Gibson's Lodge Limited

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Inspection report

Gibson's Hill
London
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Date of inspection visit:
19 September 2018
20 September 2018

Date of publication:
10 January 2019

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 19 and 20 September 2018 and was unannounced. Gibson's Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Gibson's Lodge is located in a quiet residential road in Streatham close to transport links and shops. The service is registered to accommodate up to 53 elderly people. At the time of this inspection 41 people were living at Gibson's Lodge. The majority of the people at Gibson's Lodge were living with dementia.

At our previous inspection of the service in March 2017 the service was rated good. During this inspection we found breaches of the regulations relating to safe care and treatment, staffing, the lack of effective recruitment procedures, the suitability of the premises and the provider's failure to protect people from abuse and improper treatment. We also found breaches in relation to the lack of person-centred care; failure to respect people's privacy and dignity, the provider's failure to support staff, the provider's failure to submit statutory notifications and the lack of good governance.

The inspection was prompted by information shared with CQC about incidents which indicated a cause for concern regarding the management of risk relating to people using the service. This inspection examined those risks.

The home had 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.

The provider had safeguarding policies and procedures in place but the registered manager and some staff did not have a clear understanding of these procedures. This meant that incidents which should have been reported to local authority safeguarding teams and the CQC were not always reported.

Management plans were in place to support people where risks associated with their health and care needs had been identified. The provider recorded accidents and incidents but did not always take action to prevent recurrence. The equipment people required to be kept safe was not always available.

People's medicines were not always stored safely. People received their medicines when they were due and in the correct dosage. People had a sufficient amount to eat and drink and were satisfied with the variety and quality of their meals.

People were not adequately protected from the risk and spread of infection because staff were not following the provider's infection control procedures. Many areas of the home were not hygienically clean. This

included equipment and soft furnishings. There were ongoing building works which posed a risk to people's safety. Building materials and tools were left in an unlocked room to which people had access on both days of our inspection despite this being pointed out to the registered and area managers on the first day of the inspection.

The provider's recruitment process was not sufficiently robust to ensure the staff employed had the competence, skills and experience to perform the role for which they were employed. Additionally, once recruited staff did not receive appropriate support from the provider through an induction or regular supervision. Staff training was inconsistent with some staff not receiving the training they needed to meet people's needs. The provider did not always deploy a sufficient number of staff to meet people's needs and this impacted the care people received.

People's needs were assessed with their or where appropriate their relatives input. Care plans comprehensively covered people's health needs but contained little information in relation their social needs, dislikes and preferences. Consequently, the care people received was not person-centred.

People had access to external health care professionals and were supported well by staff to maintain their physical health. However, care was not provided in a way which respected people's privacy and dignity. People were dissatisfied with the quality of care they received and did not feel the staff were caring.

There were limited arrangements in place for monitoring the quality and safety of the care people received. The provider did not have effective systems in place to seek people's views on the care they received. The provider did not always respond in a timely manner to feedback and recommendations made by external agencies to improve the home and the quality of care people received.

Staff said they enjoyed working at the home and felt supported by the registered manager. However, they felt that the provider did not listen to their views on what was required to improve the quality of care people received.

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.

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.

Information about the CQC regulatory response to the concerns found during this inspection can be found at the back of this report.

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 adequately protected from the risk of abuse because the registered manager and some staff were not fully aware of how and when to report concerns. The provider did not always deploy a sufficient number of staff to meet people's needs.

The home was not well-maintained or hygienically clean. People were not adequately protected from the risk of infection.

People's medicines were not stored at a safe temperature. People received their medicines when due and in the correct dosage..

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

The provider did not ensure that staff received appropriate support through an induction, regular supervision, relevant training and annual appraisal.

Staff supported people to eat and drink sufficient amounts, monitored their general health and supported people to access healthcare services when they needed to.

Staff were aware of their responsibilities in relation to the MCA and Deprivation of Liberty Safeguards (DoLS).

The provider had not made appropriate adaptations to the environment to meet the specialist needs of people living with dementia.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

Not all staff were attentive and caring.

Some staff did not treat people with respect or respect their right

to privacy.

Family members and friends were made to feel welcome and had no restrictions placed on them when visiting the service.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

People did not receive care which met their needs.

People did not feel listened to and did not feel in control of the care they received.

People knew how to make suggestions and complaints about the care they received but they were not always responded to appropriately.

People had the opportunity to participate in organised activities.

People's preferences and choices for their end of life care were clearly recorded.

Is the service well-led?

Inadequate

The service was not well-led.

There were limited systems in place to assess and monitor the quality of care people received.

The provider did not seek people's views on the quality of care people received.

The provider did not submit statutory notifications. People's records were not securely stored.

Gibson's Lodge Limited

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.

This unannounced inspection was carried out on 19 and 20 September 2018. The inspection team on the first day consisted of an inspector, a specialist advisor and an expert by experience. The specialist advisor's specialism was nursing care. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The second day of the inspection was conducted by a single inspector.

Before the inspection we looked at the information we held about the home including notifications they had sent us. A notification is information about important events which the service is required to send us by law. We also looked at the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also received feedback from a local authority that commissions services from the provider. We used this information to help inform our inspection planning.

We spent time observing the care and support being delivered. We spoke with eight people using the service. Some people were unable to communicate their views to us so we also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spoke to two relatives, the registered manager, area manager, deputy manager, two registered nurses, four care staff and the staff member responsible for maintenance. We also spoke to a healthcare professional who has visited the service and a representative of a local authority which commissions the service.

We looked at records, including eight people's care records and four staff members' recruitment files, as well staff training and supervision records. We looked at other records relating to the management of the service such as audits and policies and procedures. We also looked at areas of the building including communal areas and external grounds.

Inadequate

Is the service safe?

Our findings

We received mixed views from people on whether they felt safe living at the home. People commented, "I don't feel safe", "It's not safe here", "I feel safe enough" and "I think I'm safe." Staff had received safeguarding training. However, three of the staff we spoke with did not know how to recognise the signs of abuse or who to report their concerns to outside of the service. There had been several recorded incidents of people with unexplained bruises or marks on their body. This included one person who had a laceration on his head and eye. The registered manager had not taken any steps to investigate what had caused this and had not reported these incidents to the local authority or CQC.

People felt at risk from other people living in the home. "I don't feel safe, I have been attacked a few times by other residents". We saw that people who had been assessed as often displaying behaviour that others find challenging were frequently involved in incidents involving other people and staff. Records indicated that one person had been pushed over by another person. Also, a person had punched a staff member in the mouth. However, people's behaviour charts were not being completed. This made it difficult for staff to monitor behaviour, identify any deterioration in a person's behaviour or make appropriate referrals to external healthcare professionals. This meant that people were not adequately protected from the risk of abuse and improper treatment.

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

People were not adequately protected from the risk and spread of infection. Many of the chairs in the communal areas had liquid stains and were dirty. The material on one of these chairs was ripped. These chairs were not made of impermeable material which meant there was a risk of cross infection from body fluids. We saw a bag of soiled clothes on a communal bathroom floor. People's clothes were left on a trolley in the communal bathroom. It was unclear whether these clothes were clean or dirty. We asked the registered manager whether they were clean or dirty and she did not know. Some of the equipment used in communal bathrooms such as shower chairs, were dirty and rusty. Pedal bins in the communal lounge were broken so people and staff had to use their hands to open the bins. Intimate care items such as incontinence pads and bed linen were stored on trollies in hallways.

These issues amount to a breach of Regulation 12 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014

The home was not hygienically clean. There was not a cleaning schedule in place. It was therefore unclear when and how often the home was cleaned. There was an unpleasant odour throughout the home. Staff frequently sprayed air freshener to mask the odour but that left an overpowering mix of unpleasant odours. Communal areas and people's rooms had dust on surfaces such as window sills and radiators. We also saw ground-in dirt on the skirting boards throughout the home. The carpets throughout the home had large stained areas. The home was in need of redecoration and refurbishment. We saw torn and stained wallpaper in some people's rooms. A damaged floor had been covered with board and tape which made the

surface uneven and dangerous for people with mobility difficulties. Parts of the ceiling on the upper floor had been removed which meant that people could see and had access to the roof.

Some areas of the home were not safe or well-maintained. There had been an incident in the home in February 2018 where a person had jumped over a bannister to the floor below. The person was unhurt. After receiving the notification of this incident the CQC contacted the area manager who gave assurances that action would be taken to secure the stairwell so that a similar incident did not happen again. However, it was clear when we arrived for the inspection that no action had been taken to secure the stairwell. The building was in the process of being extended. We found building materials and tools including hammers, drills and gas canisters in an unlocked room to which people had access. Despite us informing the registered and area managers of this on the first day of our inspection, on the second day of the inspection we again found the room where the builder's tools were kept unlocked. Some areas of the home had been closed off with hazard tape or boarding, including a fire exit. We saw loose wires hanging from a ceiling and pointed this out to a member of staff. We were told that people did not access that part of the home but the next day we saw people sitting in that area and having lunch. There were no warning notices to inform people that work was in progress.

People had personal emergency evacuation plans (PEEP) in place but these were not fit for purpose. The PEEP for 25 people with mobility difficulties stated that staff should use equipment which the provider did not have. This meant that in the event of an emergency such as fire, these people could not be moved to a place of safety. We raised this with the area and registered managers who agreed that without this equipment people who had mobility difficulties were at risk of serious harm in the event of a fire. The provider has purchased the relevant equipment since our inspection.

These issues amount to a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments had been carried out to assess the levels of risk to people in areas such as, moving and handling, nutritional needs and skin integrity. For example, risk assessments had been completed for malnutrition and there was guidance for staff to follow for supporting people who had difficulty swallowing. However, the risk to people posed by the ongoing building works had not been assessed. There were therefore no risk management plans in place to help ensure people were safe while building work was being undertaken.

The provider did not operate effective recruitment procedures to ensure that staff employed had the competence, skills and experience necessary to perform their role. Appropriate checks did not take place before staff started to work with people. We looked at the recruitment records of four members of staff and found that professional references were not always obtained. This was despite the provider's policy stating that two professional references should be obtained before staff were employed. Three staff members had been employed without any references being obtained. Two of these staff members had no previous care experience. One staff member had a reference from a fellow college student. Additionally, the provider did not consistently check that staff were physically and mentally fit to perform the role for which they were employed. Once employed staff did not receive an induction. This is dealt with in more detail in the Effective section of this report.

These issues amount to a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records indicated the provider conducted criminal record checks and confirmed that job applicants had the

right to work in the UK before they were employed. We saw that checks were carried out to make sure nurses were registered with the Nursing and Midwifery Council (NMC).

The provider did not always deploy a sufficient number of staff to meet people's needs. The staffing levels on the day of our inspection were good. However, feedback from people indicated that there was an insufficient number of staff particularly at night and weekends and that this impacted the quality of care they received. The lack of staff numbers at night and weekends was confirmed by staff and the records we reviewed. People told us, "There is hardly anyone around at weekends and I don't get to leave my room", "At night you have to wait for such a long time and sometimes they don't come at all", "Nights are the worst. You press the call bell and nobody comes" and "During the week things are fine but I don't think they have enough staff at weekends." Records of staff meetings showed that staff had asked the registered manager to, "sort out the shortage of staff at weekends". Staff told us, "They can't get staff to work at weekends" and "Staff are on the rota but don't turn up and then it's difficult to get staff to come in at short notice at weekends." The registered manager did not have a contingency plan in place for when this happened which meant that the home was frequently understaffed at weekends. More information on the impact of staff shortages on people can be found in the responsive section of this report. The registered manager told us they were in the process of recruiting additional staff.

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

People told us they received their medicines as prescribed. We spoke with a nurse about how medicines were managed and observed a medication round. They told us that nurses and senior carers administered medicines to people and confirmed that medicines competency assessments had been completed before they could administer medicines and was repeated annually. People's medicines were administered safely. However, on two occasions a nurse left a full medicine trolley open and unattended in a communal area. This posed an obvious risk to people who had the opportunity to take other people's medicines. We raised this with the area manager who took appropriate action.

People's medication administration records (MAR) were completed and did not contain any gaps. The room temperature where people's medicines were stored was recorded daily. The room temperature recorded was regularly above the recommended temperature of 25 degrees. On some days the temperature had been recorded as 30. On the day of our inspection it was recorded as 27 degrees. Medicines may not be effective if they are not stored at the correct temperature. We raised this with the registered manager who said that she would arrange for a fan to be placed in the room where medicines were stored. Fridge temperatures were in the correct range. Controlled drugs were appropriately stored. There were detailed instructions in place for staff on how to prepare and administer medicines which were given covertly. Covert is a term used when medicines are administered in a disguised form without the knowledge of the person receiving them such as in food or drink. The decision making process for administering a person's medicines covertly was recorded.

Requires Improvement

Is the service effective?

Our findings

Staff were not appropriately supported by the provider to ensure they had the skills and training to provide effective care. We looked at the files of four newly recruited staff members. There was no evidence that these staff members had received an induction. We spoke with a nurse who had recently started to work at the home. The nurse was unsure whether she had received an induction. The nurse was unfamiliar with the main provisions of the Mental Capacity Act (MCA) 2005, or the requirements relating to the deprivation of liberty safeguards. The nurse was not fully aware of the importance of safe medicine management.

Staff did not receive regular supervision. The registered manager told us that staff were meant to attend six supervision meetings a year but that staff supervision was not up to date. We asked the registered manager for the staff supervision records. The registered manager gave us a file which contained the supervision records for ten staff members. Nine of these staff had attended one supervision meeting in 2018. One member of staff had attended two supervision meetings. This meant staff did not get regular opportunities to discuss issues relating to their role, their training requirements or receive guidance on good practice. The system of annual appraisal was not consistently offered to staff, although we could see that there had been an increase in the number of appraisals conducted in the months before our inspection.

We looked at the training records for staff and saw that there were gaps in the records which indicated that some staff did not have training in areas relevant to their role. For example, some people at Gibson's Lodge exhibit behaviour which people may find challenging. Half the staff had not completed their training in "managing behaviour that challenges". The provider's failure to support staff through induction, supervision and relevant training meant that people were at risk of receiving care and treatment which was inappropriate or unsafe.

These issues amount to a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessments of people's care and support needs were carried out before they moved into the home and during the process of them settling in to the home. These assessments were used to identify people's specific needs and to create individual care plans. Nationally recognised planning tools such as the multi universal screening tool [MUST] were used to assess nutritional risk. People's care plans described their needs and included guidance for staff on how to best support them. For example, the care plans of a person who was at risk of choking contained detailed information for staff on how to support them at mealtimes. The catering staff were also made aware of people's specific dietary needs.

People's meals were freshly prepared daily and were nutritious. People who required assistance with eating, or who required a special diet were given the support and diet they required. People had a sufficient amount to eat and drink and were satisfied with the quality of their meals. People commented, "The food is nice" "They give me quite a lot to eat" and "I look forward to dinner time."

People were supported to maintain good health because a variety of checks were conducted regularly and

recorded. We saw that people were weighed monthly. People with diabetes had their blood sugar monitored daily and people at risk of pressure ulcers had their Waterlow score recorded. The Waterlow pressure ulcer risk assessment tool is a nationally recognised system used to identify the likelihood of a person developing a pressure ulcer. People had access to a variety of external healthcare professionals. For example, people who were assessed as being at risk of choking were referred to the Speech and Language Therapy (SALT) team. We saw that people had been referred to the Community Mental Health Team when required. GP from three local surgeries visited the home.

The majority of people at Gibson's Lodge were living with dementia. People living with dementia can become disorientated in time and space which can make it difficult for them to find their way around the home without support. The provider had not made appropriate adaptations to the environment to meet the specialist needs of people living with dementia. For example, there was no signage on people's room doors to help them identify their rooms.

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 application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. Care plans we looked at showed that where people lacked capacity to make specific decisions for themselves, mental capacity assessments were conducted and decisions were made in their best interests, in line with the requirements of the MCA. For example, in relation to covert medicine administration. Where people had capacity or fluctuating capacity to make decisions we saw this was documented. We saw that applications had been made to local authorities to deprive people of their liberty where this was assessed as required. Where these applications had been authorised, we saw that the appropriate documentation was in place, they were kept under review and conditions of authorisations were complied with by staff. We observed that staff asked for people's consent before providing care.

Requires Improvement

Is the service caring?

Our findings

People made negative comments about the attitude of staff. People commented, "Some are nice and some are not", "I don't think they care. They sometimes ignore me", "They can be rude to patients if they are in a hurry", "Some of the staff are not nice. I am very, very unhappy here", "I don't like the attitude of staff", "Sometimes I don't ask the staff when I want something because I know they won't do it. It depends on who you get though" and "Some staff are not very friendly." One person told us, I'm happy with the staff. They do everything for me." We observed some staff sitting next to people for long periods of time without speaking to them or having any interaction with them.

People told us their privacy and dignity was not respected. People's doors were left open except when staff were providing personal care. People told us that other people living in the home frequently went into their rooms uninvited. People commented, "People are always wandering into my room and I don't like it", "Residents come into my room when they feel like and touch my things" and "If I close my door when they [staff] see it, they open it again. I don't like having my door open all the time. I've had food stolen from my room before."

We observed that people's privacy and dignity were not protected. One person who was bed-bound was dressed only in an incontinence pad and had a full urine bottle next to his bed. The door to this person's room was open throughout our inspection which meant that anybody walking past their room including visitors could see in. Another person was seen sitting in the downstairs dining area wearing just an incontinence pad which was soiled. We raised this with a member of staff who told us that the person preferred not to wear clothes. The staff member hurriedly ushered the person out of the dining area when we pointed out that the person's incontinence pad was soiled and that people could see this. We saw a person in a room with no furniture other than a bed, table and chair. There was no bed linen on the bed and the mattress was stained. Staff told us the person's room had been stripped because the person sometimes behaved in a way which others found challenging. They told us a referral had been made to the Community Mental Health Team although there was no evidence of this in the person's care files. The person spent most of the first day of our inspection sitting in the chair in the same position. In the afternoon we had to call staff to attend to his personal care needs because he was sitting in soiled clothing. We asked the registered manager to urgently review this person's care.

People were not supported to be as independent as they could be. People told us, "They wash me in bed even though I can move around. I don't like it at all" and "I can't walk so I spend all my time in here [bedroom]. I very rarely leave this room."

These issues amount to a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw some positive interactions between staff and people. For example, we saw one person and a staff member engaged in light-hearted banter. We saw another member of staff gently encouraging people to participate in the organised activities. Over the course of the two day inspection we noticed that it tended to

be the same staff who interacted well with people and treated them with respect. It was clear that some staff enjoyed their role. Staff told us, "I enjoy working here. I like helping people", "I look forward to coming to work. Every day is different" and "Most of us work well together and will help each other out but there are a few [staff] who will do as little as possible. It's not fair on the people here."

Staff supported people to maintain relationships with relatives and friends which helped to avoid people becoming socially isolated. Several relatives visited the home during our inspection. Staff knew them well and were welcoming.

Requires Improvement

Is the service responsive?

Our findings

People were not satisfied with the quality of care they received. People commented, "There are a number of things I'm not happy with. health and safety, the place needs decorating and a good clean", "I'm not happy here. I want to leave. I feel like my human rights are being violated", "They are not meeting my needs. They ignore me "and "It's not very good here." One person told us their needs were being met.

We saw evidence that where people were able, they contributed to planning their care and support. People's care plans contained comprehensive information in relation to people's healthcare needs but there was limited information on people's preferences, emotional and social needs. Consequently, people did not receive person-centred care. Four people told us they had problems with the staff responding to call bells, "If I use the call bell too often they get frustrated and put it so I can't reach it", "They have done something to the call bell so that I can't call them", "I don't call them at night now because so many times I have pressed the call bell and I've waited and waited looking out of the window until it's daylight and nobody came" and "There's no point pressing the call bell because they don't come. I wait until I see someone walking past and shout out to them." We observed that some people did not have call bells within their reach which meant that they had no way of letting staff know they needed support. There was not a system in place to ensure that people's care plans were reviewed. This meant the provider could not be sure that care plans reflected people's current needs or that their needs were being met.

People's daily routine and the way their care was provided was not determined by their preferences. People told us they were not supported to leave their rooms and go to the communal areas when they wanted to. They also did not receive personal care at a time or in the way they preferred. People told us, "I would like to have a wash before breakfast but sometimes it's nearly midday before they come to give me a wash" and "sometimes I am not changed until 12 midnight. I asked to be changed earlier but the staff told me they don't have time. They have other work to do." We spoke to three people on the first day of our visit who had not been supported with personal care by 11.30 that morning. One of these people told us, "I don't like just lying here all morning waiting for them to come when it suits them." Other people told us, I would like to go to the lounge every day because it lifts my spirits when I'm around other people but when I ask the staff say I can't", "I go to the lounge most days but not as often as I like" and "My life is now that I do what they want when they want it not what I want." A staff member told us that people who were bed bound were unable to go to the lounge every day; they had to take it in turns as there were not enough reclining chairs to meet the needs of all the people living in the home. We raised this with the registered and area managers who told us that additional chairs would be ordered.

These issues amount to a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People knew how to complain but did not always have confidence their complaint would be dealt with to their satisfaction and therefore did not always complain when they wanted to. They told us, "There is no point complaining. They're not going to do anything about it", "I don't think it'll make any difference if I complain. Some people here are worse off than me" and "When I've said I'm not happy with something, it

might change for a bit but not for long so I don't bother now." We looked at the provider's complaints records and there were two complaints recorded both of which had been investigated and responded to appropriately. The provider needs to do more to ensure that people feel they can make a complaint and that their complaint will be responded to appropriately.

Regular activities were organised by an enthusiastic activities co-ordinator who clearly had a good rapport with people. The activities took place in the lounge. People who were supported to the lounge to participate in activities told us they enjoyed the activities on offer. They commented, "I do enjoy the exercise", "I like the board games" and "I like the activities." We were concerned that people who stayed in their rooms did not have the opportunity to participate in group activities. The area manager told us they were trying to recruit a second activities co-ordinator to help with this.

People who chose to do so were supported to plan their end of life care and their wishes were recorded in their care plans. We also saw completed Do Not Attempt Cardio-pulmonary Resuscitation (DNAR) forms in some peoples care files. The DNAR is a legal order which tells a medical team not to perform Cardio-pulmonary Resuscitation on a patient. These had been fully completed, involving people using the service, their relatives, where appropriate, and were signed by their GP.

Inadequate

Is the service well-led?

Our findings

People received care and support from a service which was not well-led at either provider or registered manager level. The provider had failed to comply with their obligation to submit statutory notifications in a timely manner. Statutory notifications are information about important events which the provider is required to tell us by law. As mentioned in the safe section of this report, the registered manager had failed to submit relevant notifications regarding incidents involving people living in the home.

The providers failure to submit statutory notifications is a breach of Regulation 18 of the Registration Regulations 2009.

People told us the service was not well-managed. They told us, "It's gone downhill", "There isn't much that's good about the place", "I don't think it's managed at all. It's chaos" and "It could be better." Staff told us they felt supported by the registered manager but felt the provider did not listen to their concerns or suggestions for improving the service. Staff told us, "We all know what is wrong here and we raise it at meetings but the owner is focused on the extension", "The managers here do their best but there is only so much they can do. At the end of the day the owner has to agree before anything can be done" and "The owner knows what is needed. I don't know what happens once the requests are made."

The provider did not have effective systems in place to assess and monitor the quality of care people received. The provider's auditing systems had not identified many of the areas which we found required improvement. The provider's monthly medicine audits had not identified that the room temperature where people's medicines were stored was consistently above the recommended temperature for the safe storage of medicines. The provider had not identified that people were not being treated with dignity and respect or that they were not receiving care which met their needs. The provider was unaware that people were dissatisfied with the care they received and felt that it was pointless to complain. This was in part because the provider had not established effective systems to obtain people's feedback.

Additionally, where issues had been identified by internal or external audits, the provider had not always taken the necessary action to ensure that the care people received was safe and appropriate. In 2018, a feedback survey was sent to relatives. Two relatives responded and their feedback was that many areas of the service were poor including the atmosphere and odours in the home. Months before our inspection, staff had made the provider aware that in order to move people with mobility difficulties to a place of safety in the event of an emergency, specialist equipment was required. However, the provider had taken no action to obtain this equipment until they received our feedback. A local authority conducted an audit in May 2018 and found many of the issues which we identified which meant the provider had not taken action to make the required improvements in a timely manner. For example, the local authority report raised concerns about the lack of cleaning schedules and the standard of hygiene in the home.

The provider did not have a system in place to ensure that people's records were kept securely. People's care files were kept in a storage cabinet in the reception area. On the first day of our inspection the storage cabinet was left open. We found care plans and notes relating to people's care on open shelving in the

reception area and in boxes in communal areas. This meant that anybody in the home including visitors, had access to people's personal and confidential information.

The registered manager was not fully aware of the responsibilities of her role and therefore did not always follow the provider's policies and procedures or ensure that staff did so. For example, the provider had an established procedure to ensure that newly recruited staff received an induction and that all staff received regular supervision but this was not being adhered to by the registered manager. The provider's safeguarding policy and procedure stated that the registered manager was responsible for taking a number of actions if there were concerns about a person's safety. This included establishing the facts about the circumstances giving rise to the concern, completing body maps, contacting the local authority and CQC. However, there were a number of recorded incidents where the registered manager did not follow the provider's policies and procedures. Records indicated that the registered manager had expressed during a supervision meeting that she did not feel able to discipline staff. Consequently, where areas of poor practice had been identified robust action was not always taken to ensure that it was not repeated.

These issues amount to a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since our inspection, the provider has taken a number of steps to make improvements to the quality and safety of care people received. However, we remain concerned about the wide-ranging systemic issues we found and the provider's failure to identify and act on these issues previously.

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 18 Registration Regulations 2009 Notifications of other incidents The registered person did not notify the Commission without delay of abuse or any allegation of abuse in relation to a service user. Regulation 18 (1) and (2) e.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not ensure that the care and treatment people received was appropriate, met their needs and reflected their preferences. Regulation 9 (1) (a) (b) and (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not operate effective systems to ensure that persons employed were of good character or had the competence, skills and experience necessary for the work to be performed or that they were physically and mentally fit to properly perform tasks intrinsic to their role. Regulation 19 (1) (a) (b) (c) and (2).

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider did not ensure that sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed to meet people's needs or support staff through training, and supervision.

Regulation 18 (1) and (2) a.

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 10 HSCA RA Regulations 2014 Dignity and respect Service users were not treated with dignity and respect. The registered person did not ensure the privacy of service users or their autonomy, independence and involvement in the community.

The enforcement action we took:

We have issued a warning notice telling the provider that it must make improvements by 31 December 2018.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided to service users in a safe way by assessing the risk of and preventing, detecting and controlling the spread of infections. Regulation 12 (1) and (2) h.

The enforcement action we took:

We have issued a warning notice telling the provider that it must make improvements by 31 December 2019.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not protected from abuse and improper treatment. The Provider did not establish and operate effective systems to prevent the abuse of service users, or to investigate where there was evidence or any allegation of abuse. Regulation 13 (1), (2) and (3).

The enforcement action we took:

We have issued a warning notice telling the provider that it must make improvements by 31 December

2019.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises and equipment were not clean or properly maintained. The standards of hygiene of the premises and equipment were not appropriate. Regulation 15 (1) (a), (e) and 2.

The enforcement action we took:

We have issued a warning notice telling the provider that it must make improvements by 31 December 2019.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not establish or operate effective systems to assess, monitor and improve the quality and safety of the services provided or to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users or maintain securely an accurate, complete and contemporaneous record in respect of each service user. The provider did not seek and act on feedback on the services provided in the carrying on of the regulated activity. Regulation 17 (1), (2) (a), (b), (c) and (e).

The enforcement action we took:

We have issued a warning notice telling the provider that it must make improvements by 28 February 2019.