Byron Lodge (West Melton) Limited

Byron Lodge Care Home

Inspection report

Dryden Road
West Melton
Rotherham
South Yorkshire
S63 6EN

Tel: 01709761280

Date of inspection visit:
18 October 2017
19 October 2017

Date of publication:
04 January 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 18 and 19 October 2017 and was unannounced on the first day. The last comprehensive inspection took place in March 2017, when we identified breaches across all domains. The service was rated inadequate and placed in special measures. This inspection took place to check if improvements had been made. We found that the provider had failed to make or sustain sufficient improvements. You can read the report from our last inspections, by selecting the 'all reports' link for 'Byron Lodge' on our website at www.cqc.org.uk.

Byron Lodge is a care home providing accommodation for up to 61 people. It is situated in the area of West Melton, approximately six miles from Rotherham town centre. It provides accommodation on both the ground and the first floor and has parking to the front of the building and a secure accessible garden at the rear. The home is split up in to four units; Shakespeare and Ruskin providing nursing care and Wordsworth and Browning providing residential care. At the time of our inspection these were 44 people using the service.

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

Following the inspection Byron Lodge Care Home have notified the Care Quality Commission of a serious incident which is currently being investigated by the Safeguarding Authority.

The home had a dependency tool in place in care records which identified the level of support people who used the service required from staff. We observed staff interacting with people during our inspection and found there were times when the deployment of staff could have been managed more effectively. We spoke with people who used the service, relatives, visiting professionals and staff. They all felt there were not enough staff to meet people's needs in a safe way.

Systems were in place to manage medicines safely. However, we found these were not always followed to ensure people received their medicines as prescribed.

Assessments identified risks to people and management plans to reduce the risks were in place to ensure people's safety. However, we found these were not always followed.

The provider had a safeguarding procedure to ensure people were protected from abuse. However, some concerns had not been reported to the safeguarding authority.

Systems in place for infection prevention and control were not effective. The environment was not well maintained and therefore, could not be effectively cleaned.

We found that staff received training and support, but this was not always effective. For example staff had completed dementia training but lacked knowledge about assisting people who were living with dementia. Staff told us they did not feel supported by their managers and did not receive effective supervision.

We found the service was not always meeting the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). We found people's best interests were not always clearly documented, did not always involve all relevant people and did not clearly detail the outcome. Decisions recorded were sometimes very general and not specific.

Mealtimes were relaxed and calm; however, staff did not always ensure people received adequate nutrition. Some people required a fortified diet to ensure they received adequate nutrition. There was little evidence to show that this need had been fulfilled. Some people's food preferences were not respected.

We observed staff interacting with people and found they were kind and caring, but only interacted with people when carrying out a task. We also saw that staff had not recognised that some people were distressed and we had to inform staff that they required assistance.

We found care plans were in place and had been updated since our last inspection. We found for the most part people's needs had been identified. However, we found they did not always reflect people's current needs as they were not always reviewed when needs changed. We also observed lack of social stimulation and activities. People we spoke with told us they were bored. Staff we spoke with also told us there had been no activity co-ordinator for some time.

People we spoke with gave mixed opinions about how the registered manager handled their concerns. Some people did not feel listened to, but others felt their concerns had been dealt with satisfactorily.

Changes within the management team had impacted on the performance of the team. The nursing unit manager was no longer in post and another unit manager had not been consistently at work. However, the registered provider had not taken appropriate actions to ensure the units were managed effectively.

We found a lack of leadership and oversight on a day to day basis and communication between all was not effective at all levels of staff. Staff we spoke with told us they did not feel listened to, they said communication was poor and there was lack of direction. Systems in place to monitor the service had not been completed consistently. The quality and safety audits in place had not always been effective. For instance, the shortfalls that we found at this inspection had not been identified by the registered provider's monitoring systems.

We found six continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered provider to take at the back of the full version of the report.

The overall rating for this service remains 'Inadequate' and the service will therefore remain in 'special measures.'

The service 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.

Full information about CQC's regulatory response to the more serious 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.

We observed that staff were not always deployed effectively to enable them to meet people's needs.

Risks associated with people's care had been identified and plans were in place to manage risks. We found risk assessments were not always followed by staff and that plans did not always include actions to be taken to minimise the risk.

People's medicines were not always managed in a safe way. We identified concerns regarding the storage, recording and administration of medicines.

The provider had a safeguarding procedure to ensure people were protected from abuse. However, some concerns had not been reported to the safeguarding authority.

The provider had a safe recruitment system in place.

Is the service effective?

Inadequate

The service was not effective.

We found that staff received training and support, but this was not always effective.

We found the service was not always meeting the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS).

Mealtimes were relaxed and calm; however, staff did not always ensure people received adequate nutrition.

Is the service caring?

Requires Improvement

The service was not always caring.

We observed staff to be kind and caring, although often busy, which led to them to be very task focused.

We also saw that staff had not always recognised when some people were distressed.

Is the service responsive?

Inadequate

The service was not responsive.

We found care plans were in place and had been updated since our last inspection. Overall, people's needs had been identified. However, the plans did not always reflect people's current needs and were not always reviewed when needs changed.

There was a lack of social stimulation and people were at risk of becoming socially isolated.

The provider had a complaints procedure and complaints had been recorded. However, we did not see any analysis or lessons learned documented.

Is the service well-led?

Inadequate

The service was not well-led.

There was a lack of leadership and oversight at all levels.

Audits in place to monitor the service had not identified the concerns we found at this inspection, therefore they were not effective.

We received mixed comments from people about the confidence they had in the management team. Some people felt the management team were good whilst others had not had the same experience.

People who used the service and their relatives had the opportunity to attend meetings to discuss the service. However, people's views were not always considered.

Byron Lodge Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

The inspection took place on 18 and 19 October 2017 and was unannounced on the first day. The inspection was carried out by two adult social care inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. We were also joined by a member of the local authority contracts team and a member of the care homes team who has a remit of looking at quality in care homes. At the time of our inspection there were 44 people using the service.

Prior to the inspection visit we gathered information from a number of sources. We also looked at the information received about the service from notifications sent to the Care Quality Commission by the manager. We also spoke with the local authority and other professionals supporting people at the home, to gain further information about the service.

We spoke with 11 people who used the service and four relatives, and spent time observing staff supporting with people. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with seven care workers, four nurses, the cook, two ancillary staff, the registered manager, the regional support manager and the regional manager. The registered provider was also present at the feedback meeting. We looked at documentation relating to people who used the service, staff and the management of the service. We looked at eight people's care and support records, including the plans of their care. We saw the systems used to manage people's medication, including the storage and records kept. We also looked at the quality assurance systems to check if they were robust and identified areas for improvement.

Inadequate

Is the service safe?

Our findings

At the last inspection we found a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, staff were not always deployed effectively to meet people's needs. The provider sent us an action plan telling us about the action they would take to address this. At this inspection we checked to see if improvements had been made.

At our inspection of 18 and 19 October 2017 we found continued concerns in this area. People we spoke with and their relatives told us there were not enough staff around. One relative said, "With regard to staff numbers I don't believe there are enough. Even though they [the staff] are good they are stressed. It's a serious situation. It has all been raised at meetings." Another relative said, "There are never enough staff. Sometimes only one or two [on this unit]. They are desperately short of staff." One person who used the service said, "You can see most of the time there is only one staff on this unit. If I need the toilet I have to wait." One visiting professional told us of a recent visit to the home when no staff could be found on one unit and a person who was using the service required assistance. They were told that all staff were assisting with meals.

The home had a dependency tool in place in care records which identified the level of support they required from staff. We observed staff interacting with people during our inspection and found there were times when the deployment of staff could have been managed more effectively. For example, during a walk around the home we saw one person, who did not have access to a call system, was shouting out trying to summons staff to assist them. Another person was trying to eat their breakfast and have a drink whilst in bed, in a laid down position. We had to alert staff to assist the person to sit up.

During observation we saw staff were not always available in communal areas. When staff were carrying out personal care in bedrooms and the nurse was administering medication this left no staff available for support if required. We spoke with the provider regarding staffing and we were informed that they were struggling at present due to staff sickness. This meant that there were not always staff available who had the right mix of skills, competencies, experience and knowledge to meet people's individual needs.

This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff were not always deployed effectively to meet people's needs.

At the last inspection we found a breach of Regulation 12 (1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was not doing all that was reasonably practicable to mitigate risks associated with people's care and treatment.

At our inspection of 18 and 19 October 2017, we found that the provider had not taken enough action to address this breach and to ensure people were supported in a safe way. We looked at care plans and found they contained risk assessments. However, they did not always contain accurate information required to ensure people's safety. For example, one care plan we looked at showed that the person had continued to lose weight over a six month period. In April 2017 the person weighed 76.6kg and continued to lose weight.

In September 2017 the person weighed 69kg. This person was then weighed during our inspection and weighed 67kg.

We looked at the Malnutrition Universal Screening Tool (MUST), and this had been completed incorrectly. The risk to the person should have been assessed as a medium risk and action should have been taken. Instead the MUST indicated no risk although we saw that staff had actioned a first line treatment plan on the 30 June 2017 and 3 October 2017. A first line treatment plan sets out guidance to improve dietary intake and prevent further weight loss. This should be completed prior to referring people to a dietician. From the first line treatment plan we saw that the person should have been weighed weekly, their food and fluid intake should have been monitored and recorded and fortified drinks and snacks should have been offered regularly. We found that the person had not been weighed weekly. The last time their weight was recorded was 30 September 2017. Their food and fluid charts had not always been completed and when they were, they lacked information and showed that fortified and nutritious meals, drinks and snacks had not been offered regularly. The person had not been referred to the dietician.

Another person had a care plan in place to address the support they required to mobilise. The person's care plan stated that they moved around the home using a wheelchair. However, we observed the person using a specialist chair, which they remained in and that staff moved the person whilst in the chair. This showed the care plan had not been updated to reflect the person's current needs.

We looked at risk assessments in relation to moving and handling and found moving and handling risk assessments were in place. Although slings were kept in people's rooms and staff were clear what sling to use we found the risk assessments did not always document sufficient detail to ensure all staff were aware of correct procedures to follow. For example, some risk assessments did not give details of the sling sizes, or the loop configuration to use, as directed by the health care professional, to ensure people's safety.

Care records included Personal Emergency Evacuation Plan (PEEP) in place for people who may not be able to evacuate the service quickly in an emergency. The PEEP's were not always completed fully. For example, one person required the use of a hoist to move around safely. This was not included in their PEEP.

Accidents and incidents were not always recorded and analysed to identify patterns and trends. We saw clear records had been maintained up to June 2017, but from this time there was no detailed audit and some accidents had not been recorded and analysed effectively. For example, we saw from care records that one person had four falls, but only one fall had been entered in the falls diary. The same person had an unwitnessed fall, which resulted in them being found on the bedroom floor. There was no evidence that any analysis had taken place to ensure the falls were monitored. This meant the person was at risk of falling and no further action had been taken to minimise the risk.

This was a continued breach of Regulation 12 (1) (2) (g) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

At the last inspection we found a breach of Regulation 12 (1)(2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have safe arrangements in place for managing people's medicines.

At our inspection of 18 and 19 October 2017 we found concerns in this area. We looked at the systems in place for managing medicines in the home. This included the storage, handling and stock of medicines and medication administration records (MARs).

We found medication storage rooms had air conditioning installed and this was set to 18 degrees centigrade. However, in the upstairs medication room the unit was turned off. Staff told us the air conditioning was not always required in this room and the temperatures were checked each day. However, the thermometer used was not a minimum maximum thermometer, so it was not possible to determine if the storage room maintained the correct temperatures over a twenty four hour period.

We found records to show the amount of medicines received and the amounts carried over from the previous month were not completed on the upstairs units. This made it difficult to account for medicines and evidence medicines were administered as prescribed. For example, the pharmacy pre-printed chart detailed 14 tablets were sent, the staff had administered five, which would mean nine tablets should be left. However, five were left in stock, leaving a shortfall of four tablets. The amount received had not been completed, so it was not clear if 14 tablets had been received and four were unaccounted for, or if ten tablets had been received and the pharmacy chart was incorrect.

The staff member we spoke with told us there were aware the carried over amounts had not been recorded and told us, "These have not been completed for the last three medication cycles." They explained the home was using agency staff to cover night shifts and this was when the medication should have been checked. The agency staff had not completed the records and the day staff did not have time to complete them.

We found people were prescribed medication to be taken as and when required known as PRN medicine. For example, medication to alleviate agitation or to manage people's pain. We found people did not always have PRN protocols in place, or if in place, they lacked detail. The protocols should detail when PRN medication should be given and explain how people presented when they were in pain or agitated. Staff told us people who were prescribed these medications were not always able to tell staff when they were in pain or distressed as they were living with dementia. This meant that people who used the service could be in pain or distressed and not have medication administered, as staff did not know the signs, to determine when it was required.

We also found that on the MAR's we checked when people were administered PRN medication the reason why it was administered was not always recorded. It was therefore, not possible to determine if the medication was effective or was given as prescribed.

We found the systems in place for recording topical medication were not followed and it was not possible to determine if people were given creams or ointments as prescribed. For example, we saw people were prescribed creams to be applied regularly each day, yet staff had not signed the topical MAR to confirm if this had been applied. This meant it was not possible to determine people were receiving their prescribed medicines as prescribed, to meet their needs.

We checked controlled drugs (CDs). These are drugs covered by the misuse of drugs regulations. We found these were stored and recorded correctly.

The medication was administered by staff who had received training to administer medication. The nurse told us they received competency assessments. However, we found errors were still occurring, so these had not always been effective. Additionally, the quality and compliance medication audit by the registered manager in September 2017 did not identify all the issues we saw. The audit did not cover the topical medication records, therefore they were not audited as part of the quality monitoring of the service.

This was a continued breach of Regulation 12 (1)(2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have safe arrangements in place for managing people's

medicines.

During our inspection we looked around the service. We found many areas were not kept clean and infection prevention and control policies were not adhered to. We found store rooms were cluttered and not well organised. Many items were stored on the floor, which meant it was difficult to clean. Kitchen units were damaged and unable to be kept clean, seals around sinks and wash hand basins were dirty with engrained dirt. Chair cushions were stained and dirty and many had ingress of fluids to the under cushion. We found one cushion had gone mouldy. We also identified an area of floor covering in the main corridor that was loose and was a potential tripping hazard. This was bought to the attention of the registered manager and was addressed immediately. However, this had not been identified prior to our visit and had posed a risk to people's safety.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The environment was not always kept clean and well maintained.

The provider had a procedure in place to safeguard people from abuse. Staff we spoke with were knowledgeable about the types of abuse and what to do if they suspected abuse. Staff we spoke with felt confident that the registered manager would take appropriate action to ensure people were safe. However, we looked at care records and found that one incident had not been referred to the safeguarding authority. This meant that signs of potential abuse were not always recognised and reported in line with the provider's policy and procedure.

We looked at the recruitment files for two new members of staff. We found all the required information had been obtained prior to commencing in post. This meant robust recruitment was followed to ensure people were safe.

Inadequate

Is the service effective?

Our findings

At the last inspection we found a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing. Some staff had not received appropriate support, supervision and appraisal necessary for them to carry out their duties. Staff were not always knowledgeable about people's needs and there were some gaps in the training record.

At our inspection of 18 and 19 October 2017, we found some improvements in this area since the previous inspection. We looked at staff training records and found they were up to date and evidenced that regular training had taken place. Staff we spoke with told us they received training regularly and had access to on line training. However, through our observations we found that the training had not always been effective. For example, staff had received training in dementia care, but it was not always evident that they understood the needs of people living with dementia.

Staff told us they did not feel supported by their managers and did not receive effective supervision. One staff file we checked showed a new starter had received three supervisions since commencing in post in April 2017. These were each two months apart and did not show any evidence of mentor observations or how they were performing in their role. It was their first job in care and they had no prior experience, so we would expect their supervisions to cover performance and competency. The supervision records only stated, 'continues to enjoy care.' The supervisions, although taking place, were not meaningful or effective.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing.

At the last inspection we found a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Decisions made did not follow best practice and did not evidence decisions were made in the person's best interest. We identified people's conditions in relation to the authorised DoLS were not being followed putting them at risk that they may be deprived of their liberty.

At our inspection of 18 and 19 October 2017, we found the service was not always meeting the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). The staff we spoke with had a satisfactory understanding and knowledge of this, and people who used the service had been assessed to determine if a DoLS application was required. However we identified people's conditions in relation to the authorised DoLS were not being followed, so they were being deprived of their liberty. For example, one person's condition was for the service to monitor behaviour and the activities they participated in and to document, so this could be reviewed. We saw lack of documentation on their behaviour monitoring chart, yet from daily records it was clear the person did, at times display behaviour that may challenge. We also saw the activity log did not evidence what activities were offered, what the person participated in and what they enjoyed or refused. From July 7 2017 to 13 October 2017 there were only four entries recorded for activities that had taken place. This meant these conditions were not met, to determine if the person's needs were met.

We found people's best interests were not always clearly documented, did not always involve all relevant people and did not clearly detail the outcome. Decisions being made were sometimes very general and not specific. For example, many people had a best interest decision for all aspects of care and support, including washing, dressing, continence and nutrition.

We identified some best interest decisions showed involvement of health care professionals, family and key workers to ensure where a person lacked capacity to make a decision it was made in their best interest. However, in some care files we looked at decisions made did not follow best practice. For example, we saw consent had been signed by relatives when people lacked capacity to make a decision without the legal authorisation in place to consent on their behalf.

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

At the last inspection we found a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The mealtime experience and lack of support did not ensure people received adequate nutrition.

At our inspection of 18 and 19 October 2017, we observed that breakfast on Ruskin unit was served very late. People were just starting breakfast at 9.55am some people had already had a hot drink but others had not. All people who were up and dressed were sitting in the lounge waiting to come through to the dining room. There didn't appear to be any flexibility for serving breakfast to people at different times if they wished. We saw that lunch commenced at 12.15pm. This provided very little time between meals. We discussed this with the cook who told us that this had been brought to the attention of the registered manager and was being looked at.

We saw the main meal being served throughout the home. Overall, we found this was served in a relaxed way. However, although the meal experience on Ruskin unit was calm, music was playing, but the music disc kept getting stuck and not playing properly. Staff did eventually change the song. Staff told us the disc player had been doing this for a number of days, but had not been fixed. It did not provide a relaxing environment for people to enjoy their meal.

Meal service did not always meet the needs of people living with dementia; there were no picture menus for people to be able to make choices. We also found a plate with sandwiches and a sausage roll on, which had been left on one unit. The food covers used did not protect the food effectively, so the sandwiches had gone hard. This stale food was left in a communal area, where people living with dementia had access to it.

We received mixed opinions about the food. For instance, one person said, "There is very little taste in the food and it's not very warm when I get it." While another person said, "I think the food is alright." One person told us that they had requested that the bread used to make sandwiches was not placed in the fridge. This was causing the person difficulty in eating the sandwiches and therefore they had begun to refuse them. This request was not actioned. This meant the person's preferences were not considered and the person did not eat their lunch on a regular basis.

We observed meals being served throughout the home on both days of our inspection. We found staff were task orientated and did not offer personalised support to people who required assistance with eating. This meant people did not always eat their meal.

Some people were served their meal in their bedrooms. We saw that service users were not assisted to sit up

properly so they could eat their meal safely and comfortably. We saw some of these people did not eat their meals. We saw one person attempting to eat their breakfast in bed. However, they were struggling as they required sitting up.

This was a continued breach of Regulation 14 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that people had access to healthcare professionals when they required their support.

Requires Improvement

Is the service caring?

Our findings

At the last inspection we found a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not always treated with dignity and respect.

At our inspection of 18 and 19 October 2017, we saw staff were kind and caring. The interactions we observed between care staff and people they supported were kind and respectful. Staff we observed maintained people's dignity. However, due to lack of leadership and deployment of staff, we saw at times the care and support could be task orientated. For example, at meal times people waited in wheelchairs in the lounge to go through to the dining room to all eat at the same time. This was not a person centred or individualised approach. We also saw personal information about people, which was available in communal areas. For example, bathrooms had a list on the windowsill, which recorded when people had been bathed.

We saw that the domestic team were kind and considerate. We observed them knocking on doors before entering and chatting with people. They had laughter and banter together. It was clear the people had a good relationship with the domestic staff and knew them well.

We spoke with people who used the service and their relatives and they told us the staff were kind and caring. One person said, "The staff treat me with kindness." Another person said, "Staff that are here are pretty good." One relative said, "The staff are respectful of [my relative's] privacy and dignity."

We looked at care records and found limited information about life histories and preferences. Where these had been documented, they didn't always reflect people's current views. For example, one person told us they enjoyed spaghetti bolognaise, but the care record stated they did not like pasta.

We also saw that staff had not recognised that some people were distressed and we had to inform staff that they required assistance. For example, one person was trying to drink a cup of tea and eat their breakfast in a half prone position in bed. We asked staff to reposition the person, so they would be more comfortable. Another person was sitting in the lounge and showing signs of distress. Staff were present, but did not intervene. We asked staff to assist the person to prevent them from falling from their chair.

Staff we spoke with told us they would respect people's privacy by knocking on bedroom doors and ensuring curtains were closed.

Relatives we spoke with told us they were able to visit their family member at a time that suited them. We saw relatives visiting the home throughout our inspection.

Inadequate

Is the service responsive?

Our findings

At the last inspection we found a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People did not always receive person-centred care which was appropriate and met their needs.

On our inspection of 18 and 19 October 2017 we found care plans were in place and had been updated since our last inspection. We found that generally, people's needs had been identified. However, the plans did not always reflect peoples current needs and were not always reviewed when people's needs changed. For example, we saw one person had a fall on 16 October 2017 the incident form had been completed and documented in their daily notes. The care plan had not been updated to reflect the fall, to ensure the management of falls was addressed to prevent further falls.

During our inspection we observed care and support in communal areas. We found staff were not always responsive to people's needs. For example, one person refused to leave the lounge and go to the dining room for lunch; the staff did not continue to try to encourage the person and left them on their own in the lounge. We observed the person became very agitated and upset, trying to get out of their chair. We raised this with the staff on duty, as the person was at risk of falling. Following this up later, we found the person had been given medication to alleviate agitation. However, no other care or support had been explored before this. The person may have wanted to go to the toilet, may have been in pain or may have been distressed, as they were left alone. The care plan detailed that the person could become agitated when they were incontinent of urine, yet the person had not been taken to the toilet to determine if this was the cause of their agitation. No other methods had been explored first to ensure the person's needs were met in the least restrictive way. We also saw the medication administered had not been properly recorded.

We also observed a lack of social stimulation and activities. People we spoke with told us they were bored. Staff we spoke with also told us there was no activity co-ordinator as they had been off work on a long term basis. They told us care staff were meant to provide activities if they had time, however they said, "We don't have time to do activities, there is not always time to provide the care we should." We saw many people were nursed in bed in their rooms and received no social stimulation. One person said, "I am left in this room all day, it is very lonely." A relative we spoke with said, "I do not see any activities, I know [my relative] is not happy." Activity records we saw showed many activities took place up to June 2017. From then very little stimulation or activity had taken place. For example, one person's record only recorded four entries of participation in activities from 25 June 2017. Another person who was nursed in their bedroom, had only two entries in their activity log since 25 June 2017 and these were not stimulating activities. The staff had documented, 'Enjoyed listening to music,' and, 'Enjoyed watching TV.'

This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People's needs were not always met and social stimulation was not available.

We looked at records of complaints received. There had been four since our last inspection. Two were regarding poor staffing levels and people's needs not being met. One was about poor care received and the

other was regarding poor staff attitude. We also received some concerns on the day of our inspection regarding poor staff attitude form visiting health care professionals. The concerns were documented and we saw evidence they had been investigated. However, we did not see any analysis or lessons learned documented. This would have been helpful, as some complaints were regarding the same issues and identifying lessons learned may have prevented any further complaints.

We spoke with people who used the service and their relatives and they told us they would tell staff if they had a concern. One relative said, "We have had problems in the past which were resolved to our satisfaction." One person said, "Yes I know how to complain I would tell my carers. I have made many complaints, but they [staff] don't take any notice."

Inadequate

Is the service well-led?

Our findings

At the last inspection we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The system in place for monitoring the quality and safety of the service was poor and did not always identify areas of improvement.

Following our previous inspection we could see that some improvements initially took place. There was a unit manager appointed for the nursing unit and the residential unit was supported by a unit manager. The manager was registered with the Care Quality Commission and was being supported by the regional manager and regional support manager. We saw improvements in quality monitoring had taken place. However, this had changed again since July 2017. The unit manager on the nursing unit was no longer in post and support for the registered manager had been reduced. There were also high levels of sickness within the staff team. We saw that sickness levels had an impact on the day to day management of the service. We spoke with the regional manager who confirmed that staff sickness had impacted on the service, they said, "If you [CQC] had inspected the service three months ago you would have seen the improvements."

The management team consisted of the registered manager, nurses and senior care workers. There were plans in place to recruit a deputy manager who would be the clinical lead for the home. We found a lack of leadership and oversight on a day to day basis and communication between all levels of staff was poor. Staff we spoke with told us they did not feel listened to, they said communication was poor and there was lack of direction. One member of staff said, "After your (CQC) last inspection we saw an improvement, more support and peer meetings, but this has stopped, not in place now." Another said, "We are not listened to."

We saw audits were in place to ensure any issues were identified and addressed. However, we found that these were limited after July 2017 and had therefore, not taken place as scheduled. We found that audits completed had not identified the concerns we found on inspection. For example, issues with care plans, risk assessments, infection control, lack of activities, staffing levels and ensuring staff competencies following training. Where issues had been identified there was no evidence that actions had been completed, no review or sign off. For example, the last care plan audits recorded took place in June 2017. These identified some shortfalls, for completion as soon as possible. However, there was no record of these actions having been completed and therefore, no oversight. There was no record of care plan audits from this date and no evidence that the concerns we raised during this inspection had been identified.

The infection control audit was last completed in July 2017 and identified that there was no formal check being carried out on mattresses. It stated that staff inspected them, but no formal audit was in place. During our inspection we found one mattress cover was heavily stained and no audit had identified this.

In addition to the audits completed by the management team, the regional management team completed audits. For example, the regional support manager completed a monthly audit tool. This covered areas such as finance, health and safety, medication, infection control, and care documentation. This audit was last completed at the end of September 2017 and the service had been scored highly and rated good by the

regional support officer. Many areas we identified as part of this inspection were not identified.

Some staff were champions for areas such as dignity, infection control, safeguarding and activities. We saw some of these roles were not being utilised. For example, there were three staff identified as champions for activities. However, we saw no social stimulation provided for people to prevent them becoming socially isolated.

We saw that residents' and relatives' meetings took place and people who attended the meeting in September 2017 had raised concerns about the staffing levels. Everyone we spoke with at this inspection raised concerns and worries about not having enough staff around. One relative told us, "I have attended relatives meetings and expressed my disappointment with the staffing levels because the problem is even worse now, with more residents." This showed that people's views were not always considered.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

We spoke with people who used the service about the confidence they had in the management team. We received mixed comments. Some people felt the management team were good whilst others had not had the same experience. One person said, "My view of the management is that they are no good at all." A relative said, "The management are not good. They are lacking in staff availability and management." Whilst another person said, "I am happy with the level of communicating with the staff and management. I have a really good relationship with them all."