AMAFHH Healthcare Limited

Quorn Orchards Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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 16 October 2018 and was unannounced.

This was the second comprehensive inspection carried out at Quorn Orchards Care Home, the last inspection in February 2016 was rated as good.

Quorn Orchards Care Home provides residential care for older people. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care home accommodates up to 30 people. On the day of our visit, there were 29 people using the service, some people were living with dementia.

At this inspection we found that Quorn Orchards Care Home were in breach of five regulations relating to safe care and treatment, safeguarding, complaints and governance of the home. They were also in breach of one registration regulation.

The service had a registered manager. 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 and associated Regulations about how the service is run.

The provider had not ensured there were sufficient processes in place to assess, monitor and to maintain the health, safety and welfare of people. The provider had not carried out environmental audits to identify where repairs and maintenance were required. People living with dementia were at potential risk of harm due to access to the stairs, hot water, hot radiators and hot pipes.

The registered manager did not meet all the requirements of notifying CQC of important events.

The provider had not ensured the fire safety systems and procedures were in place; the provider had not acted upon fire safety recommendations in a timely way.

People were at risk of abuse as the registered manager had not reported unexplained injuries or recorded all incidents where people had altercations.

People did not have all of the required risk assessments or care plans in place to mitigate risks associated with dementia or deteriorating mental health. Staff did not always follow people's care plans, putting people at risk of acquiring pressure ulcers.

People did not have the opportunity to be involved in the assessment and planning of their care or make their preferences known.

There were not enough staff to provide care to meet people's needs. People did not always have the opportunities to carry out activities they enjoyed.

People's complaints were not recorded or responded to appropriately. People did not always receive their medicines in a safe way.

The provider had not always ensured the conditions of people's Deprivation of Liberty Safeguards were met. Staff demonstrated their understanding of the Mental Capacity Act, 2005 (MCA). Staff gained people's consent before providing personal care.

Staff did not always record key events in people's daily records, making it difficult for health professionals to assess people's conditions.

Staff did not have all the information they required about people's dietary requirements. People were supported to have enough to eat and drink to maintain their health and well-being.

People were not always adequately supported to access relevant health and social care professionals.

Staff received supervision and support to carry out their roles. Safe recruitment processes were in place.

We made three recommendations relating to accessible information, dementia friendly environments and end of life care.

Further information is in the detailed findings below.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Quorn Orchards Care Home on our website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were not protected from abuse.

People were not always protected from the risks associated with health and safety.

There were not enough staff deployed to meet people's needs.

People's risks were not always assessed and staff did not have guidance on how to mitigate risks.

People did not always receive their medicines safely.

The provider followed safe recruitment procedures.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always assessed before admission to ensure the service could meet their needs.

The provider did not ensure the environment was dementia friendly.

The provider did not always comply with the conditions of Deprivation of Liberty safeguards.

People's consent was sought before staff provided care.

People were supported to eat and drink enough to maintain a balanced diet.

Staff received the training and support they required to carry out their roles.

Is the service caring?

Requires Improvement

The service was not always caring.

People did not have the opportunity to record or tell staff about their past lives.

People did not have the opportunity to give their feedback or take an active part in how the service was run.

People were treated with kindness and respect by staff.

People's privacy was maintained and respected.

Is the service responsive?

Requires Improvement

People did not always receive care that met their needs.

People did not receive responses to their complaints.

The provider had not made arrangements for people with sensory impairments to communicate using technology.

People did not have the opportunity to express their wishes for their end of life care.

Is the service well-led?

Inadequate

The service was not well led.

The provider did not have suitable systems in place to monitor, assess and make improvements to the health, safety, welfare and quality of care of people using the service.

People did not have the opportunity to feedback about the service to drive improvements.

The registered manager did not meet all the requirements of notifying CQC of important events.

Quorn Orchards 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.

This unannounced comprehensive inspection took place on 16 October 2018 by two inspectors.

This was the second comprehensive inspection; the last inspection was rated Good in February 2016.

Before the inspection we asked for a 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 took this into account when assessing the service.

We reviewed the information we held about the service, including statutory notifications that the provider had sent us. A statutory notification provides information about important events which the provider is required to send us by law. We also contacted health and social care commissioners who place and monitor the care of people living in the home.

During this inspection we spoke with six people using the service and three visiting relatives and friends. We spent time observing people's care and how staff interacted with them. We also spoke with four members of staff including the registered manager, two senior care staff and a member of kitchen staff.

We looked at the care records for three people who used the service including daily records and medicines records. We also examined other records relating to the management and running of the service. These included four staff recruitment files, training records, supervisions and appraisals. We looked at the staff rotas, complaints, incidents and accident reports and quality monitoring audits.

After our visit we asked the provider for more information relating to the management of the environment and unexplained injuries. We asked for this information to be provided by 12 November 2018. We received the information on 12 November 2018. We took this information into account when we made judgements in

this report.

Requires Improvement

Is the service safe?

Our findings

People were not always protected from the potential risks of abuse. The provider did not have systems in place to identify or recognise potential abuse, or follow procedures to report these.

Staff completed accident and incident records; these showed seven people had unexplained bruising, grazes and skin tears in the 10 weeks prior to this inspection. Records also showed that people had been subject to abuse from other people living at the service who had behaviours that challenged others. These records had been reviewed by the registered manager, however, they had not reported the unexplained injuries or altercations which could indicate potential abuse, to the local authority safeguarding team or CQC. We brought this to the attention of the registered manager who arranged for notifications to be submitted to CQC and safeguarding. We raised a safeguarding alert with the local authority.

Although staff told us they reported their concerns to the registered manager, the registered manager had not reported these concerns to the local safeguarding team. Staff had access to detailed information about the safeguarding process in their staff room, however, there was no simple guide or readily available information for staff to follow.

The provider failed to have systems and processes in place to prevent abuse or identify and report abuse or improper treatment. This constitutes a breach of regulation 13 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

The provider did not always ensure there were enough staff to meet people's needs. The registered manager told us they required four staff; a senior and three care staff daily, to meet people's needs. However, the staff rota showed that these staffing levels were not always achieved. For example, the week before our inspection the rota showed there were only three members of staff on duty one morning and two members of staff one afternoon. Where staff were absent through sickness, training or holidays there were no additional staff to call upon to cover these shifts. One member of staff told us, "Staffing is ok until we have an incident, then there are not enough of us to give everyone the care they need." Records showed there were daily incidents and altercations between people using the service.

We observed most people spent their day in the communal areas. Some people had been identified as at high risk of falls; there were not always staff around to support them to mobilise safely. Records showed there had been 11 unwitnessed falls in communal areas since July 2018. One relative told us, "Staff have no time to spare, they sometimes leave the lounges with no staff and let the 'wanderers' to get on with it." There were not enough staff deployed to communal areas to help prevent the risk of falls. Another person was in a communal room alone all day without any staff support or interaction.

There were not enough staff to meet people's needs. One person told us they would prefer to bathe more often but were restricted due to the number of staff available, they said, "I am helped to shower every six

weeks; I have a strip wash most days, it depends if there are enough staff."
The registered manager had recognised the increase in dependency in the last three months; they told us it was particularly difficult to manage the behaviours that challenged others. The provider had not ensured there were enough staff to keep people safe from the altercations or provide close supervision for people who had behaviours that challenged others. We observed the registered manager provided care to help meet people's needs and regularly sought additional health professionals support for the assessment and treatment of people with deteriorating mental health. We raised a safeguarding alert relating to the low staffing levels. This issue was resolved the day after our inspection when one person was moved to a more appropriate healthcare setting.

People were not always protected from the risks associated with fire safety. Although the provider had a full fire safety risk assessment completed in July 2018, they had not completed all the recommendations in the timescale indicated. Four of the recommendations required action within 90 days; these had not been completed at the time of our inspection which was more than 90 days since the fire safety assessment. There was no action plan in place to demonstrate how the provider planned to make the required repairs to comply with the fire safety recommendations. There were also items stored in the boiler room and under the stairs leading to the attic which could pose a fire source risk. We contacted the local fire safety officers who liaised with the provider. The provider subsequently demonstrated how they were going to complete all the actions required to meet the fire safety requirements by 26 October 2018.

The provider did not ensure there were regular fire checks carried out. The provider said, "Some monthly tests have been overlooked but the weekly fire tests are consistent." However, we found not all the weekly fire safety checks had been completed for a month between July and August 2018 and for the 11 days before this inspection. The provider explained the maintenance person had not been present; they said they would arrange for regular checks to be carried out by the provider in the future when the maintenance person was absent.

The provider did not ensure that people living with dementia and reduced mobility were protected from the risks associated with hot radiators and pipes. Eight people had broken radiator covers in their bedrooms, two radiators did not have protective covers and one person had exposed hot pipes in their room. The provider had not carried out an environmental assessment; they had not identified that people were at risk of burns due to exposed hot radiators and pipes. We brought this to the attention of the registered manager who carried out an environmental assessment and arranged for all radiator covers to be checked and repaired and exposed pipes covered.

The provider did not protect people from the risks associated with very hot water. Although regular checks had been made to test the temperature of the hot water in people's bedrooms and bathrooms, records showed for two weeks in September one person's hot water was over 44 degrees Centigrade. There was no information to staff to advise what the safe parameters for water temperatures were, or what action to take if these were exceeded. The Health and Safety Executive (HSE) state where hot water used for showering or bathing is above 44 °C there is increased risk of serious injury or fatality. We brought this to the attention of the registered manager who arranged for a new regular audit with the required information and actions; records showed the person's hot water was below 44 degrees Centigrade on the day of inspection.

There were no regular checks of the temperature of the cold water in people's rooms, showers, sluice and laundry room. The water from unused showers or taps were not run regularly to clear the pipes from stagnant water, and there were no systems in place to regularly descale and clean the shower heads and hoses. There were no records of the hot or cold water checks in the kitchen or linen room. These checks are necessary to ensure people are not exposed to pathogens that can cause disease that could be present in

water sitting in pipes, such as Legionella bacteria. We brought this to the attention of the registered manager and signposted them to water safety guidelines. These water safety processes have yet to be implemented. Records showed water samples had been sent for analysis which were clear of pathogens in September 2018.

The provider did not always protect people from the risks associated with very hot water, equipment or substances that may be hazardous to health. People living with dementia, or people who were experiencing confusion from ill health had access to areas such as the kitchens, store rooms and the linen room. Staff left these doors unlocked and open when they were not in use. The hot water supply to these areas can be over 44 degrees centigrade and are likely to scald an older person if used by them. In addition to the iron in the linen room and hot appliances in the kitchen, people had access to washing liquids and other substances that could be hazardous to health. We brought this to the attention of the registered manager who arranged for systems to be put in place to ensure staff kept doors leading to the kitchen, store rooms and linen areas locked when not in use.

The provider did not always protect people from the risks associated with steep stairs. People living with dementia had access to the stairs from the first floor. Although the provider had placed a stairgate at the top of the stairs, this was very loose and opened both ways, allowing access to the stairs. We brought this to the attention of the registered manager who explained access was required to the stairs as this was a fire exit; they installed a secure gate.

People's risks were not always assessed. People who were living with dementia, and those who had behaviour that challenged others did not have their risks assessed. For example, one person's behaviour affected every person living at the service; there was no risk assessment or plan of care to protect them or others from their actions. Staff did not have guidance on how to identify what triggered behaviours, or how to manage the behaviour. This meant people continued to be at risk of verbal and physical abuse from each other as there were no safeguards in place to protect them.

Not all risk assessments reflected people's current needs. For example, one person had been identified as at risk of choking; staff had instructions on how to position the person when they ate or drank. However, their medicines risk assessment stated they were not at risk of choking and did not advise staff how to position the person to take their medicines safely. There was a potential risk that staff would not position this person safely to take their medicines to prevent choking.

People could not be assured they would always receive all their medicines safely. Staff did not reliably record when people received their medicines via a patch. There was a risk that previous patches had not been removed, or staff rotated the sites they applied the patches. There was a risk that people could receive too much or not enough of these medicines as there was no reliable system in place to manage when and where the patches were applied and removed. There had been a recent medical alert regarding the risks to people relating to the management of medicines in patches; the provider had not implemented any systems to mitigate this known risk.

The food standards agency had inspected the home on 8 May 2018; they found the cleanliness and condition of facilities to be good. During our inspection there were areas of the kitchen where the cleanliness had not been maintained. There was a risk of infection from dirt or harmful bacteria that could collect in chipped plates and cups, dirty and stained plastic cups, jugs and food storage containers as seen at the inspection.

Staff did not always follow infection prevention procedures. People's bedding was not always changed

when soiled. We observed two people's beds had been made but had unpleasant smells; these beds had soiled sheets. Other beds did not have sheets or duvet covers. We brought this to the attention of the registered manager who arranged for the beds to be changed and reminded staff to make people's beds with clean linen and ordered more bedding.

The provider did not assess the risks to people's health and safety, ensure there were enough staff to meet people's needs, follow infection control and safe medicines procedures. This constitutes a breach of regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

The registered manager followed the provider's recruitment and selection processes. Staff recruitment files contained all relevant information to demonstrate that staff had the appropriate checks in place The manager arranged for this to be provided. Staff files included written references and a satisfactory Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

Although the registered manager was responsive to findings at the inspection, by putting into place systems to make the service safer, these had not been embedded or assessed for their effectiveness. The provider did not have systems in place to pro-actively use information from incidents or accidents to make changes to the service or share the learning from these with staff.

Requires Improvement

Is the service effective?

Our findings

The provider had systems in place to assess people to identify the support they required before moving into Quorn Orchards Care Home. However, some people had been admitted to the home at short notice as a local authority emergency, without a full assessment of their care needs. In these instances, the registered manager did not have all the information they required to ensure the service could meet people's needs. For example, one person had complex needs that were not being met; there were not enough staff deployed or staff that had the skills and knowledge to manage the behaviour that challenged others. This had a negative impact on the person and on people living at the home.

The provider did not have systems in place to liaise with the local authority to ensure a full assessment of people's needs were reviewed before being admitted to the home.

The provider failed to ensure people's needs were assessed before admission to the home to ensure the service could meet their needs. This constitutes a breach or Regulation 9 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

Most people living at Quorn Orchards Care Home were living with dementia. The environment they lived in was not dementia friendly. All the doors in the home were brown, most were unlabelled; this made it difficult for people to navigate their way around the home as every door looked the same. One person told us, I keep my door locked as people are always coming into my room. They think it's the toilet." Where doors were labelled, the labelling was confusing, for example a person's photo and room number was displayed on paper, but the room number did not correspond with the metal room number attached to the same door.

The provider had upgraded a bathroom to be a wet room with all the facilities people would need to bathe safely. However, this room was not in use as it was used for storage. This meant people did not have access to areas of their home that were designed for their use.

We recommend the provider follow research based guidance on creating a dementia friendly environment.

People were at risk of not receiving food and drink that met their needs. Kitchen and care staff did not have information about people's dietary needs, such as diabetic, vegetarian or soft diets. There was a risk that people who had been assessed by health professionals as requiring soft foods or thickened drinks to prevent choking would not receive these as this information was not available to staff. We brought this to the attention of the registered manager who arranged for a complete list of dietary needs to be displayed in the kitchen, for staff to refer to.

The menu was displayed offering people choices of meals however, there was limited variation in the types of food. The cook told us, "Our stock does not allow for a variation in menu choices. Our stock runs really low on a weekly basis; [provider] amends my order request which limits my options."

People were assessed for their risk of not eating or drinking enough to maintain their health and well-being.

Where people had been identified as at risk of losing weight, staff followed care plans to mitigate the risks. For example, staff prompted or supported people to eat and provided alternative foods where people had refused. Records showed that most people's weights were stable. People were supported with meals to be independent and encouraged appropriately.

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 to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. There were insufficient systems in place to ensure people always received their care in line with conditions. For example, one person had conditions on their DoLS authorisation; these had been assessed by their legal representative at a routine check; they found the conditions had not been met. The registered manager had taken immediate action to ensure the condition was met. At the time of our inspection the conditions were being met.

All new staff received initial training which gave staff the basic skills needed in their roles. One member of staff told us, "All new staff have an induction with the registered manager and senior staff to learn the basics first. They have 12 weeks probation." Records showed staff received a wide range of training including moving and handling theory and practice, infection control, food hygiene and fire safety. Staff had been encouraged to do vocational training in health and social care. Staff received supervision to support them in their roles.

People had access to healthcare services. The registered manager referred people to appropriate mental health professionals where required; however, they did not ensure staff recorded people's behaviours in order the health professionals could make an informed assessment. Staff did not always refer people to their GP when they incurred unexplained injuries. People were referred to the GP or district nurse when they showed signs of ill-health. One relative told us, "When [Name] was ill, staff got the GP in and she went to the hospital." Records showed the registered manager liaised closely with health professionals to ensure people received the assessments they needed.

Requires Improvement

Is the service caring?

Our findings

Where people were relatively new to the home, there was no system in place to record or ask about people's past histories to help inform staff of their skills and life experiences. This meant that new staff did not have information about people's past lives to stimulate conversations which were relevant to each person. People's care plans were basic and did not provide enough information to demonstrate the care plans were individually created with the person in mind.

The provider had not ensured there were enough staff for people to access activities and there was less time for interaction with staff; this had impacted on people's daily life in a negative way. One person was in a communal room by themselves all day, without a television, radio or company; they told us they felt isolated. Staff told us this happened every day and they did not have time to talk with them. We brought this to the attention of the registered manager.

The provider had not sought the opinions or feedback from people about the service. People did not take an active part in choosing how the service was run or influencing how their care was provided.

The provider did not ensure people's care met their needs. This constitutes a breach of regulation 9 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

Staff who had worked at Quorn Orchards Care Home for many years knew most people well. One person told us "I've no grumbles, all the staff are good to me, they know me well." Staff told us they had got to know people over time and understood their likes and dislikes.

Relatives told us they were happy with the way staff treated their relatives. On person told us, "Staff are fantastic, they work hard. The registered manager is very good."

People were supported to maintain relationships with those who were important to them. Relatives and visitors were encouraged to visit the service and there were no restrictions on visiting. One relative told us they visited every day and helped to provide support for their relative. They told us, "I have my meals with [Name] every day, I help [Name] to eat."

Staff helped people to celebrate their birthdays. One person told us, "They [staff] made a cake for [Name's] birthday, they [staff] are really good, no matter who is on."

People told us that staff respected their privacy and dignity and we saw that staff knocked on bedrooms doors before entering and that they were careful to close toilet doors when assisting with personal care. When staff did interact with people, they spoke kindly and treated people with respect.

People's privacy and dignity were maintained. People were supported to make decisions and express their views about their care. They could have access to an advocate if they felt they needed support to make decisions, or if they were being discriminated against under the Equality Act, when making care and support

choices. An advocate is an independent person who can help someone express their views and wishes and help ensure their voice is heard.

People continued to follow their religion, for example, there were regular visits from a minister from the church and the Baptist chapel. One person told us, "They [ministers] come to us, we sing hymns and read prayers."

Staff respected people's confidentiality. There was a policy on confidentiality to provide staff with guidance and staff were provided with training about the importance of confidentiality. Information about people was shared on a need to know basis. We saw that people's files were kept secure in filing cabinets and computers were password protected to ensure that information about people complied with the Data Protection Act. Handovers of information took place in private and staff spoke about people in a respectful manner.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive their care as planned. People who had been assess as at risk of acquiring pressure ulcers had care plans in place for staff to follow to help prevent skin damage and pressure ulcers. Staff did not always follow these care plans in the day time or record the current state of their skin condition. For example, the care plan for one person stated they needed support to change their position every two hours. Staff recorded they carried out two hourly pressure area care overnight, however, in the day they transferred the person into a wheelchair and did not support them to relieve their pressure areas. This person did not have sufficient support for their head whilst they were in the wheelchair, we observed they had discoloured skin on their head at the pressure point. This meant this person was at high risk of acquiring skin damage and pressure ulcers. We made a safeguarding alert to the local authority relating this person's risks of skin damage.

People living with dementia did not have care plans to instruct staff how they required their care. People's individual dementia needs had not been identified. For example, where people had behaviours that challenged others, staff did not have information on what would trigger these behaviours or what to do to help protect people from these. Staff did not record incidents of behaviours that challenged others which made it difficult for health professionals to assess the behaviours to prescribe treatments. This meant that people continued to experience behaviours that led to anxiety and put themselves and others at risk of harm. We brought this to the attention of the registered manager who said they would look into this.

The provider had employed one person to facilitate activities in the mornings, however, this member of staff could not always carry out their role as they were providing care due to the increased needs of people. One person told us, "We used to have activities, but as these only happen sometimes in the mornings, I miss them." People mainly spent their day in the communal areas; the television was on without the sound, and the radio was on. This could be confusing to people living with dementia as the radio commentary did not match the picture. There were not enough staff to provide conversation or activities, people were sitting for long periods without anything to do. One person told us, "I get lonely." Another person told us, "In the afternoon all we do is watch TV."

The provider did not ensure there were adequate resources to provide care that met people's needs and preferences. This constitutes a breach of regulation 9 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

People's complaints had not been recorded or responded to. People using the service and their relatives had expressed their concerns at the number of verbal and physical assaults they had experienced over the last three months. None of these concerns had been recorded and there was no evidence that the registered manager had responded. The provider's complaints procedure was displayed in the home; the procedure stated staff must record all complaints in the complaints book. The registered manager had not followed the provider's complaints procedure as there was no record of any complaints being received.

The provider did not have systems in place to identify, receive, record or act upon complaints. This constitutes a breach of regulation 16 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

The provider had not yet explored ways to make sure people had access to the information they needed in a way they could understand it, to comply with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given.

We recommend the provider follow best practice guidelines for implementing the Accessible Information Standard.

People had not had the opportunity to discuss their wishes about where they wanted to receive their care at the end of life. People had not discussed their beliefs and needs. People had end of life care plans, but these were blank. The registered manager told us they were waiting to talk to relatives about people's wishes. People were at risk of not receiving end of life care that met their individual preferences or spiritual needs.

People had been referred to the GP or district nurse for assessment for symptom control and palliative care. Staff worked with the nurses to help people to be comfortable and liaised with people's families to keep them informed.

We recommend the provider sources best practice guidelines on end of life care in care homes and implement these.

Inadequate

Is the service well-led?

Our findings

There was a registered manager who had managed the home May 2012. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 registered manager did not understand their responsibility of reporting incidents to CQC. The registered manager had not made all the appropriate notifications to CQC regarding incidents of people incurring unexplained injuries or verbal and physical abuse by people using the service. We brought this to the attention of the registered manager who subsequently submitted notifications of unexplained injuries.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The provider did not have systems and processes in place to assess, monitor and mitigate risks in the environment. The lack of regular environmental checks and lack of subsequent action plans meant areas of the home had gone into disrepair and an environment not suitable for people living with dementia. The provider had not identified people were at risk of harm due to broken radiator covers, exposed water pipes and access to the stairs. Where the fire assessment had given specific recommendations, the provider failed to ensure these had been carried out in the timescales required.

The provider did not have systems in place to check key areas of the home were protected to ensure people were not put at risk of accessing hot water or items that could be hazardous to health such as cleaning products and false-teeth cleaner.

There were no systems in place to ensure people's risk assessments reflected their current needs, or that the care plans provided staff with the information they required to mitigate the risks. There was no system in place to ensure people were receiving their care or that their care was being reviewed on a regular basis. This meant that people were put at risk of choking, pressure ulcers, falls and altercations from behaviours that challenged others.

The provider did not have oversight of the impact of the increased dependency. People did not receive all of their care as planned as there were not enough staff to meet their needs. The provider had not made provision for the increased dependency which left people without activities, or supervision when mobilising.

The provider did not ensure people's records reflected their current care needs or the care they received. Daily records did not reflect all incidents and altercations, or behavioural changes, this meant that health professionals did not have all the information they required to make an informed assessment.

Staff did not have all the information they required about peoples' dietary needs; people were at risk of receiving meals that did not meet their needs. The provider did not have systems in place to assess the

nutritional value of the meals provided. The cook reported, "The food stocks run really low on a weekly basis. [Provider] amends the order requested which does not allow for variation to menu choices." There were no systems in place to check the hygiene in the kitchen which meant that people were receiving food from dirty containers and chipped crockery.

The registered manager carried out unannounced inspections of the home in May, July and October 2018. These inspections had not identified the staffing or the health and safety issues. A staff meeting was held in September 2018 but staff did not have the opportunity to express their concerns, or provide ideas or input into how the home was run. The meeting did not include lessons learnt from incident or accidents to help prevent future occurrences.

The provider had not carried out a survey, or sought people's feedback about the service. People did not have the opportunity to have a say in how the home was run.
After the inspection we wrote to the provider to ask them to provide information on how they planned to ensure the issues identified in this inspection relating to the environment, fire safety, accessing the kitchens, stairs and store rooms, water safety, staffing and safeguarding. The registered manager's response demonstrated the provider had mitigated the environmental risks in the short term, but these new audits and practices had not been assessed or embedded into practice.

The provider did not have suitable systems and processes in place to assess, monitor and improve the health and safety of people using the home. This constitutes a breach of regulation 17 (2b and dii) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. Good Governance

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had not displayed their rating at the service, we brought this to the attention of the registered manager who displayed the rating by the end of this inspection. The provider did not have a website.

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 manager failed to make all appropriate notifications to the Commission as they are required to by law.

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 people were involved in the assessment and care planning of their needs or preferences. Regulation 9 (1)(3)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not assess or mitigate the risks to people's health and safety, ensure there were enough staff to meet people's needs or follow infection control and safe medicines procedures. Regulation 12 (2)

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 The provider failed to have systems and processes in place to prevent abuse or identify and report abuse or improper treatment. Regulation 13 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not have systems in place to identify, receive, record or act upon complaints.

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 17 HSCA RA Regulations 2014 Good governance The provider had not ensured there were sufficient processes in place to assess, monitor and improve the quality, health, safety and welfare of service users. Regulation 17 (2)(a)(b)

The enforcement action we took:

We issued a Warning Notice to the provider and the manager; they were to be compliant with Regulation 17 by 20 December 2018.