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

The overall rating for this service is 'Inadequate' and the service is 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.

We carried out a previous comprehensive inspection on 09 September 2015 and 11 September 2015 and the service was rated Good.

We have since carried out an announced comprehensive inspection on 12 June 2017 and 15 June 2017. Prior to our inspection the Commission had received concerns regarding the leadership of the service, the recruitment of staff, staffing levels and the management of people's medicines. During our inspection we looked into the concerns which had been raised.

Appleby Lodge provides accommodation for up to 18 older people who require personal care. The provider also operates a day centre offering meals and companionship to local people. The service is on one level. There are shared bathrooms, shower facilities and toilets as well as a lounge and dining area. There were 15 people living at the home at the time of our inspection and two people using day care facilities.

People told us they received their medicines when required, however people's medicines were not always managed and stored safely.

People lived in an environment which had not been assessed to ensure it was safe. Weekly fire tests were not always carried in line with the provider's policy. People had personal emergency evacuation plans in place (PEEPs), however these had not been updated to reflect people's changing care needs. PEEPs help to give a summary of people's individual needs for the emergency services in an event such as a fire. Following our

inspection, because of concerns identified, we contacted the fire authority.

People were not always protected from risks associated with their care. People did not always have risk assessments and care plans in place relating to their individual care needs, and when these were in place, they were not reflective of people's current care needs. This meant staff did not have the most up to date recorded information to enable them to know how to support people safely. However, whilst information was not documented, staff did know people well and communicated with each other about how to meet people's needs at staff handovers and through-out the day.

People told us they felt safe living at Appleby Lodge. People were supported by sufficient numbers of staff to meet their needs. People's needs were taken into consideration in determining staffing levels. People's call bells were answered promptly. Recruitment checks were carried out to ensure staff working with vulnerable people, were suitable. However, gaps in an employee's previous employment were not always scrutinised.

People did not always receive care from staff who had undertaken training to be able to meet their individual needs. For example, skin care, dementia, end of life and moving and handing. We were also unable to determine what training staff had undertaken because training certificates did not match the providers overall training records.

People's human rights were not protected. When someone did not have the mental capacity to make certain decisions, this was not always detailed within their care plan to enable the person to be supported effectively. People's consent to care was obtained, however this was not always documented.

People told us they liked the meals and people were supported to eat and drink when necessary, however people's care records were not always reflective of the care and support they required. This meant staff did not always have up to date information about the best way to support people in order to meet their individual needs.

People's likes and dislikes were not recorded to help ensure people received meals which met with their preferences. However, staff told us they knew people well and that people were able to tell them what they liked and did not like. People were not always offered a choice for their main meal and the menu had not been created by involving people/and or their relatives. The manager told us they had already recognised improvements were needed, and action had been taken to appoint a new member of catering staff who had been tasked with making the necessary changes.

People and/or their loved ones were involved in making decisions about their care and support. However, this was not always recorded so the manager was taking action to rectify this, by speaking with staff, people and/or their families. People had access to external health and social care professionals. People's records showed GP's, community nurses and specialists had been involved in their care.

People's privacy and dignity was not always promoted. People's bedroom doors were left open but it was not detailed in their care plans if this was their choice. People's care needs were not always discussed respectfully by staff. People told us they regularly received the wrong clothing back from the laundry.

People who were being cared for at the end of their life were not being cared for in an environment which took into consideration their dignity, privacy and respect. People being cared for at the end of their life, were not always cared for by staff who had undertaken training. People did not always have end of life care plans in place to ensure staff were aware of their wishes.

People and their families, told us staff were kind and caring. Some people told us there was not always enough to do, to keep them occupied. The manager told us they had already recognised social activities were not always suitable and plans were in place to gather people's views and to make changes. People's cultural and spiritual needs were being met by religious events, and Holy Communion was held at the service on regular occasions.

People told us they would feel confident about raising concerns. People's complaints were used to improve the service.

People were not protected by the provider's systems and processes to help ensure the quality of their service was monitored. As a consequence of this, the provider had failed to recognise the service had been deteriorating.

Since our last inspection there was a new manager in post. At the time of our inspection the manager had been in post for two weeks and was already working hard to make changes.

The provider did not have robust governance system in place to help capture people's views and drive continuous improvement.

People were not protected by the provider's policies and procedures. The provider's policies were out of date and did not always reference changes in new legislation.

The provider and manager demonstrated an open and transparent approach throughout our inspection, for example showing us what they had identified themselves as already requiring improving. This demonstrated their understanding and recognition of the Duty of Candour. The Duty of Candour means that a service must act in an open and transparent way in relation to care and treatment provided when things go wrong. The provider had displayed their latest rating in line with legislation.

As a result of our inspection the provider told us they would voluntarily stop any new admissions to the service to give them time to make the necessary improvements.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

## 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's medicines were not always managed safely.

The environment, in which people lived in, was not always assessed to ensure its ongoing safety.

People were not always protected from risks associated with their care. However, whilst information was not documented, staff knew people well and how to meet their needs.

People were supported by sufficient numbers of staff to meet their needs.

People were protected by staff who had been recruited safely.

People were protected from abuse because staff knew what action to take if they were concerned about a person's wellbeing.

### Is the service effective?

**Requires Improvement**

Aspects of the service were not effective.

People did not always receive care from staff who had undertaken training to help meet their individual needs.

People's consent to care was obtained, however this was not always documented. People's human rights were not always protected by the Mental Capacity Act 2005.

People were supported to eat and drink, however people's care records were not always reflective of the care and support they required. This meant staff did not always have up to date information about the best way to support people in order to meet their individual needs.

People told us they enjoyed the meals.

People had access to external health and social care professionals to maintain their health and wellbeing.

## Is the service caring?

Requires Improvement

Aspects of the service were not caring.

People and/or their loved ones were involved in making decisions about their care and support. However, this was not always recorded so the manager was taking action to rectify this.

People who were being cared for at the end of their life were not being cared for in an environment which took into consideration their dignity, privacy and respect.

People's privacy and dignity was not always promoted.

People and their families, told us staff were kind and caring.

## Is the service responsive?

Requires Improvement

Aspects of the service were not responsive.

People's plans care plans were not always effectively updated to ensure they were reflective of people's current care needs. However, whilst information was not documented, staff knew people well and how to meet their needs.

People told us there was not always enough to do, to keep them occupied. Action was already being taken to address this.

People's complaints were used to improve the service and the provider had a policy to help investigate complaints effectively.

## Is the service well-led?

Inadequate

The service was not well-led.

People were not protected by the provider's systems and processes to help ensure the quality of their service was monitored.

The provider did not have robust governance system in place to help capture people's views and drive continuous improvement.

People were not protected by the provider's policies and procedures.

People were living in a service which was now being managed by a new manager.

People, staff and families had confidence in the new manager,

and of the positive changes which had been made in the short time they had been employed.

# Appleby Lodge

**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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We visited the care home unannounced on 12 June 2017 and 15 June 2017. The inspection team consisted of one adult social care inspector and an expert by experience - this is a person who has personal experience of using or caring for someone who uses this type of service.

Before our inspection we reviewed the information we held about the home. We reviewed notifications of incidents that the provider had sent us since our last inspection. A notification is information about important events, which the service is required to send us by law. We also contacted Healthwatch Cornwall, and spoke with the local authority quality assurance and service improvement team.

During our inspection, we spoke and met with seven people living at the service, two relatives, four members of care staff, the chef, the manager and a community nurse. We observed care and support in shared areas. We spoke with people in private and looked at six care plans and associated care documentation. We assessed the environment for safety and looked at training records and catering records. We also looked at three recruitment files, medicine administration records, policy and procedures and quality assurance checks.

Following our inspection, because of concerns identified we raised four individual and a whole home safeguarding alert with Cornwall Council.

Inadequate

# Is the service safe?

## Our findings

People's medicines were not always managed safely.

People's MARs had not been signed by two members of staff when new medicines had been prescribed. This meant people were at risk of receiving incorrect medicines, because records were not being robustly checked for accuracy as recommended by the National Institute of Clinical Excellence (NICE) guidelines.

People's medicines were not always administered safely. For example, one member of staff had not taken time to read one person's MARs to ensure they had dispensed all of their medicines. This resulted in the member of staff releasing at the last minute that the person's pain medicine was missing from their medicine pot. People's medicines were given to them and MARs were signed, prior to staff knowing if the person had taken their medicines, however this was not 'best practice' recommended by NICE guidelines.

People's medicines were not always stored safely which meant people were at risk of taking medicines which had not been prescribed for them. For example, the trolley which contained people's medicines was left out of staff line of sight, open, unlocked and unsupervised when staff went to administer people's medicines at the dining table, and the cupboard used to store medicines requiring additional security, was damaged.

People were prescribed medicines to be taken when required (PRN), such as paracetamol. However, there were no records in place to provide information to guide staff in their administration; such as what the medicines were for, symptoms to look for, the gap needed between doses or the maximum dose. Staff did not monitor or record the outcome of giving a 'when required' medicine, so could not be sure that it was effective. This meant people may not receive their medicines when they actually required them, for example to help manage pain.

People prescribed topical medicines (creams and gels) did not have records in place to provide guidance and direction to staff about where and when to apply them. People's MARs did not match the creams or gels stored in their bedrooms. People's creams and gels were not always dated upon opening to ensure expiry dates were being considered. By the second day of our inspection, the manager had taken action to date people's creams and gels and had devised and implemented a new topical medicine chart. Staff, were able to confirm what creams and gels people required.

People's medicines which required additional security were recorded in a separate medicine record. However, the record was not an accurate description of the medicines stored. This was not in line with 'best practice' as recommended by NICE.

People's medicine's which needed to be stored at fridge temperature were stored securely. However, the temperature of the fridge was not recorded to ensure medicines were being stored at the correct temperatures. By the second day of our inspection the manager had taken action to implement a new temperature record, and temperatures were being taken. However, temperatures were only being taken

once a day and not twice a day as recommended by the National Institute of Clinical Excellence (NICE) guidelines.

The provider had a medicines policy however; the policy had not been updated to reflect NICE guidelines. Meaning, the administration of people's medicines was not underpinned by 'best practice'.

Staff, had received training to administer medicines but were not checked to show they were competent to undertake the medicines tasks asked of them. This meant staff may be administering medicines, not in line with best practice.

People's medicines were not always managed, stored and administered safely. Best practice guidelines were not being followed. Their medicine records were not always accurate. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People lived in an environment which had not been assessed for fire safety. For example, weekly fire tests were not always carried in line with the provider's policy. When fire tests had been carried out and had identified action was required, this had not always been followed up. For example, from 02 February 2017 to 14 February 2017 records detailed seven fire doors had failed to close. However, no action had been taken. Since this, the new manager had taken action to ensure fire doors closed securely by contacting the service provider. However, no fire tests had been carried out since the fire system received its quarterly service on 16 May 2017.

Staff had also not been trained in fire safety, in line with the providers own training schedule. However, at the time of our inspection, the manager was in the process of arranging training for all staff. People had personal emergency evacuation plans in place (PEEPs), however these had not been updated to reflect people's changing care needs. For example, one person was now not able to walk independently, however their PEEP stated that they could walk by the use of an aid. PEEPs help to give a summary of people's individual needs for the emergency services in an event such as a fire. By the second day of our inspection the manager had started to take action to update people's PEEPs. Following our inspection, because of concerns identified, we contacted the fire authority.

People's environment had also not been assessed to ensure they were protected from risks. For example, cleaning products were not being stored securely without an assessment being carried out to establish if people may be at risk of inappropriate consumption. For example, the cleaning trolley was left unattended and cleaning products were found in bathrooms. By the second day of our inspection the cleaning products had been removed and the manager told us she had spoken with the housekeeping staff.

People's environment had not been assessed to ensure it was safe. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always protected from risks associated with their care. People did not always have risk assessments in place relating to their individual care needs, and when these were in place, they were not reflective of people's current care needs. This meant staff did not have the most up to date recorded information to enable them to know how to support people safely.

People who were at risk of skin damage did not have care plans or risk assessments in place to help provide guidance and direction to staff about how to mitigate the associated risks. This meant care may not be delivered consistently and in line with external professional advice. For example, records which had been put into place to record staffs actions relating to the repositioning of one person had not always been

completed. Their records detailed they should be repositioned four hourly; however records detailed ad hoc interventions and staff told us repositioning turns were taking place two hourly. Whilst this person's skin was in good condition, we were unable to ascertain if risks associated with this person's skin care were being mitigated safely, and in line with external professional advice.

One person's skin care needs, meant that at times they required specialist boots to be placed on their feet. Although, staff knew when and how to put on the boots, the details of this were not recorded in a risk assessment to help ensure the person was being supported consistently and safely by staff who may not be so familiar with supporting this person with their care.

A community nurse told us they did not have any concerns regarding the management of people's skin care, was complimentary of staff's knowledge, and had confidence in staff seeking advice and raising concerns, promptly.

People, who required one to one assistance with eating and drinking, or otherwise they were at risk of not consuming enough, did not have risk assessments in place, and whilst staff knew how to support people monitoring records were not accurately completed to record when a person had been offered something to eat or drink. For example, two people had food and fluid charts in place, but gaps in these charts indicated both people had not been supported regularly with their hydration and nutrition. This meant we were unable to ascertain if people were receiving the correct nutritional support.

People's weight was not being managed effectively, and when people had been weighed the results did not always prompt responsive action to be taken, such as implementing and amending care plans and risk assessments and contacting external health care professionals. For example, one person's weight records detailed there had been a pattern of a two stone weight loss since 2016 however no action had been taken. Some people who had been identified as being at nutritional risk had not been regularly weighed. For example, one person who was assisted with their meals because of nutritional care needs had not been weighed since 2013. Staff and the manager were unable to confirm if this person had lost weight during this time. When a person had been unable to stand on scales, the provider had not taken into consideration other methods of obtaining a person's weight, such as by use of the Malnutrition Universal Screening Tool (MUST). By the second day of our inspection the manager had started to take action to update people's risk assessments, had researched the MUST and liaised with the community nursing team.

People who used moving and handling equipment did not have up to date risk assessments in place to help ensure staff had the correct recorded information about how to support them safely and the manager told us staffs moving and handling training required updating. For example, one person's care plan detailed they did not require the use of any specialist equipment. However, we were told by staff that equipment was used. In some people's bedrooms they had their own equipment, however this had not been recorded, or its use risk assessed.

People's accident and incidents were recorded and body maps were put into place to record what part of the body an injury had been sustained. This helped to provide a good record of when a person had experienced unavoidable harm. However, when people had fallen, this had not prompted people's risk assessments or care plans to be reviewed and updated if necessary. This meant no consideration had been given to ensure people were protected from repeated events.

The provider did not take prompt action in order to keep people safe. People's risks associated with their care had not always been assessed and documented to help staff know how to mitigate risks associated with people's care. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

Whilst information was not documented, staff knew people well and communicated with each other about how to meet people's needs at staff handovers and throughout the day.

People told us they felt safe living at Appleby Lodge, commenting "It's the staff that work here, they make me feel safe", "Somebody is always popping in to make sure I'm ok", "I feel safe because everybody is on the ball", and "People are always coming in to see how I am". A relative told us "There's always somebody popping in to check on mum".

People were supported by sufficient numbers of staff to meet their needs. People's needs were taken into consideration in determining staffing levels. For example, the manager told us an additional member of staff now worked between 7am and 9am because this had been identified as being a busy time. Changes to night staffing had also been made because of an increase in people's care needs. People's call bells were answered promptly. Recruitment checks were carried out to ensure staff working with vulnerable people, were suitable. However, gaps in an employee's previous employment were not always scrutinised. The manager told us, they would update their recruitment policy to ensure this took place.

Requires Improvement

# Is the service effective?

## Our findings

People did not always receive care from staff who had undertaken training to help meet their individual needs. For example, skin care, dementia, end of life and moving and handing. We were also unable to determine what training staff had undertaken because staff training files did not match the providers overall training records. The provider did not have a training policy, so we were also unable to establish what the training requirements were for staff working at the service.
The manager told us they were already aware some staff required training updates, and action was already being taken to book training courses.

Staff joining the organisation undertook an induction which had been designed by the provider.
The care certificate had not been incorporated into the provider's induction, but the manager told us this would be implemented in the future. The care certificate is a national induction, and aims to equip health and social care support workers with the knowledge and skills which they need to provide safe, compassionate care.

Staff one to one supervision of their practice and appraisals of their performance had not been undertaken since 2015. The manager told us these would be commencing again. In the meantime, staff told us the manager was visible and that they felt supported and could speak with them at any time.

People were not always supported by staff who had the skills and qualifications to meet people's needs safely. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked whether the service was working within the principles of the Mental Capacity Act (MCA) 2005, and whether any conditions on authorisations to deprive a person of their liberty were being met.

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. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

When someone did not have the mental capacity to make certain decisions, such as in respect of their care this was not always detailed within their care plan to enable the person to be supported effectively. For example, staff had made a joint decision to dress one person in jumpers rather than blouses to promote their dignity. Where decisions were being made for people, there was no recorded evidence that best interests meetings had taken place to ensure the least restrictive options were being considered. For example, it was decided by their GP that for one person it would be in the person's best interest to give their medicines disguised in food (covert administration). However, there were no recorded details within the

person's care plan regarding this. Not all staff had received training in respect of the legislative frameworks but staff did have an understanding of what mental capacity meant, and how this impacted on the care and support they provided to people. The manager had an understanding of Deprivation of Liberty Safeguards (DoLS) applications.

People's consent to care was obtained, however this was not always documented. For example, we saw people being asked for their permission prior to being support, but people had not provided their written consent to their ongoing care and support at the service, in line with their care plan . Some people also had pressure mats in place, which altered staff if they got up from their bed or chair. However, the reasons for why these were in place had not been documented, no best interest meetings had been conducted nor had people consented to having the restrictive monitoring equipment in place.

People's human rights were not protected by legislative frameworks. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 .

People were supported to eat and drink, however because staff did not have up to date recorded information about what actual support people needed, people's needs were not always met. For example, there was confusion amongst staff about whether one person, who was at nutritional risk, required assistance with their lunch or not. So as a result of this, the person had eaten very little and their meal was subsequently taken away because it had gone cold. After lunch, this person's nutritional needs were talked about at the staff handover and the staff team were told the person had been assisted at lunch time; however we observed this had not occurred.

People's care plans were not always reflective of how their nutritional needs should be met. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's likes and dislikes were not recorded to help ensure people received meals which met with their preferences. However, staff told us they knew people well and that people were able to tell them what they liked and did not like.

People were not always offered a choice for their main meal and the menu had not been created by involving people/and or their relatives. People did not know what they were having for lunch. The manager told us they had already recognised improvements were needed, and action had been taken to appoint a new member of catering staff who had been tasked with making the necessary changes.

People's care and support did not always reflect their preferences. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they liked the meals, commenting "All the meals are very nice", "The food is very good", "The food is alright, could be better" and "No complaints at all about the food". A relative told us, "My relative tells me there's nothing she doesn't like about the food".

People had access to external health and social care professionals. People's records showed GP's, community nurses and specialists had been involved in their care. An occupational therapy referral had recently been made for three people as the manager had observed changes in people's mobility.

Requires Improvement

# Is the service caring?

## Our findings

People's privacy and dignity was not always promoted and there was an occasional culture that demonstrated a disrespectful attitude in how staff spoke about people. People's bedroom doors were left open but it was not detailed in their care plans if this was their choice. People's care needs were not always discussed respectfully by staff during staff handover, we heard words such as "foul mood" and "stinking" used to describe people. We spoke with the manager about this, who told us action would be taken to speak with staff and that the process of staff handover was being re-devised.

People who were being cared for at the end of their life were not being cared for in an environment which took into consideration their dignity, privacy and respect. For example, bedroom doors were open, bedrooms were untidy, topical medicines, paperwork and continence aids were on display. By the second day of our inspection, action had been taken and people's bedrooms had been tidied.

People told us they regularly received the wrong clothing back from the laundry, with one person showing us five items of clothing that were not theirs.

People were not always treated with dignity and respect. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they protected people's dignity by closing doors and curtains when supporting people with their personal care, as well as discreetly asking people when they thought they may need to use the bathroom.

People and/or their loved ones were involved in making decisions about their care and support. However, this was not always recorded so the manager was taking action to rectify this, by speaking with staff, people and/or their families.

People being cared for at the end of their life, were not always cared for by staff who had undertaken training. People did not always have end of life care plans in place to ensure staff were aware of their wishes. People's care plans, did however contain information regarding their wishes in respect of continued treatment and resuscitation.

People's cultural and spiritual needs were being met by religious events, and Holy Communion was held at the service on regular occasions.

People and their families, told us staff were kind and caring, comments included "The staff do everything for me" and "The care from the staff is absolutely wonderful". A relative told us, "The staff show my relative so much respect, it's wonderful".

People and their families were being asked to contribute to a 'life story' care plan to help capture what people had achieved in their life, prior to coming to live at the service. This would help to ensure staff were

able to have meaningful conversations with people. People's bedrooms were individual and personalised.

Requires Improvement

# Is the service responsive?

## Our findings

People's plans care plans were not always effectively updated to ensure they were reflective of people's current care needs. For example, one person required assistance with their mobility, so moving and handling equipment was required. However, the moving and handling equipment which was to be used was not detailed in their care plan. Their care plan also gave incorrect information about how many staff were required to assist with this task. However, whilst information was not documented, staff knew people well and most people were able to communicate how they wanted their care needs to be met.

People's care plans were not always reflective of how their care and support needs should be met. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff shared how people's needs were being met and if they had changed during a daily handover. The handover however, was not formalised therefore information about people was not always spoken about. For example, the staff receiving the handover had to prompt the staff member giving the handover for specific information about people's needs. The manager told us a new handover was going to be devised to ensure people's needs were spoken about in a more detailed and constructive way.

People told us they could get up and go to bed when they chose and had their personal care needs met. Commenting, "I can get up and go to bed whenever I want" and "I always have a bath once a week, that's enough for me". A hairdresser visited the service weekly.

People's social activities were mainly met by outsider entertainers, as there was no activity co-ordinator employed at the service. A display board advertised activities such as tranquil and healing moments. However, some people told us there was not always enough to do, to keep them occupied, with one person telling us "There's not much to do, but I don't mind". Others told us they liked to spend time alone commenting, "I like to sit in my room and have some peace and quiet, and "I like to sit in my room and read or do a crossword". The manager told us they had already recognised social activities were not always suitable and plans were in place to gather people's views and to make changes.

People told us they would feel confident about raising concerns, but confirmed at the moment they had no reason to do so. People's complaints were used to improve the service and the provider had a policy to help investigate complaints effectively. The manager was in the process of reviewing the policy and told us they would ensure it was in a suitable format for everyone to understand.

Inadequate

# Is the service well-led?

## Our findings

People were not protected by the provider's systems and processes to help ensure the quality of their service was monitored. As a consequence of this, the provider had failed to recognise the service had been deteriorating since our last inspection in 2015. For example, they had failed to know that staff one to one supervisions had not been undertaken since 2015, weekly fire tests had not been carried out since 16 May 2017 and that staff training was out of date. In addition to this, people's care records were not accurate, people were not protected from risks associated with their care, medicines were not managed safely, and people's human rights were not being protected.

The provider had also failed to ensure robust governance systems were in place to help capture people's views and drive continuous improvement. People's views were not collated, for example by meetings or questionnaires. The manager told us she was planning to do this. Staff told us the provider visited sometimes and they felt comfortable to speak with them. However, there were no records of the provider's visits, so we were unable to ascertain how they ensured the ongoing quality and compliance of the service.

The manager had recently created a weekly and monthly medicines audit in order to identify any issues and raise quality. Although the audit was yet to be used, the content of the new audit was not detailed, and would have failed to identify the areas requiring improvement found during our inspection.

People were not protected by the provider's policies and procedures. The provider's policies were out of date, some of which had not been updated since 2003, and although there was a whistle blowing policy in place, the policy had failed to support staff to raise concerns promptly about the failings occurring at the service since 2015.

The provider had not ensured the new manager, who was in day to day charge of the service had received an induction to the organisation which meant they were not aware of the provider's current policies and procedures, systems and processes.

The provider did not have systems and processes in place to ensure the ongoing monitoring and quality of the service. The provider did not seek and act on feedback from external professionals in order to improve the service. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager explained that prior to our inspection the provider had requested a quality audit of the service to be completed, which had identified areas requiring improvement and an action plan had been created.

Since our last inspection there was a new manager in post. At the time of our inspection the manager had been in post for two weeks and was already working hard to make changes. They told us they recognised there was a lot of work to be done, but they were passionate about making improvements for people and staff. Staff told us the manager was "visible" and "approachable". Staff told us they felt confident that when they spoke with them, "Things would get done".

The new manager had experience of working within the health and social care sector, and told us she would be keeping up to date with best practice by liaising with external stakeholders and contacting other care home managers in the local area.

The provider and manager demonstrated an open and transparent approach throughout our inspection, for example showing us what they had identified themselves as already requiring improving. This demonstrated their understanding and recognition of the Duty of Candour. The Duty of Candour means that a service must act in an open and transparent way in relation to care and treatment provided when things go wrong. The provider had displayed their latest rating in line with legislation.

The new manager was trying to ensure the service remained in the heart of the community by inviting local schools into sing and play musical instruments.

As a result of our inspection the provider told us they would voluntarily stop any new admissions to the service to give them time to make the necessary improvements.

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<br><br>Regulation 9 (1) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.<br><br>People's care and support did not always reflect their preferences. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>Regulation 10 (1) (2) (a) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.<br><br>People's privacy and dignity was not always promoted. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>Regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.<br><br>People's human rights were not protected by legislative frameworks. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or | Regulation 18 HSCA RA Regulations 2014 Staffing |

personal care

Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always supported by staff who had the skills and qualifications to meet people's needs safely.

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<br><br>Regulation 12 (1) (2) (1) (a) (b) (d) (g) (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.<br><br>People's medicines were not always managed, stored and administered safely. Best practice guidelines were not being followed. Their medicine records were not always accurate.<br><br>People's environment had not been assessed to ensure it was safe.<br><br>The provider did not take prompt action in order to keep people safe. People's risks associated with their care had not always been assessed and documented to help staff know how to mitigate risks associated with people's care. |

**The enforcement action we took:**

We have imposed a condition on the providers registration.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Regulation 17 (1) (2) (1) (2) (a) (b) (c) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.<br><br>People's care plans were not always reflective of how their nutritional needs should be met.<br><br>People's care plans were not always reflective of how their care and support needs should be met.<br><br>The provider did not have systems and processes |

in place to ensure the ongoing monitoring and quality of the service. The provider did not seek and act on feedback from external professionals in order to improve the service.

**The enforcement action we took:**

We have imposed a condition on the providers registration.