Caring Homes Healthcare Group Limited

St Georges Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 25, 26 and 27 January 2017 and was unannounced.

In April and May 2015 St Georges Care Home received its first 'rating' inspection and was rated requires improvement. We issued five regulatory requirement actions for regulatory breaches relating to safe care and treatment, person centred care, staffing, good governance and dignity and respect. After the inspection, the provider wrote to us to say what they would do to meet the legal requirements.

We undertook a focused inspection on 6 and 7 January 2016 to check the provider had followed their plan and to confirm they now met the legal requirements. We had also received information from the local authority that had concerns about the quality and safety of the service provided for people in the home.

We found insufficient actions had been taken in response to some of the breaches identified at the previous comprehensive inspection in 2015. There were five regulations breached at this inspection in relation to safe care and treatment, safeguarding service users from abuse and improper treatment, person centred care, staffing and good governance. A warning notice was issued in relation to safe care and treatment.

The last comprehensive inspection took place in July 2016; the service was rated requires improvement. We found that sufficient action had been taken in relation to the warning notice we had issued following the previous inspection. Improvements had been made since the last inspection however further improvements were needed to embed the changes. There were two breaches of regulations in relation to staffing and good governance at this inspection.

At this inspection (January 2017) we found nine breaches of regulations. Both of the previous breaches from the last comprehensive inspection in July 2016 had been repeated. We also found seven further breaches in relation to safe care and treatment, person centred care, safeguarding people from abuse and improper treatment, consent, complaints, dignity and respect, and statutory notifications.

St Georges Care Home is a 68 bedded home that provides accommodation for persons who require nursing or personal care. At the time of our inspection there were 50 people living in the care home.

At this inspection the overall rating for the service is 'Inadequate' it will therefore be placed into special measures. The commission is now considering the appropriate regulatory response to resolve the problems we found.

There was a registered manager in place at the time of our inspection; 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.

There were widespread and systemic failings identified during the inspection. Overall we found that quality and safety monitoring systems were not fully effective in identifying and directing the service to act upon risks to people who used the service and ensuring the quality of service provision. The failings included issues around staff management and staff cohesiveness that impacted on service delivery.

The registered manager and provider had failed to make appropriate statutory notifications; notifications tell us about significant events that happen in the service. We use this information to monitor the service and to check how events have been handled.

There was a failure to safeguard people. The registered manager had failed to report and take appropriate action regarding adverse incidents. The registered manager had failed to recognise the inappropriate restraint of people.

The registered manager had made applications for Deprivation of Liberty Safeguards (DoLS) where they had been assessed as being required. These safeguards aim to protect people living in care homes from being inappropriately deprived of their liberty. These safeguards can only be used when a person lacks the mental capacity to make certain decisions and there is no other way of supporting the person safely.

We found however that the registered manager and other staff had a variable understanding of the Mental Capacity Act 2005 and DoLS. The registered manager had failed to ensure staff met the DoLS conditions for a person with DoLS.

There were not enough suitably trained staff to meet people's needs. Staff had not received training and supervision which supported them in their roles.

Care plans were not person centred. Peoples' risk assessments were not reflective of people's needs. Records used to monitor peoples' health were not always completed. This exposed people to risks of neglect and unsafe or inappropriate care or treatment. The administration of people's medicines was not in line with best practice.

We observed occasions when care delivered by staff compromised peoples dignity and respect. There was a divisive staff culture and poor communication between staff which impacted negatively on care delivery. Complaints made by people and relatives were not always recorded and resolved to the satisfaction of complainants.

Recruitment procedures were followed appropriately to ensure safe recruitment practices

We found nine breaches of regulations at this inspection and will be asking the provider to send us a report of the improvements they will make.

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

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

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of

preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There was a failure to safeguard people. Abusive incidents were not always reported appropriately. The provider had also failed to recognise the inappropriate restraint of people.

There were not enough suitably skilled staff to meet people's needs safely and effectively

Risk assessments did not always reflect actions required to reduce risks to people.

The administration of people's medicines was not in line with best practice.

Is the service effective?

Inadequate

The service was not effective.

Staff supervision and training was not effective in ensuring staff were supported, suitably skilled and competent in their roles.

The provider did not protect the rights of people living in the home in line with the Mental Capacity Act 2005 and DoLs.

Records relating to peoples' care and treatment were not fully completed to protect people from the risks of unsafe care.

Risks relating to people's nutritional needs were not managed effectively.

Is the service caring?

Inadequate

The service was not caring.

We observed occasions where peoples' care and dignity were compromised.

We observed occasions where care delivery was rushed and uncaring.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans did not contain sufficient information to enable staff to deliver person centred care.

Sufficient action had not been taken to ensure people's care and monitoring records were analysed to prevent deterioration in their health.

People did not receive person centred activities.

Not all complaints were recorded and resolved to the satisfaction of complainants.

Is the service well-led?

Inadequate

The service was not well led.

There was a divisive staff culture which had not been addressed by the provider.

The systems in place for monitoring quality and safety were not effective in ensuring that the risks to people were identified and managed.

Statutory notifications had not been made to the Commission for notifiable incidents.

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

The inspection took place on 25, 26 and 27 January 2017. This was an unannounced inspection, and was carried out by three inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Prior to the inspection, we reviewed information we held about the service including statutory notifications. Statutory notifications are information about specific important events the service is legally required to send to us.

Some people at the home were not able to tell us about their experiences. We used a number of different methods such as undertaking observations to help us understand people's experiences of the home. As part of our observations we used the Short Observational Tool for Inspection (SOFI). SOFI is a way of observing care to help us understand the needs of people who could not talk with us.

As part of our inspection, we spoke with 22 people, 10 relatives, the registered manager, the regional manager, the operations director, 14 members of staff and a visiting GP. We tracked the care and support provided to people and reviewed 13 care plans relating to this.

We also looked at records relating to the management of the home, such as the staffing rota, policies, recruitment and training records, meeting minutes and audit reports. We also made observations of the care that people received.

Inadequate

Is the service safe?

Our findings

There was a risk that people were not safeguarded against the risk of abuse. The staff we spoke with told us they had received training and understood their responsibilities with regard to safeguarding people. They were able to tell us where to locate contact details for the Commission and the local safeguarding team. Staff told us they were not confident that action would be taken if they raised concerns.

Although all staff said they knew what whistleblowing was, not all staff felt that their concerns would be investigated thoroughly. Staff said "I've made formal complaints and raised my concerns, but I never hear anything back." Another member of staff said "I feel happy to blow the whistle if I need to and hopefully, I will be listened to."

The service had failed to report unexplained bruising to people to the local authority safeguarding team. There was no recorded investigation of these incidents. Staff had also failed to report and recognise that the omission of care to people by staff amounted to potential abuse/neglect.

An allegation of 'force feeding' was raised with inspectors during the inspection. We found that the incident had not been reported to the local authority safeguarding team by the service. We asked the managers present to report this alleged incident.

Records showed that one person fell regularly from their wheelchair. In response to this the service had made the decision to use a restraining 'lap belt' on the person's wheelchair to strap them in.

There was no consent agreement, mental capacity assessment or best interest decision recorded for the decision to use the lap belt. This meant that the service had failed to demonstrate they had considered lesser restrictive options prior to introducing the 'lap belt'. The service was unable to demonstrate they were using a proportionate form of restraint in response to a risk of harm.

Staff were unsure if the person needed or had a DoLS application in process. We saw the following comments written in the person's records about them; 'Not really aware of her whereabouts'; the staff were unable to tell us if the person was being deprived of their liberty with lawful authority.

These failings amounted to a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not enough qualified, skilled and experienced staff to meet people's needs. We were told by the registered manager that the majority of people living in the home required two to one care for help to transfer/move and personal care. People also required assistance with eating and changing their position. We observed that due to the numbers of people that required two to one assistance staff were task orientated and did not stop to spend any social time with people. All care staff we spoke with described their roles in relation to tasks and said that they had little time to spend with people during the day; they told us that every morning was particularly hectic.

The nurses explained that some staff worked much better than others and that a well-run shift depended on whether you had 'a good team on'. We asked what this meant and were told that some staff lacked the skills and experience for care or did not work well together.

Staff told us there was not sufficient staff to meet the needs of the people in the home. Comments included "We're always short staffed, it's not safe", "Staff sickness makes it worse but we do use agency", "There's just not enough staff. It's impossible to get the residents washed and dressed at a decent time". Other members of staff said there was not enough staff to meet the needs of the people on the first floor. One member of staff said "Sometimes people are left in bed because it's easier." A nurse said "This floor is busy. Its lunch time and I still have lots to do and I haven't had a break. Sometimes people buzz [use their call bell] for a pad change before lunch, but they just have to wait, often more than 10 minutes."

During the inspection we were aware of call bells ringing constantly. We noted that call bells were not always within reach of the people who remained in their rooms, either in bed or sitting in an armchair. When asked about staffing levels people told us that they thought the home was short of staff. Comments included; "All carers are busy, there is not always enough staff, they are harassed; it is getting too much; call bell response depends on how busy they are with others, usually it is 10,15 minutes." "They say they are not short of staff but they are, so I try not to bother them"," Not enough staff, never enough, call bell varies, usually about 10 minutes, but have had to wait for an hour."
Care staff told us they struggled to get through their 'workload' especially during the morning. They told us some people stayed in bed because it was easier for staff. For example, one member of staff told us that one person was often left in bed because it was easier for staff. Another member of staff told us people were often not encouraged and staff readily accepted when people 'declined' the offer of support on occasions. Service users and relatives told us that service users were often left without the support they required and that call bells were not answered quickly.
People's relatives said "Staffing levels are ok, there is the use of a lot of agency staff, especially at weekends", "There are not enough staff now because residents' requirements have intensified." "On Sundays, staff are few and far between, so short my [relative] has still been in bed at lunchtime" and "Staff are run ragged, but I have noticed extra staff on duty during the CQC inspection."

We asked the registered manager if they had undertaken a review of peoples' care needs to evaluate the numbers of staff required. The registered manager told us that the staff numbers were based on dependency. The registered manager was unable to demonstrate that they had considered the skill set of staff to ensure the effectiveness of the staff team.

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

People's medicines were not always managed safely because current and relevant professional guidance was not always followed and documentation in relation to medicine administration practice was poor. In addition, the process for ordering medicines for people in a timely manner was not robust.

Two people were having their medicines crushed. Crushing a medicine can alter its mode of action and therefore pharmacist advice is recommended to ensure the medicine remains safe and effective. The provider's policy also referred to the need to gain appropriate advice and to document such advice. However, this documentation was not in place. We discussed this with the registered manager and with the nurses on duty, neither of whom appeared to be familiar with the correct procedures that should be followed. On the third day of our inspection, the registered manager provided us with a letter from the GP in relation to one person. This letter confirmed the GP's approval for crushed medicines, but there was still no

advice in place from the pharmacist.

Medicine audits had been undertaken however the audits in relation to crushed medicines appeared to have been completed inaccurately. Although the latest audit findings dated 20/01/2017 read '[person's initials] has crushed med but care plan not in accordance', the previous audit dated 05/12/2016 read 'compliant', and the one prior to that dated 05/11/2016 read 'non-compliant – no care plan for PEG'.

Staff did not always sign medicine administration records (MARs) when giving medicines. This meant it was not always possible to check if people received their medicines as prescribed and on time. In addition there were gaps when some prescribed items had not been administered. For example, eye drops for one person had not been signed as administered on 23/01/2017. Another person had been prescribed antibiotics; the staff had written "F" in the signature column. This indicated that they had not been administered for some reason, but the reasons had not been documented on the reverse of the MAR. For both of these medicines missed doses reduced the effectiveness of the medicine. In addition, there was a Medication Check List in place for the "incoming nurse to check MARs for omissions". However, this was inconsistently completed by staff. The chart had not been signed for three days during the week of our inspection.

Two people had been prescribed nutritional supplements. Neither of these people had received any for up to five days because staff had documented 'none found' or 'no stock' on the reverse of the MARs. When we asked the nurses who was responsible for ensuring people's medicines were ordered on time, one said "Nobody seems to know who does the orders". We checked the order book and saw that the nutritional supplements had not been ordered. None of the nurses on duty during the five day period had identified that people had not been receiving their supplements as prescribed, and none had taken responsibility for ordering more. When we checked the care plans for these people, both had been prescribed supplements due to weight loss concerns. The provider's policy stated 'It is the care home staff's responsibility to follow up prescriptions and medication to ensure the residents never miss their doses.'

We saw no evidence that topical medicines (for example, creams and lotions) were being applied as prescribed. Topical medicine administration records (TMARs) were difficult to locate. One nurse and one member of care staff did not know where the charts were kept when we asked them. When we did locate the charts, some had not been completed since November 2016 and none had been signed for during January 2017. In addition, the instructions for care staff were vague. Directions on all of the charts stated 'apply when required.' When we asked nurses how they could be assured that creams and lotions were applied as prescribed, they were unable to provide us with an answer. One said 'It's all gone to pot". When we looked at the TMAR folder with one nurse, the file contained charts in relation to one person who had died. This issue had also been noted during the latest pharmacy advice visit on 30/11/2016, where it had been advised 'Poor completion of TMARs. Not signed since August. Carers need easy access to charts and to complete daily.'

One person had been prescribed a topical pain relieving gel. In their care plan it had been documented 'intermittent pain and unlikely to tell staff if in pain.' The instructions on the MAR were 'apply up to three times a day' and someone had handwritten on the chart 'where?' This entry was undated. On 16/01/2017, the gel had been omitted and the member of staff had written 'I don't know where to apply.' On 23/01/2017, the member of staff had written 'out of stock' and on 24/01/2017 'ordered.' On 26/01/2017 it had been written 'no stock' on two occasions. We looked at the tube of gel that was in use and on the dispensing label the date dispensed was 25/01/2017. One nurse said "I couldn't find something the other day either. Everyone seems to put new stock in different places."

Some people were prescribed medicines to be taken when required. We saw that additional guidance in the form of PRN (as required) medicine protocols were in place for some people, but this was not consistently

seen. For example, one person had been prescribed a medicine for pain relief; there was no protocol in place to indicate where the person might experience pain, how frequently the pain relief could be administered or the maximum dose.

The local GP told us a nurse had asked them to prescribe end of life medicines for one person who really needed them. The GP told us they had already prescribed the medicines which had been issued by the pharmacy and were available in the home. The nurse was not aware of this and this caused a delay in administering the medicines the person needed by approximately four to six hours.

Relatives told us of concerns they had around medicines. One relative said their relative living in the home is asked whether they want painkillers but does not always say 'yes', yet is still in pain. Another relative said their relative living in the home had difficulty in swallowing and staff did not make sure they had swallowed their medicines and painkillers were often found stuck inside their cheek.

Risk assessments were completed and risk management plans were in place. However, these were not always accurate and when they were reviewed, shortfalls were not always identified. For example, one person had a risk assessment completed for the use of bed rails. The person was recorded as not wanting to have bed rail protectors because they made them feel 'closed in.' The risk management plan stated the person was not at risk of entrapment and did not require the use of protectors because the risk of entrapment was mitigated as the person had integral wooden rails fitted to the bed. Several entries and reviews in the care records, from July 2014 to date included comments about the reduced risk of the person sustaining skin tears because the rails were integral. The bed rails were not integral. The person had third party metal bed rails fitted to the bed. We spoke with the maintenance person who told us the person had not had, so far as they could recall, had a bed with integral rails. The risk of entrapment had not been correctly assessed and mitigated.

We observed a person that was not safe in bed. They had bed rails that were not fitted safely. The height of the bed rails above the pressure relieving mattress did not comply with Health and Safety Executive guidance. The height was approximately 70mm; the bed rail height should have been 220mm. The person's care records answered 'Yes' to the question, 'Does the bed rail provide sufficient height when using a pressure relieving mattress or is there a need for higher sides.' We saw the person slumped over the side of the bed rail on two occasions. We brought this to the attention of a nurse. They did not take action so we brought this to the attention of the support manager. They confirmed they had taken action to address the shortfall before the end of the inspection.

Accidents and incidents were not always fully recorded and analysed to prevent recurrence. For example one person had fallen on a number of occasions. An entry in the nursing daily notes was completed in January 2017. The exact date was not legible. The records stated the person had been found sitting on the floor. They had lacerated their left shin. An accident form had not been completed. We did see separate records, photographs and a wound dressing record completed in a wound monitoring booklet on 9 January 2016 however the service had failed to use the information from the fall incident to further assess the person's risk or look for ways to prevent recurrence of falls. We found there was a lack of recorded investigation around incidents of unexplained bruising and injuries; this may have assisted the staff in identifying potential causes and preventing recurrence. We asked the registered manager about one particular incident for which there was no recorded cause or investigation. The registered manager stated they would have completed an investigation at the time by asking staff and the person involved how the incident occurred. There was no record kept of these conversations or analysis of the information. A relative of the person who had been injured had been given an explanation for how the injury had occurred by the registered manager. The registered manager was unable to explain how they had come to the conclusion as

there was no definitive evidence to support the reason they had given the relative.

The care records for some people stated they needed checking at regular intervals to make sure they were safe; we found these checks were not being undertaken as required. For example, one person's record stated on 20 January 2017, they required observations at 30 minute intervals because they were 'High risk of falls.' On 21 January checks were completed hourly between 1pm and 6.45pm. On 22 January checks there were 12 checks completed between 7.32am and 6.10pm. Checks were completed two hourly at night. The increased observation chart was not in place after these dates. The care records did not state the observations were to be discontinued.

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

The home premises were not clean and suitably maintained. Equipment that was used to deliver care and treatment was not clean, maintained and stored securely.

We brought some of the shortfalls to the attention of the regional manager. We showed them where there was a build-up of dust and ingrained grime on the bed bases and the base of hoists.

The regional manager told us they had allocated some rooms on the first floor as store rooms. In several rooms and bathrooms items of equipment such as hoists, mattresses, wheelchairs, walking aids, soiled hoist slings and other items littered the rooms and had not been placed with care.

Some people's rooms, including their toilets, were cluttered. In one toilet there were two wheelchairs and a commode being stored. A relative told us they had found soiled pads on the floor and in a bin in the person's bedroom.

On the first floor of the home two bathrooms out of five were not being used; in one there was bath full of discarded items, the other unused bathroom was out of order. Staff told us this had been reported approximately three to six months ago to the providers' property team. When we asked the registered manager about this they were not aware that the bathroom was out of order. There was one working bathroom and two working showers on this floor.

There was a robust selection procedure in place. An enhanced Disclosure and Barring Service (DBS) check had been completed. The DBS check ensured that people barred from working with certain groups such as vulnerable adults would be identified. We saw that the recruitment process also included completion of an application form, an interview and previous employer references to assess the candidate's suitability for the role.

Inadequate

Is the service effective?

Our findings

Staff told us they had not received sufficient training to enable them to carry out their roles safely or effectively. Staff told us they had received training that the provider deemed as mandatory to their roles and completed refresher and update courses. They told us they did not however receive training to help them meet the specific needs of people living in the care home. This included training to support people whose behaviour may be considered challenging and those living with diabetes, epilepsy, wound care and nutrition and hydration. These were some of the illnesses and issues affecting people living in the home. For example one person became distressed and shouted in an aggressive manner at other people. Staff ignored the behaviour initially then asked the person what the problem was. Staff told that us this was quite usual behaviour for this person but did not appear to know of a strategy for managing this behaviour consistently.

A relative whose relative living in the home lived with epilepsy told us that care staff failed to recognise when this person was having a 'petit mal', a brief seizure causing temporary loss of awareness. On occasion staff had thought the person was declining care or meals as they did not recognise the person having a petit mal.

Many care staff who provided end of life and palliative care had not received relevant training and did not understand what palliative or end of life care entailed. One member of staff said "I haven't had any end of life training." Other members of staff also told us they had not received this training and they received different guidance from different nurses.

Supervision is dedicated time for staff to discuss their role and personal development needs with a senior member of staff. Staff received supervisions regularly. However there was very little recorded to show support and development for staff and appeared to be focused on issues around poor performance. When concerns had been raised about poor communication and of issues between staff during supervisions there was no evidence to demonstrate the concerns were followed up by senior staff or the registered manager.

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

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

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

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible.

Consent to care was not always sought in line with legislation and guidance. Mental capacity assessments were not always in place and when they were, they were not decision specific. Although we saw evidence of best interest decision making in relation to two aspects of one person's care, we saw no evidence of this in the plans of other people.

Staff told us they had received training for MCA and DoLS. The staff we spoke with told us about a person who had a DoLS in place but were not clear in their understanding of what it meant when people had DoLS. (There were several DoLS applications in progress).

Staff told us they understood they needed to obtain consent from people before they provided support with personal care or treatment. One member of staff said "We ask and if people refuse, we go back later. It may be they need to see a different face, so we might ask another member of staff to try." However, over the two days we often heard people being told about their care rather than being asked. We heard people being told they were going to have a wash or told it was time to get up rather than being asked or given choices.

The care records did not provide clear or consistent information or detail about how people consented to care. Where there was reference to best interest decisions, the records did not provide detail about the specific decisions the records referred to. The care records did not always state that DoLS applications had been made. Where DoLS applications had been made there was no system in place to ensure that the progress of applications was tracked and updated to ensure DoLS were legally authorised as expediently as possible.

Records did not show that the principles of the MCA were being applied in respect of best interest decisions. For example one person's records included 'resident preferences' sheet was completed and signed by a nurse. Another document 'care plan decisions' that included confirmation of the person's agreement to the taking of photographs was signed by a nurse. For both documents there was no confirmation of how the person, their relatives or any other relevant person had been involved in making these decisions. The person's 'resident of the day' document recorded 'Yes' to the question, 'Is there evidence the care plan has been developed with the patient and/or family.'

The person's records stated if they refused personal care then a best interest decision was required to be undertaken. The records later stated, 'If I object by hitting out, scratching, becoming distressed then establish the cause and walk away. Ensure I am safe and attempt at a later time.' The record stated in a care review on 25 December 2016 the person's family 'continue to make decisions in her best interests.' There was no information with regards to what decisions the family were making or if they had the relevant Lasting Power of Attorney. There was a signature in the relative section for agreement for the use of bed rails.

The records were incomplete and did not provide clear guidance or detail about specific decision making and the level of relative involvement.

We also saw templates of mental capacity assessments pre-completed in respect of the questions used to assess service user's mental capacity. All of the answers were pre-completed to reflect that the service user to be assessed lacked mental capacity. The template was already marked in the section 'This person lacks capacity to make this specific decision for themselves.' These templates were also pre-signed by the registered manager.

These failings amounted to a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person had a DoLS in place. The authorisation included conditions, one of which was 'separate documentation to be in place to record offers made to leave his room and what alternative offers were i.e. sitting and chatting with him.' The condition had been made on 14/07/2016. However, there was no evidence of this condition being met. We observed the person in bed all day throughout our inspection. There was no separate documentation in place for staff to record when they had asked the person if they would like to get up and leave their room. The nurse on duty was not aware of the condition. Care records did not show the person had been offered the choice of getting up. We did not observe the person engaging in any activities with staff. The person's 'Engagement booklet' listed their recent social activities as one to one sessions lasting five to ten minutes. According to the records the person had 10 minutes of one to one time on 11/01/2017, and then a total of 20 minutes one to one over a 15 day period (four occasions of five minutes). The provider had failed to ensure that conditions on the person DoLS were met.

These failings amounted to a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans for people who had been risk assessed as at risk of malnutrition and dehydration was not always clear or provide staff with enough information. Although care plans showed that external advice and support was sought, it was not clear how this information was cascaded to staff. One person had been assessed as at high risk of choking. They had been reviewed by the speech and language therapy team (SALT) and the recommendations were 'Swallow reflex poor – needs to sit at 90 degree angle for eating' and 'soft diet.' We observed a member of care staff assisting the person with their lunch. They were not positioned at a 90 degree angle, which meant the risk of them choking was increased. We asked the member of staff if they were aware of the correct position for the person to be in, but they weren't. We asked a nurse to intervene and the person was subsequently moved to the correct position.

Food and fluid records were poor; for fluid charts there were no daily intake or output targets recorded or effective monitoring in place. For example the food and fluid charts for one person recorded that on 24/01/2017 they had eaten a liquidised meal at tea time, but had not eaten anything else during the day. Their fluid intake for the 24 hour period was documented as 180 millilitres. The chart had not been totalled or signed to indicate if staff had recognised the poor fluid intake or whether it had been reported. The nursing daily notes for this person for the day read 'Comfortable day – assisted with food and fluids.' However, this entry did not reflect the chart for the day so it was not clear how this conclusion was reached. The same person's fluid intake for another day was 570 millilitres and the nursing daily notes read 'no new concerns.' 'No new concerns" had also been documented in relation to another person whose fluid intake for the day was just 170 millilitres.' It was not clear how daily intakes were monitored and checked and when, or if, concerns were escalated or acted upon. The recommended daily intake for older people is a minimum of 1500 millilitres. There was no accountability or system for checking and acting on the food and fluid information that was recorded.

Several food and fluid charts often recorded that food was 'declined.' We spoke with one relative who told us they did not believe staff tried to persuade their mother to eat. They told us their mother was sometimes hungry when they visited. Many relatives were concerned about the food and fluid people received. Comments included "My [relative] was left many hours without a drink and they became dehydrated which caused their mind to wander and see creepy crawlies, they were supposed to be encouraging my [relative] to drink, but they are often forgotten."

People we spoke with made variable comments about the food; "Food on the whole is good, there is a choice, if I do not like either I can have ham mash and salad" and Food is not too bad, not home cooking, not always well cooked, passable enough to eat, there is always a lot of waste." "There has been an

improvement the last six to eight months, we get a lot of casseroles, they will find an alternative if you do not like it." "Food OK, enough to eat, plenty to drink." One person told us they do not eat any food provided by the home and that their family bring in freshly cooked meals and homemade cake and sandwiches daily."

Another relative claimed that on one occasion staff wrote down that their relative who lived in the home had drunk a cup of tea, but there was not a cup of tea in the room so they could not have had one. They added they had complained about the way staff supported their relative with meals, saying "Staff were standing up just shovelling it down without giving eye contact." The relative said that most evenings people on a soft diet received a potato based meal. They said "Every night residents on a soft diet get this potato mush, it's basically mashed potato with something stirred through it, sometimes some cheese and onion, sometimes some corned beef. It's not what's on the menu, they put a load of cream and butter in food. It makes me think they want to keep peoples' weight up but aren't bothered if they enjoy the food." We looked at the evening meal for people on soft diets on two evenings of the inspection. We found that on one night the meal was potato mash with a tomato sauce added to it and on the second night the soft meal was soft cauliflower cheese. The evening meals being offered on the days of our visit did not correspond to the printed menu.

Another relative visited the home daily and brings in snacks and drinks which they give to their relative who lives in the home because they said staff did not have time to do so. Their relative who lives in the home requires support from staff to eat their meals.

We spoke with the kitchen manager who showed us how they recorded people's food preferences on admission. They also showed us that the kitchen staff were provided with copies of recommendations from the SALT team. They said that people were regularly asked for feedback about the food, either as part of the 'Resident of the day' or at resident meetings. The kitchen manager told us they added cream and butter to foods such as soups and sauces for all people. There was no consideration as to whether all people required this level of additional fat in their diet.

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

Residents in the first floor dining room all sat around a large table. One staff member sat supporting a person, at the same time prompting and encouraging others to eat. One person who had their food cut up was struggling to put it onto their fork, eventually gave up and picked the food up with their fingers. We were told there were no plate guards or adapted cutlery in the dining room, but later were approached by a member of staff to say they had found some plate guards which they would use in future where appropriate. The lunch meals being offered on the days of our visit did not correspond to the printed menu.

On the ground floor, people were sitting in their wheelchairs at tables; where necessary a staff member sat beside them and supported them with their meal, taking their cues from the person and not rushing. Where required, care staff asked people if they would like help to cut up their food.

People had access to healthcare professionals however as demonstrated in other sections of this report we could not be assured that appropriate referrals were raised when there were concerns due to a lack of accountability and poor recording .

Inadequate

Is the service caring?

Our findings

Staff were not supported to provide consistent end of life care. On the first day of our inspection we asked a senior member of staff if anyone was receiving end of life care. They were unsure and said they would check with the nurse on duty. The nurse told us no one was receiving end of life care.

Staff told us they were not provided with sufficient or consistent information about the care people needed when they supported with end of life care. One member of staff said "We get told different things by different nurses." For example there was different guidance about the frequency of positional changes. We found that the majority of staff had not received end of life training to enable them to deliver this care in a caring and effective manner.

People had advanced care plans that were partly completed. The advanced care plans provided information about people's preferences about where they would like to be cared for if they became unwell, and what was important to them. The records also stated people's resuscitation status.
These were two page records and for all of the records we checked; only one had the two pages fully completed, dated and signed.

Although the majority of staff spoke positively about their roles, not all felt that people received good care. Some comments included "The quality of care depends on who is working" and "I'm not always sure people will get the care they need". Other staff said "I think the care here is good" and "I think people get good care. We ask people if they're ok."

Some of the staff said they knew people's preferences, but not all did. At least three members of staff said they had not read people's care plans but knew about people's care needs from their colleagues. Another said "I try and give people choice, but we're restricted. If I offer someone a bath today and they refuse they won't get offered another one until next week."

People were at risk of neglect of their personal care. An audit of personal care records reflected that staff often missed recording personal care on some days (blank on audit) and many people were being washed regularly rather than receiving showers or baths. There was a lack of assurance that people received the appropriate assistance with their personal care.

One person said "I get a bath or shower once a month." When asked if this was their preference they stated "It's what I've got used to living here." A visitor told us that their relative's teeth were dirty and stained. They thought they did not get prompted to clean them. Staff told us most people did not get regular or weekly baths or showers. The bathroom temperature records we viewed concurred with this. There were recordings that two people had baths and one person had a shower since 1 January 2017 on the first floor of the home.

We observed staff using poor moving and handling techniques; with a person's permission, we observed two care staff using a hoist to move the person from their wheelchair onto their bed. This was done in a rushed fashion, without the person being told what was about to happen or given reassurance or encouragement

except "sit forward flower" as they were being moved into the position, and staff taking and placing the person's hands on the bars to hold onto. When we asked if the sling about to be attached to the hoist was the person's personal sling, the care staff member put it aside and then fetched the person's own sling from their bathroom. During the process, when the person was suspended above their bed, the battery on the hoist failed and staff had to manually lower them onto the bed; the staff did not reassure the person through this process.

We observed that people were not routinely offered the choice of where to sit in one of the lounges. People were brought into the lounge in wheelchairs and were not asked if they wanted to sit in an armchair despite notices displayed on the walls in the lounges directing staff to ask people if they wished to move into a more comfortable armchair. One person was wheeled into the lounge and was left sitting behind someone else with no clear view of the TV or other people in the room. Other people were wheeled to the area by the television, but were not routinely asked what they wanted to watch. On only one occasion did we see a member of staff ask people if they were happy with the programme that was on.

We observed many people sitting in their wheelchairs all day. When we asked people about this, we were told they preferred to stay in their wheelchair, in some cases this was for their safety as they needed to be 'strapped in' or would fall. However people stated a clear dislike of being hoisted due to the poor manner in which it was undertaken.

We observed that one person's ankles were caught between the footplates of their wheelchair, one member of care staff attempted to pull out the ankles without taking care not to knock the person's ankles. Another member of care staff took over and gently moved the person's ankles into the correct position.

Some people ate their meals in their rooms and some of these people were assisted by staff. However, the lunchtime experience we observed for people in their rooms was not always sociable and on occasion did not promote a respectful meal time. For example, we asked one member of staff what the meal was that they were assisting someone with. They did not know and therefore had not informed the person what they were giving them. On at least three occasions we observed different staff members standing over people whilst assisting them to eat, rather than sitting alongside them. We also observed a staff member who was sitting supporting a person to eat in bed chatting with another member of staff who was stood on the other side of the person's bed. They conducted a conversation over the head of the person disregarding their meal experience whilst looking at photographs on a mobile phone; the person was not involved in the conversation. We also observed another person who was being supported to eat slumped down in their bed and close their eyes after a spoonful of food. The member of staff assisting them shouted out their name several times to stir them, then said "[Person's name] do not play with me, do not do that" in a stern tone of voice.

Whilst staff often spoke kindly when they were with people, on many occasions throughout the inspection people were repeatedly referred to in a disrespectful way and by the room number they occupied. For example, the following loud communications were heard, with staff calling to other staff along the corridors "Take the soft (meal) to [room number] not [room number]. They're a feed" and "Just going to do [room number] (support a person with personal care)." We also observed staff regularly talking over people, ignoring people's questions and delivering assistance to people without explaining what they were doing. For example, moving people away from the dining table whilst in their wheelchair without any forewarning.

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

Inadequate

Is the service responsive?

Our findings

People did not always receive care that was personalised and responsive to their needs. The records we looked at contained pre-admission assessments completed by the registered manager. Assessments were completed on admission to the home and care plans were completed. There was a lack of confirmation about how much of the information in the care plans was obtained. Most of the records included details about relatives that were involved at the time of admission. The records also contained a section for people and relatives to confirm if and how often they wanted to be involved in care reviews. Whilst most of the care plans also included letters sent from the registered manage that invited relatives to make an appointment to attend a care review, there was no evidence in most care records to confirm the person or a relative had been consulted or involved. A family member told us they made an appointment to have a care review with their relative's named nurse. The relative said they went to the home to arrange the review to find the nurse was on holiday. The relative was given a folder of notes and asked to sign them. The notes were incorrect and the relative refused to sign them; however, they had already been signed by the registered manager as being complete although they were undated and had not been signed by the relative.

Care plans did not always provide detail about how to provide the care people needed, what they could do independently and what specific support they needed. The records did not specifically confirm the care people had received. For example, the care staff daily notes often stated people had been supported with 'personal care.' They did not provide detail about whether the person had showered, bathed, washed in bed or in their chair.

Care staff told us they did not have time to read the care plans. The files in people's rooms contained documentation in relation to the care that had been delivered each day, but there was no summary of people's needs held within the files. It was therefore difficult to assess how staff who were new, or unfamiliar with people's needs, such as agency staff, would know about how people preferred to receive their care. Staff told us they were not always kept to date with people's health care needs and they were not always informed of changes in people's conditions. They told us they attended staff shift handovers. They told us these handover meetings provided a brief update, however they stated that handover meetings did not always take place on the late shift. One member of staff told us they read care plans on a regular basis. They told us this was to make sure they kept up to date with people's current care needs. However the majority of care staff told us they did not read the care plans. They told us they were not encouraged or asked by senior staff to read them. For example, one member of staff said "We don't get much time during the day to read the plans, so we rely on the information provided during handover."

The nurses and a senior care staff told us people were asked about their preferences each day, and were able to choose. The regional manager told us there was an allocation file that contained allocation and handover sheets that designated staff duties such as to which 'zone' they were allocated to work in, lounge duties and responsibilities for completion of menus and fluid charts and a bath list that confirmed the days people usually had baths or showers. The staff were unable to locate these records for the first floor of the home during the inspection.

There was a significant risk of deterioration in peoples' physical and mental health because staff were not responsive to their individual needs. The plans showed that care was not always responsive. For example, in one plan it had been documented that the person 'liked to be in company' and 'inconsolable when left alone.' Yet, the person was sat alone in their room for the duration of our inspection. We saw there were periods of time throughout the inspection when the person was upset and called out for attention and was not reassured by staff. In another person's plan it had been documented that they had a history of confusion and didn't often speak and they sometimes became agitated. However the plan guided staff to 'anticipate her needs' and 'check regularly.' There was no detail in relation to what triggers might cause the agitation, how staff should anticipate the person's needs, what they should check or how they should support the person

One person's records stated they were unable to use their call bell, and needed to be checked on a regular basis. The daily care records contained repeated entries of 'call bell in reach.' This meant that although the care records appeared to be written in a personalised way for that person, they were not accurate and did not reflect the person's needs or staff understanding of their needs.

One person's night care records for 24 January 2017 stated, 'RGN (registered nurse) informed a dressing to be applied onto sacrum. RN (registered nurse) told me she will look in the morning as busy at the moment. Pro-shield applied.' The person this record related to told us they were uncomfortable when we spoke with them on the morning of 26 January 2017. They told us their pressure relieving mattress was faulty. We reported this to the nurse on duty at approximately 8.45am and to the maintenance person. The maintenance person turned up the setting on the mattress. They told us the pressure relieving mattress was an old one. There were no manufacturer's instructions available. The nurse told us they would change the mattress. The mattress was changed after we followed up and asked for a further update at 11.30am.

Some people had monitoring charts in place, for example for food and fluids, change of position, mouth care, safety monitoring and recording of bowel movements. Many of these records were incomplete and actions had not been taken in response, such as when people had not had sufficient fluids or had their bowels opened. We were also unable to locate some of these records. We were told they had probably been archived.

The bowel monitoring records for one person did not have any recordings made between 1 and 14 January 2017. For another person who required bowel monitoring the last recorded entry for bowel monitoring was made on 20 January 2017. We also found that required night checks for the person had not been completed for 15, 23 and 24 January 2017.

Records dating back to October 2016 were incomplete. For example, one person's food and fluid records were incomplete for the week commencing 3 October 2016. Records were not completed for 4, 6, 7 and 8 October 2016. The person also had an oral hygiene chart in place. For the same week, this was completed on 3 October where the record stated, 'Teeth brushed-lip balm applied.' The records were not completed for the remainder of the week.

At the time of our visit at least nine people on the first floor of the home were usually cared for in bed. The nurse on duty told us most people were frail or there was no suitable seating for them. The care records did not provide detail about the decision making for people that stayed in bed all of the time.

Peoples' wellbeing was not promoted due to a lack of activities to meet their social, mental and emotional needs. During the week days of our inspection there was an activity planned for morning and afternoon, 4 days a week, with bingo, scrabble and arts and crafts with a 'pampering day' on one day. Hairdressing, nail

care and a meal survey were also counted as activities on the schedule despite these being essential activities associated with living in the home. There were no activities at the weekends. There was a musical session once a month with an outside entertainer. The activity co-ordinators were scheduled to spend one to one time with people who were cared for in their bedrooms; however, this was at best a five minute 'pop in' for a chat.

During the days of our inspection a planned arts and crafts session did not take place because of a staff meeting; this meeting lasted only 30 minutes. We were told the planned activity would be deferred to the afternoon however the activity was changed. Although there were two activities co-ordinators, the only activity taking place during the three day inspection was a game of bingo with four people playing and two members of staff, a 'pampering' nail painting session for some people and a few one to one visits for people in their bedrooms. For the majority of people there was minimal social interaction.

People who required individual person centred activities on a one to one basis with staff did not receive them. We looked at the activities records for people who were unable to leave their bedrooms. We found that very little had been recorded in respect of activities or social stimulation for these people. For example we looked at people's had engagement booklets that were kept in their rooms. The booklets recorded the one to one social activity time spent with people. These were not completed on a regular basis. For example, for one person, in January 2017 they were recorded as receiving one to one time 10, 11, 12,16,18,19 & 23 January. There were no entries recorded on the other days of this month.

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

The provider had a complaints procedure and people and their representatives said they knew how to complain. We looked at the complaints log. We saw that the recorded complaints had been investigated and satisfactorily resolved.

The registered manager had not responded to all complaints made by people and relatives as set out by the provider's complaint policy. We were told by relatives of verbal complaints they had made directly to the registered manager. We asked to see records of the verbal complaints and were told these were not recorded in the complaints file.

The provider's complaint policy clearly defined that any member of staff who received a complaint must record the details on a complaint log form (including verbal complaints).The policy also explained how complaints assist the provider in learning how to improve from what people tell them.

The lack of reporting verbal complaints meant that the provider could not be assured that they were aware of the issues affecting people using the service and were able to act on these complaints to improve the service. We were unable to assess whether the verbal complaints had been resolved and closed satisfactorily. This also meant the provider was unable to use the detail of the complaint to assess for any trends or improvements.

We spoke with relatives who told us they had expressed concerns about their loved ones care at the home on several occasions directly with the registered manager. One relative told us they continued to have concerns about the care provided for their mother despite having complained to the registered manager on a number of occasions. They were concerned the person was not safely cared for, they were not given sufficient food or fluids and that records were sometimes inaccurately completed. They told us they did not have confidence in the registered manager who they believed 'pays lip service' to complaints but does not

resolve them. This was echoed by other relatives.

These failings amounted to a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

The culture was not positive. The staff we spoke with were unable to tell us about the provider's vision and values. We found that there was a divide within the staff team; we were told that some staff were reluctant to change to improved ways of working and staff who did not like each other would not assist each other whilst working to the detriment of people. We were also told that some staff did not like working with others whose background was diverse from their own.

Comments from staff in relation to morale included "I don't feel totally supported", "It never used to be like this, but there is no team work", "On one unit (upstairs) there is no sense of urgency, with buzzers for example. Care staff say they don't feel respected by the nurses" and "It doesn't feel like there is a plan to change things."

During the course of the inspection we observed senior staff treating care staff with disrespect by publicly correcting them about their practice. We also heard staff talking about other staff in a derogatory way. Relatives told us they were concerned about the way in which the staff team were managed and told us of occasions when staff were 'told off' in front of them by the registered manager and other senior staff, they had also observed staff arguing. In addition to this some people were also aware of issues between staff. One person said "I don't want any company from the staff, all they do is tell tales on each other and I don't want to get involved."

None of the staff we spoke with spoke positively about the management of the home. The majority of staff felt there was a lack of leadership from the registered manager.
Comments about the culture and atmosphere had been recorded within staff supervision meeting notes and in other audits of the service however up until the week before the inspection there had been no structured approach to dealing with these issues.

The provider's quality assurance systems and processes did not ensure that they were able to assess, monitor quality provision and mitigate the risks and relating to the health, safety and welfare of people and others who may be at risk in the service.

The quality assurance systems used by the provider and the service were ineffective in assessing where the service required improvement and implementing and sustaining improvement effectively within a reasonable timescale. There were widespread and systemic failings identified during the inspection.

Since our last comprehensive inspection there had been no improvement in the level of service provided and some areas had deteriorated. At this inspection we identified nine breaches of regulations; most of these were repeated breaches from the last two comprehensive inspections of the service. The provider had failed to take sufficient action in response to shortfalls previously identified.

Care plan audits were undertaken by senior staff on a monthly basis; these had been ineffective as these had not led to improvements in the quality of the care plans.

The registered manager told us that they and other senior staff undertook audits in relation to different aspects of the home. The regional manager also completed monthly quality assurance visits. These audits were ineffective because they were not carried out in a way that improved upon the service. Some of the audits picked up on concerns however the concerns were not addressed robustly. Other audits were not completed in a meaningful way. For example a senior member of staff had completed a kitchen audit in November 2016; there were Y (yes) or N (no) answer boxes to be marked in relation to questions such as 'Is the cleaning equipment clean and in good order?' For the first set of questions the answer to all questions in order to reflect a good standard was N. In the first set of questions other than the first question all the remaining boxes were marked N. For the second set of questions the answer to all questions in order to reflect a good standard was Y. We saw that the boxes in this section had been marked N. For example the questions 'Is the grill free from dirt and grime?' and 'Is the milk pergola tap clean and have no leakage' were marked N. The person completing the audit had continued ticking the same column of answers (N) from the first set of questions into the second set of questions. There wasn't any correlation against the actual standard seen; there was no action plan to address the issues relating to the questions which highlighted a poor standard. The registered manager had date stamped and signed the audit in December 2016 to evidence a review of the audit. The registered manager's review had not picked up that either the audit was completed incorrectly or the standard of cleanliness in the kitchen was poor and required addressing.

We saw other audits completed in a similar manner with no action plan to address poor standards, these had also been signed as reviewed and date stamped by the registered manager.

Meetings and surveys of people and relatives were used for quality assurance purposes and to enable continuous improvement. We found however the same issues for example poor response to call bells and a lack of staff communication were consistently raised as requiring improvement. It was evident during the inspection that these issues had not been addressed satisfactorily.

Other areas where there was a lack of oversight related to the maintenance and environmental aspects of the service. We saw a number of maintenance related action plans which required completion which had not been marked as complete or undertaken these related to areas such as lift maintenance and Legionella and fire risk assessments. The registered manager was unaware of the status of action plans and works required. We raised the concerns with the operations director who immediately started to address the issues we had raised initiating works where they were required.

A fire risk assessment was undertaken of the service in March 2016 it noted a number of findings that required further action within 12 months of the inspection or sooner. We found during the inspection that action had not been taken within 11 months of the assessment. We raised our concerns with the provider's operations director who initiated some of the required works to be completed. The registered manager was unaware of these requirements when asked.

The provider's regional manager had conducted quality assurance visit reports in September, October and November 2016. The September and October reports noted that actions from the fire risk assessment were outstanding and the registered manager was required to follow them up. The November report noted 'Y' which stands for yes in the section relating to evidence of the completion of the fire risk assessment despite the fire risk assessment actions remaining outstanding.

There was not an effective system to monitor the quality of peoples' care records and ensure the service held current and accurate records about people. Records did not always contain enough information about people to protect them from the risk of unsafe care. There was also a failure to identify recording errors and omissions in the care records and to analyse concerns. We saw records which were undated, unsigned

incomplete and incorrect. The majority of care plans we saw had an element of this with some being significantly worse.

The storage of records was disorganised and not secure. We saw one storage cupboard on the first floor of the home; the door was open. There were numerous open boxes of peoples' care notes. We were told by staff another store cupboard on the first floor which was locked was also used to store 'archive' records. We asked for a week's worth of monitoring charts for the week prior to our visit. Staff said that they should be in people's rooms or in a filing cabinet in the nurses' office. The filing cabinet did not contain any monitoring records. There was no timescale or system of how long the monitoring charts were to be kept in people's rooms before they were removed; There were some charts in place just for the current week, some for the current month and some that were just for the day previous to our visit and the current day. We were unable to locate some monitoring charts to check previous record keeping. A box of records was later brought to us and we were told this box had been 'under the staircase' on the ground floor. The records were not in date or person order.

We spoke with a visiting GP. They told us the first floor of the home was not as organised as the ground floor. They told us, for example, they visited three times each week. On the ground floor a list was prepared to confirm the people that needed to be visited by the GP. On the first floor, this was not well-organised. They told us communication between staff was sometimes not effective and nurse staffing was not as consistent as on the first floor. For example, they told us they had completed a form for one person two days prior to our visit. They left the completed documentation in the front office (usual routine). A nurse asked the GP about the form two days later. It had not been sent upstairs to the nurse.

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

All services registered with the Commission must notify the Commission about certain changes, events and incidents affecting their service or the people who use it. Notifications tell us about significant events that happen in the service. We use this information to monitor the service and to check how events have been handled. We had not received statutory notifications in relation to allegations of abuse and neglect. A significant number of deaths had not been reported to the commission as required and one death of a person with a Deprivation of Liberty Safeguard was not reported to the coroner as required. This meant that the Commission had been unable to monitor any concerns and consider any follow up action that may have been required.

These failings amounted to a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

During the inspection we attended a meeting held by the operations director with approximately 32 staff. The purpose of the meeting was to acknowledge recent concerns staff had expressed, and to reaffirm the management team were committed to the provision of a quality service for people living in the home. The operations director invited staff to request separate meetings with them, the regional manager or the member of the provider's human resources (HR) team if they wished to discuss or report any issues of concern.

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 18 Registration Regulations 2009 Notifications of other incidents Statutory notifications had not been made to the Commission for notifiable incidents.

The enforcement action we took:

Imposed additional conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	Care plans did not contain sufficient information to enable staff to deliver person centred care. Sufficient action had not been taken to ensure people's care and monitoring records were analysed to prevent deterioration in their health. People did not receive person centred activities.

The enforcement action we took:

Imposed additional conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	People were not treated with dignity and respect.

The enforcement action we took:

Imposed additional conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	Consent to care was not always sought in line with legislation and guidance.

The enforcement action we took:

Imposed additional conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments did not always reflect actions required to reduce risks to people. The administration of people's medicines was not in line with best practice.

The enforcement action we took:

Imposed additional conditions on the provider's registration.

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 Abusive incidents were not always reported appropriately. The provider had also failed to recognise the inappropriate restraint of people.

The enforcement action we took:

Imposed additional conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Not all complaints were recorded and resolved to the satisfaction of complainants.

The enforcement action we took:

Imposed additional conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance There was a divisive staff culture which had not been addressed by the provider. The systems in place for monitoring quality and safety were not effective in ensuring that the risks to people were identified and managed. There was not an effective system to monitor the quality of peoples' care records and ensure the service held current and accurate records about people.

The storage of records was not secure.

The enforcement action we took:

Imposed additional conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough suitably skilled staff to meet people's needs safely and effectively Staff supervision and training was not effective in ensuring staff were supported, suitably skilled and competent in their roles.

The enforcement action we took:

Imposed additional conditions on the provider's registration.