Care Quality Commission

Kesh-Care Limited

The Old Hall Residential 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

The Old Hall Residential Care Home is registered to provide accommodation and personal care for up to 25 older people, people with physical disabilities and people living with dementia. At our last inspection in August 2015 we rated the home as Requires Improvement.

We inspected the home on 31January and 6 February 2017. The inspection was unannounced. There were 24 people living in the home on the first day of our inspection.

The home had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers ('the provider'), 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.

During our inspection we found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had failed to properly assess and mitigate risks to people's safety; staffing levels were insufficient; staff did not always respect people's privacy and dignity; people's legal rights under the Mental Capacity Act 2005 were not fully protected; people did not receive person-centred care that met their needs and personal preferences and the provider had failed to establish systems and processes to mitigate risks relating to people's health, safety and welfare and to assess, monitor and improve the quality of the service.

We also found one breach of the Care Quality Commission (Registration) Regulations 2009.This was because the provider had failed to notify us of issues relating to the safety and welfare of people living in the home.

We have taken action against the registered provider to ensure that they make the necessary improvements to become compliant with legal requirements. You can see what action we have taken at the end of the full version of this report.

We also found other areas in which improvement was required to ensure people received the safe, effective, caring and responsive service they were entitled to expect.

The systems for the induction and training of staff were not consistently effective. Additionally, staff were not provided with supervision in line with the provider's policy.

At times, staff supported the people who lived in the home in a task-centred way.

In a small number of areas, we found the provider was meeting people's needs effectively.

The provider had assessed each person's individual support needs in the case of a fire or other emergency that required the building to be evacuated. There was also an effective system in place to ensure that fire

safety and other equipment was serviced regularly in accordance with the manufacturers' instructions and the law.

People were provided with food and drink of good quality that met their needs and preferences and their healthcare needs were supported through the involvement of a range of professionals.

People and their relatives were comfortable raising any concerns with senior staff and formal complaints were rare.

CQC is required by law to monitor the operation of the Mental Capacity Act, 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves. At the time of our inspection, the provider had sought a DoLS authorisation for three people living in the home and was waiting for these to be assessed by the local authority.

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 consistently safe.

Some parts of the home were unclean and created a risk of cross-infection.

Some aspects of the premises were unsafe.

Some people's individual risk assessments were not effectively maintained.

There were insufficient staff to support and supervise people safely and effectively.

Some people's medicines were not managed safely.

The recruitment of new staff was not consistently safe.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's legal rights under the Mental Capacity Act were not fully protected.

The systems for the induction and training of staff were not consistently effective.

Staff were not provided with supervision in line with the requirements of the provider's policy.

People were provided with food and drink of good quality that met their needs and preferences.

People's healthcare needs were supported through the involvement of a range of professionals.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always treated with dignity and respect.

Staff did not consistently respect people's privacy.

At times, staff supported people in a task-centred way.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were provided with insufficient stimulation and occupation to meet their individual needs and preferences.

The provider's care planning system was ineffective in ensuring staff supported people in a responsive and person-centred way.

People and their relatives were comfortable raising any concerns with senior staff and formal complaints were rare.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had failed to make most of the improvements we identified as necessary at our last inspection of the home.

The systems for auditing and monitoring the quality of service provision were limited and ineffective.

The provider had failed to notify CQC of issues relating to the safety and welfare of people living in the home.

Care Quality Commission

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

We visited The Old Hall Residential Care Home on 31 January and 6 February 2016. The inspection was unannounced. On the first day, the inspection team consisted of an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day, our inspector returned alone to complete the inspection. This second visit was arranged in consultation with the registered manager, to make sure they would be available to contribute to the process.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form the provider completes to give some key information about the home, what the home does well and improvements they plan to make. The provider returned the PIR and we took this into account when we made the judgements in this report.

In preparation for our visit we also reviewed information that we held about the home such as notifications (events which happened in the home that the provider is required to tell us about) and information that had been sent to us by other agencies including the local authority safeguarding team.

During our inspection visit we spent time observing how staff provided care for people to help us better understand their experiences of the care they received. We spoke with five people who lived in the home, five visiting relatives, the registered manager, the deputy manager, three members of care staff team and the cook. We also spoke with two local health and social care professionals who had regular contact with the home.

We looked at a range of documents and written records including seven people's care records and staff recruitment and training records. We also looked at information relating to the administration of medicines and the auditing and monitoring of service provision.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us that they felt safe living in the home. For example, one person said, "I feel safe here." A visiting relative also commented, "[Name] is safe here." However, despite this feedback, during our inspection visit we identified multiple areas in which the provider was failing to properly protect people's safety and welfare.

We identified concerns with the safety of the premises. For example, the footpath leading to the front door of the home had broken paving stones and a unprotected raised edge, both of which created a risk of injury to anyone using the path whether on foot or in a wheelchair. In the garden, one of the flights of steps leading down to the lawn had been blocked with plant pots. The registered manager told us that this had been done to stop people using the steps but the plan pots themselves presented an additional trip hazard. In the library, we found a heavy wooden shelf with sharp metal brackets had been placed above head height on top of a row of books. The shelf was not attached to the wall and had the potential to cause serious injury should it fall on someone below. Access to the main stairway of the home was restricted by a solid wooden bar at the top and the bottom of the flight of stairs. The bars were held in place by metal supports but could be easily removed, creating a further risk of injury. During our inspection visit we saw one person trying to remove one of the bars before a member of staff stepped in to prevent them. On the morning of first day of our inspection, parts of the home were very cold and some people had difficulty obtaining hot water in the sinks in their bedroom. The registered manager told us that there were problems with the heating which she was trying to resolve and on the second day of our inspection the home was much warmer. But staff told us that the faults with the hot water were long-standing and that they sometimes had to carry jugs of hot water from the kitchen to people's rooms, creating a further risk to themselves and the people living in the home.

We also identified concerns with the cleanliness of some areas of the home which presented an increased risk to people's health and safety. We found high level cobwebs throughout the home and when we reviewed the cleaning record maintained by the housekeeper, we saw that the last time cobweb removal had been recorded as having been completed was on 14 November 2016, some two and a half months previously. In one of the communal bathrooms we found a dirty carpet, cracked lino, and a broken bath side, all off which created a risk of cross-infection. Similarly, the lino in one person's ensuite toilet was cracked with several pieces missing. One member of staff told us, "It's been like that for a long time. Before [the provider] took over eight years ago." Discussing the cleanliness of the home, the registered manager told us that she had been trying to recruit additional cleaning staff for "a couple of months", without success.

On our previous inspection of the home in August 2015, we identified shortfalls in medicines management and told the provider that improvement was required. However, on this inspection we again found shortfalls in this area which meant the management of some people's medicines was not consistently safe. The administration of most people's medicines was undertaken correctly. However, we found inconsistencies in the use of the codes staff used to record when people had not received their 'as required' medicines. This made it difficult to ascertain whether someone had exercised their right to decline the

medicine or it had not been given for some other reason. We also identified concerns with the stock control of liquid medicines. For example, we found a medicine that had been prescribed for one person in January 2016 was still in the medicines cabinet, despite the fact the person was no longer taking this medicine. We also found one person's medicine had been opened but was being kept in the cupboard that was used to store unopened 'spares'. Staff had not recorded when this medicine had been opened, creating the possibility that the person might have been given out of date medicine in the future. In the cabinet for 'controlled drugs' (medicines which are subject to special legal requirements) we found a bottle of medicine without a label to indicate for whom it had been prescribed. The member of staff we were accompanying at the time said, "I think it's [name's] but they stopped using it last year. It should have been disposed of." This lack of effective control of controlled drugs was compounded by the fact that the provider's key holding arrangements allowed staff who were not authorised to handle medicines, to have access to the controlled drugs cabinet. We raised this issue with the registered manager who told us she would review key-holding arrangements as a matter of priority.

We looked at people's care records and saw that a range of possible risks to each person's safety and wellbeing had been considered and assessed, for example skin care, mobility and nutrition. However, the provider's ongoing management and review of some of the identified risks was inconsistent and did not fully protect people from the risk of harm. For example, staff had identified one person as having a history of falls. Reflecting this risk, a 'moving and handling' risk assessment had been completed in February 2016. However, in October 2016 this person fell and sustained a fracture. The 'review sheet' section of the moving and handling risk assessment was blank and there was no evidence that staff had reviewed the way this person was supported to try to mitigate the risk of something similar happening again. In November 2016, staff had been assessed another person as being at increased risk of weight loss but had failed to complete the provider's monthly nutritional assessment since this increased risk had been identified. In October 2015, staff had also assessed the same person as being at 'medium risk' of developing skin damage but had failed to undertake the provider's monthly skin integrity risk review at any point since this assessment had been made.

We also found that the provider's staff recruitment procedures were not consistently safe. For example, we reviewed the file of one member of staff who had started work in the home in March 2015. However, the provider had not sought a reference from this person's previous employer until December 2015, some nine months after they had commenced their employment. Commenting on this failure to maintain safe and effective recruitment practice, the registered manager said, "That's a bit strange."

Taken together, the provider's failure to properly assess and mitigate risks to people's safety was a breach of Regulation 12(2)(a),(b),(d),(e),(g) and (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On our previous inspection of the home we found that staff were not always available to meet people's needs and told the provider that improvement was required. However, on this inspection we found that the provider had not taken effective action to address this issue and that there were still insufficient staff to meet people's needs and to ensure their safety.

The registered manager told us that she had recently increased staffing levels in the care team by deploying an additional member of staff on the morning shift. However, this increase appeared to have been prompted by feedback from staff about the difficulties they were experiencing in meeting people's personal care needs in a timely way, rather than in response to our inspection report which had been published a year earlier. Commenting on the increase, one member of staff said, "It used to be only two [front line care staff] on in the morning. It used to be a hell of a struggle. We asked and got the increase about two months

ago."

Although staff said that the change to the morning shift had been helpful, they told us of their continuing concerns about staffing levels in the afternoon which remained unchanged, with only two care staff deployed to provide direct, hands-on support. Talking of their experience of working on the afternoon shift, one member of staff said, "[Staffing levels] in the morning work [but] I don't think there are enough staff [in the afternoon]. The bells can be non-stop. We have to explain to people that they will have to wait."

Reflecting this shortfall in care staffing resources, throughout both days of our inspection we saw several people who were living with dementia walking repetitively up and down the corridors of the home with no staff support or supervision, creating an increased risk to themselves and others. We also saw that there were insufficient staff deployed in the dining room to meet people's needs safely and effectively at lunchtime. For example, on the first day of our inspection we observed a single member of staff attempting to support and supervise approximately 15 people who were having lunch in the dining room and the adjacent library. At one point, one person started to become distressed but there was a significant delay before the member of staff was able to free themselves from supporting other people and come to comfort them. On the second day of our inspection, we again saw a single member of staff had been deployed to support people who were eating in the dining room at lunchtime. At one point we saw this staff member trying to provide two people with one-to-one support to eat their pudding at the same time, meaning each person had to wait a considerable time before completing their meal. Talking of the pressures on their time, one member of staff said, "[We] very rarely get our [lunch] break. You eat a sandwich when you are feeding someone."

People also told us that staff were too busy to spend time interacting with them socially. For example, one person said, "They need more staff. There's no time for a chat." Another person told us, "There's not many people to talk to." Reflecting these comments, throughout our inspection visit we saw people sitting for long periods of time with no stimulation or occupation and only occasional interactions from passing staff. Staff confirmed that they rarely had time to sit and talk to people and that they worried about the impact this lack of stimulation and social interaction had on people's health and welfare. For example, one member of staff said, "You see them. They come in and within eight weeks their heads go down."

The provider's continuing failure to deploy sufficient staff to meet people's individual needs and to ensure their safety was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not every member of staff we spoke to was sure how to report any concerns relating to people's welfare, for instance how to escalate concerns to external organisations such as the local authority safeguarding team. This lack of knowledge of procedures designed to safeguard and protect people, created a further potential risk to people's safety. When we reviewed the provider's record of staff training we saw that over 50% of the staff employed in the home had not completed training in this area. The registered manager told us that she had recently sourced a training course to address this shortfall which staff were in the process of undertaking.

More positively, the provider had assessed each person's individual support needs in the case of a fire or other emergency that required the building to be evacuated. The provider had also established a reciprocal arrangement with another local care home, to ensure people had somewhere suitable to go in the case of an emergency evacuation. We also saw that the provider had a system in place to ensure that fire safety and other equipment was serviced regularly in accordance with the manufacturers' instructions and the law.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides the 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.

On our last inspection of the home in August 2015, we identified shortfalls in the approach to best interests decision-making and told the provider that improvement was required. However, on this inspection we found that improvement had not been made. The provider's compliance with the provisions of the MCA remained inconsistent and people's rights were not fully protected. When we reviewed the provider's staff training record we saw that less than 20% of staff had completed training in this area. Reflecting this lack of training, staff at all levels, including the registered manager, displayed a very limited understanding of the provisions of the MCA. For example, in one person's care record we found that senior staff had documented that they had taken an important decision on the person's behalf, as they believed this was in their best interests. This was despite the fact that staff had also assessed the person as having full mental capacity and therefore perfectly able make the decision for themselves. Additionally, staff told us of several people who were living with dementia and were unable to indicate what they wanted to eat. Describing their approach to the people in this situation, one member of staff said, "A lot have got dementia. They can't answer when [I ask them what they want to eat] so I just choose for them." When we looked at people's care records we found no evidence that this important decision had been taken as being in the person's best interests following a process of discussion and consultation, for instance with relatives, to understand what the person's preferences had been prior to their losing the ability to choose for themselves. Similarly, when decisions had been make to fit rails to people's bed to prevent them trying to get out and injuring themselves, there was no evidence that these decisions had been taken following a proper best interests decision-making process in which other, less restrictive options had been considered. Discussing her knowledge of best interests decision-making, the registered manager commented, "It confuses me."

The provider's continuing failure to ensure staff acted in accordance with the requirements of the MCA was a breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At the time of our inspection, the provider had sought a DoLS authorisation for three people living in the home and was waiting for these to be assessed by the local authority.

People we spoke with told us they felt well-cared for. For example, one person said, "They look after me well." Commenting on their experience of working with the staff in the home, a local healthcare professional told us, "I have no clinical concerns about the care people are receiving. They know their residents and are quick to identify any issues." We saw another healthcare professional had sent a letter to the registered

manager which stated, 'Many thanks for giving such good care to our very special [name]. [Their] leg is looking so much better!"

However, the provider's approach to staff induction and training was not consistently effective in ensuring staff had the skills and knowledge to support people safely. For example, new members of staff participated in an induction programme which included initial fire safety training and a period of shadowing experienced colleagues before they started to work as a full member of the team. Reflecting on their induction, one member of staff told us, "I was shadowing for about two weeks [and] then went straight on to the rota. No one asked me if I was ready [and I was] not signed off or anything. I didn't have moving and handling training. I was surprised [about that]." When we reviewed the provider's record of staff training we saw that this member of staff had still not completed any training in this important area, despite being in post for seven months. When we discussed this issue with the registered manager she confirmed that this training was not a core component of the provider's induction programme, increasing the risk that people might not be supported safely in line with best practice. The registered manager also told us that the provider had adopted the National Care Certificate which sets out common induction standards for social care staff. However, further work was required to ensure this was properly integrated with the provider's own induction programme. Talking about the content of the Care Certificate, the registered manager said, "I'm not quite sure what [it] covers."

Staff also told us of their concerns about the amount of training they were provided with to support them in their roles. For example, one member of staff said, "I have had no training since I came here. Apart from safeguarding [which I have just started]. We do need more training. All of us." The provider maintained a record of each staff member's training requirements but, reflecting the feedback we received from staff, there were significant backlogs in several areas. For example, in addition to the shortfalls in safeguarding and MCA training described elsewhere in this report, 50% of staff had not completed health and safety training which the provider had specified as being mandatory for all staff, over 75% had not completed mandatory food hygiene training and 55% had not completed dementia awareness training, despite the high number of people living with dementia in the home. Despite this clear evidence of the need to prioritise staff training to ensure staff had up-to-date knowledge and skills to care for people effectively, the registered manager told us, "We've not got a training plan for 2017 at the moment."

We identified concerns about the level of supervision provided to staff which also created an increased risk that people would not receive safe, effective care. Recognising the importance of supervision in ensuring that staff had the skills and support necessary to perform their role, the provider's 'personal supervision' policy stated that, 'Supervision is critical to achieving and maintaining organisational health and will contribute to the achievements of the core values of this Care Home. Supervision is not an option and is a "right" for all grades of staff…. and should take place six times a year.' However, staff told us that they were not provided with supervision in accordance with these policy requirements. For example, one staff member who had been in post for almost two years said, "My first and last [supervision session] was about six months ago." We reviewed the provider's record of staff supervisions which confirmed supervision was not being provided six times a year. Acknowledging this shortfall, the registered manager said, "To be honest, we have not been achieving it in the past. In 2016 … we didn't achieve it. Hopefully this year."

More positively, people told us that they enjoyed the food provided in the home. One person said, "They're very good with food, there's plenty of variety." Another person told us, "My tea and porridge is always warm and fresh." People were offered a variety of hot and cold choices for breakfast and also at tea time, including homemade cakes and other desserts made freshly every day. On the first day of our inspection, we saw that people had four different dessert options to choose from. For lunch, people had a choice of two main course options although the cook told us that kitchen staff were always happy to make an alternative for anyone

who requested it. For example, the day before our inspection one person had asked to have fish fingers rather than a Sunday roast for lunch.

Staff were aware of most people's likes and dislikes and used this to guide them in their menu planning and meal preparation. For example, the registered manager told us, "We involve people in the menu planning. Taste buds are changing. Some people said they wanted cheese on toast as an option at tea time. They can have what they like." Staff were also aware of people's nutritional requirements, for example people who had allergies or people whose food needed to be pureed to reduce of choking. Hot and cold drinks were available throughout the day to help prevent dehydration and other health risks. One person told us, "You only have to shout for tea and it comes quickly."

From talking to staff and looking at people's care plans, we could see that their healthcare needs were monitored and supported through the involvement of a range of professionals including GPs, district nurses and therapists. For example, the registered manager told us how they were keeping in close contact with the district nursing service about two people who were at risk of developing skin damage. Describing the provider's proactive approach in this area, one relative said, "They will always consult the doctor if there's any doubt. They never need to be prompted by me." Commenting on their relationship with the staff team, one local healthcare professional told us, "They are very good at getting in touch and always follow our advice."

Requires Improvement

Is the service caring?

Our findings

At our last inspection of the home we found that staff did not always support people in ways that maintained their dignity and told the provider that improvement was required. However on this inspection visit, we found that people's dignity was still not consistently promoted and maintained.

Perhaps reflecting the under-resourcing of the care staff team described elsewhere in this report, on both days of our inspection we saw that some staff appeared to lack time to care for people in a person-centred way. Instead, some staff displayed a task-centred approach to their work with little attempt to engage with people individually. For example, we observed one person sitting alone in one of the lounges for 20 minutes. During this time, several staff passed through the area but none made any attempt to speak to the person. Even when they came to collect the person's empty cup, we watched a member of staff take it away without saying a word. Similarly, when we observed a single member of staff assisting two people to eat their lunch at the same time, they moved backwards and forwards between each person, leaving each of them for a few minutes at a time to support the other. This assistance was provided largely in silence and at one point, the member of staff simply left one person to go and support the other person, with no attempt to explain what they were doing or apologise for the inconvenience and delay this had caused. Most of the tablecloths in the dining room were full of holes and did not promote a dignified and positive dining experience. Throughout our inspection we heard staff openly describe people who needed assistance to eat as "feeds". For example, talking about the breakfast arrangements in the home, one member of staff told us, "We've got four feeds. Night staff do two and the day staff do two." Talking of the long-standing problems with the hot water supply in some people's bedrooms and the impact this had on the dignity of one of the people they supported, a member of staff said, "I have to take jugs [of hot water] into [name]'s room. It reduces their independence as [name] could do their own hands and face."

Although staff told us of the importance of supporting people in ways that respected their privacy, we saw this was not consistently reflected in their practice. For example, we watched as one member of staff opened a door and went into a shower room without knocking or trying to establish if anyone was inside. Realising there was someone inside using the shower, the member of staff came back out saying, "Oh, someone is in the shower!" They made no attempt to apologise to the person for the intrusion. We also saw the same member of staff go into several other people's bedroom without knocking or confirming that the person wanted them to go in. Talking of their colleagues' approach in this area, another member of staff said, "Sometimes [they] go straight in [to people's rooms]. It's not what's supposed to happen."

The provider's continuing failure to ensure people's dignity and privacy were promoted and maintained was a breach of Regulation 10(1) and (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

More positively, the people we spoke to told us that staff were kind and caring. For example, one person's relative said, "They're very caring." Reflecting this feedback, during our inspection we identified examples of this approach. For instance, the cook had a list of people's birthdays and told us that she made a cake for each person, unless their relatives were bringing one in themselves. Commenting on the home's Christmas

lunch, one relative said, "It was great and had a family feel." When we arrived at the home on the first day of our inspection, we were told that the registered manager was out of the home escorting someone to their hospital appointment. Talking of the provider's approach in this area, one member of staff said, "We escort everyone to hospital. We don't let them go on their own. At night, staff will come in [even] if they are not on shift. Everyone always gets an escort."

Staff also demonstrated their awareness of the importance of helping people to exercise as much choice and control over their own lives as possible. For example, one member of staff said, "[People] get up when they want to. [They] all get up at different times. Some like a lie in." Another member of staff told us, "When someone is on the toilet I ask if they want to be left. Some like you to wait with them [but] others like you to go."

The registered manager was aware of lay advocacy services in the local area. These services are independent of the service and the local authority and can support people to make and communicate their wishes. The registered manager told us that, although no one living in the home currently had the support of a lay advocate, she would not hesitate to help someone obtain one if this was required.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection of the home we identified concerns about the amount of stimulation being provided to people and told the provider that improvement was required. However, on this inspection we found no improvement had yet been made and the provider was still failing to respond to people's individual needs and preferences in this area.

As they had done on our previous inspection, people and their relatives told us of their dissatisfaction with the lack of stimulation and occupation provided in the home. For example, one person said, "There are no activities arranged at all." Another person told us, "I would like activities to keep the mind active." Another person commented, "I get bored … stuck indoors." One person's relative said, "There are not enough activities." Another relative said, "There are no external activities such as singers." Staff also expressed their concerns about the lack of stimulation and the impact this had on people's well-being. For example, one member of staff told us, "They come in and their heads just go down and down. Dementia drags them down [and] there is nothing to stimulate them and keep the bit of brain that is left." Another relatively new member of staff said, "People get bored. They just sit pretty much all day. We don't have activities as there are no staff to do it. The activities list is just a list. I've never seen anyone do activities. Never in seven months. People just sit, eat and watch TV."

Reflecting this feedback from people and staff, throughout both days of our inspection visit we saw many people sitting in lounges and other communal areas for long periods of time, staring into space with little or nothing to do. Other people spent their day pacing up and down the corridors of the home. There was no programme of organised activities or events and although there was a variety of games, puzzles and other resources stored in the library, during our inspection, we saw only one occasion when a member of staff used these to try and stimulate someone's interest. However, even this was a brief and unsuccessful intervention. Passing by someone who was sitting alone in the dining room, the member of staff picked up a book of word search puzzles and gave it the person. However they didn't give the person a pen to help them complete the puzzles and then left the room. Without support, the person quickly lost interest and left the room themselves.

We raised our concerns with the registered manager who acknowledged that there was no activities programme although she told us staff were encouraged to organise impromptu events whenever they had time. However, when we reviewed the 'client activity sheets' that had been completed for November 2016 we found only five recorded activities, an average of one every six days. The five recorded activities comprised a visit from an optician, the monthly church service hosted in the home by a local vicar, watching the national Remembrance Sunday commemoration event on television and two short one-to-one sessions which involved two individuals only. The registered manager told us that, about two weeks before our inspection, almost 18 months after we had first advised the provider of our concerns in this area, she had identified a member of staff to take a lead on activities. Talking of this recent recruitment, the registered manager said, "They were a care worker [but] could only offer 15 hours a week which is not a lot of time for care. [We] decided they should be the activities coordinator [but] the problem at the moment is they can't get used to being on activities. It's early days but hopefully they will be able to organise things they are good

at." Although the registered manager told us that "my passion is dementia" we saw that that this had not translated into practice within the home, as the continuing lack of stimulation and occupation for people living with dementia impacted negatively on their health and well-being.

We reviewed people's individual care plans and saw that they were detailed and addressed a range of needs including mobility, continence and skin care. Staff told us they found the care plans helpful in confirming the details of each person's core care needs. For example, one member of staff said, "The care plans are in the office and I look at them … for information I need. Dietary needs, allergies, family contact numbers." Another member of staff told us, "I do look at the care plans. They are very helpful. They state what we can do and can't do." One person's plan stated they had an allergy to cheese and we saw that this information was known to, and followed by, the kitchen staff. However, we found some plans were incomplete and lacked information about the person's life before they moved into the home. For example, in one person's plan we found that only four of the 26 sections of the provider's 'life history' document had been completed. The blank sections included 'where I went to school', 'where I worked' and 'my interests'. Another's person's life history was completely blank. This information would have given staff a deeper understanding of the person and their individual needs and preferences, particularly those living with dementia who were unable to articulate it for themselves. We had highlighted this gap in the care plans on our last inspection of the home and it was concerning that the provider was still failing to ensure this potentially important information was available to support staff in their work.

Even when people's individual preferences and interests had been detailed in their care plans we found that staff did not consistently use this information to support them in a responsive, person-centred way. For example, one person's plan stated, "I like to keep busy round the home and like to help with cleaning and laying tables. I get bored easily." However, when we reviewed the completed client activity sheets for the period from November 2016 to January 2017 we found only one occasion on which staff had recorded that they had supported the person to get involved in this way. The same person had signed a document to indicate that they wished to be involved in the monthly review of their care plan but there was no evidence of the person's involvement in any review.

The provider's continuing failure to ensure systems were in place to ensure the provision of appropriate person-centred care that met people's individual needs and preferences was a breach of Regulation 9(1)(a),(b) and (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Information on how raise a concern or complaint was provided in the information booklet that was given to people when they first moved into the home. However people and their relatives told us they had no reason to complain. One person said, "I haven't needed to make any complaint … they're very good here." Another person told us, "I have nothing to complain about." The registered manager told us that formal complaints were rare as she was well-known to people and their relatives and was able to resolve any issues informally. Describing one example of this approach she said, "Someone told me that their mum doesn't like showers in the afternoon so I put it in their notes [for staff to follow]." Any formal complaints that were received were investigated in accordance with the provider's policy.

Inadequate

Is the service well-led?

Our findings

When we conducted our last inspection of the home in August 2015 we found that the people did not receive a quality service as the provider's systems to assess, monitor and improve safety and to mitigate risks were not effective. This was a breach of Regulation 17(2)(a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In response to this breach, the provider told us that they would be making number of changes to promote service improvement, including the introduction of a new 'manager audit system'. However, on this inspection when we asked the registered manager to describe how this new system worked, she said, "I did have a system in place but I scrapped it." She told us that she did still conduct infection control and medication audits but, as highlighted elsewhere in this report, these were clearly ineffective in identifying and addressing risks to people's health and welfare. The infection control audit had failed to pick up the issues with the cleanliness of the home and the other cross-infection hazards we identified during our inspection. Similarly, the medication audit had not picked up the concerns we found with coding, stock control and the management of controlled drugs. Although the registered manager told us that senior staff conducted regular audits of care plans these had failed to detect the shortfalls in people's individual risk assessments and the gaps in care plans we identified. The registered manager also told us that there was no formal health and safety audit conducted in the home. This significant shortfall in the provider's quality monitoring systems meant that some of the concerns about the safety of the premises we picked up during our inspection had gone unnoticed by the provider. There was an annual survey of people, their relatives, staff and professionals involved with the home to measure satisfaction with the service provided. Although most of the feedback received in the most recent survey conducted in August 2016 was positive, senior staff had prepared an action plan to address concerns that had been expressed about the cleanliness of the home. The action plan stated that the provider would 'maintain a high level cleaning schedule'. However, in the light of extensive high level cobwebs we identified during our inspection visit, it was clear that the provider had failed to ensure this action plan was implemented effectively.

As highlighted throughout this report, the provider had also failed to respond effectively to many of the issues that had been identified for improvement following our last inspection of the home. The management of people's medicines was still not safe; staffing levels were still insufficient to support and supervise people safely and effectively, people's rights under the MCA were still not consistently protected; staff were still failing promote people's dignity and respect; people continued to receive insufficient stimulation; life histories were still missing from some people's care plans and quality monitoring systems remained limited and ineffective. Reflecting the failure to make the improvements we had identified as being necessary, the provider was now in breach of six regulations of the Health and Social Care Act 2008. Far from improving, in the 17 months since our last inspection, the quality of the service had deteriorated and people were not receiving the safe, effective, responsive and caring service they were entitled to expect.

Taken together, the provider's failure to establish systems and processes to mitigate risks relating to people's health, safety and welfare and to assess, monitor and improve the quality of the service provided and was a continuing breach of Regulation 17(2)(a) and (b) of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

In preparing for our inspection, we reviewed the notifications (events which happened in the home that the provider is required to tell us about) we had received from the provider. We noted that, since the home was first registered with CQC in 2010, we had received no notifications about allegations of abuse relating to people living in the home. During this time there had been several such allegations which had been considered by the local authority under its adult safeguarding procedures and which should have been notified to CQC by the provider, as required by the law. Similarly, no notification of a serious injury sustained by someone living in the home had ever been submitted by the provider in the seven years since the home was registered. When we queried the absence of serious injuries notifications with the registered manager, she initially told us that there had been no notifiable injuries in this time. However, she subsequently confirmed that there had been several serious injuries sustained by people living in the home, including three fractured bones. These had not been notified to CQC, again as required by the law.

The provider's failure to notify CQC of these incidents was a breach of Regulation 18(2)(a) and (e) and of the Care Quality Commission (Registration) Regulations 2009.

Staff told us they worked together in a friendly and mutually supportive way. One member of staff said, "I enjoy working here. We work as a team." Another member of staff told us, "We all get on well. The atmosphere is quite happy." Team meetings and shift handover meetings were used to promote coordinated teamwork and effective communication although some staff told us that they would like attendance at the handover meetings to be expanded to include all staff working on shift at the time, not just the senior staff. One member of staff said, "We should go into the office for handover to ensure everyone is aware of everything. [At the moment] we don't find out sometimes."

The registered manager told us she had an 'open door' policy and was clearly well known to everyone connected to the home. People and their relatives told us that they found her approachable and responsive. For example, one relative told us that they had recently spoken to the registered manager and found her receptive to their offer to invite a befriending service to start visiting the home. However, staff had mixed views about the leadership the registered manager provided to her team, although all were very clear that she was kind and caring in her approach to the people who lived in the home. One member of staff said, "[The registered manager] is lovely. Always there for you. I feel listened to if I raise any issues." However, another member of staff told us, "[The registered manager] could do better. She could listen a lot more. She can be a little unapproachable. [But] she is fantastic with the residents."

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 provider's failure to notify us of issues relating to the safety and welfare of people living in the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider's continuing failure to ensure systems were in place to ensure the provision of appropriate person-centred care that met people's individual needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider's continuing failure to ensure people's dignity and privacy were promoted and maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider's continuing failure to ensure staff acted in accordance with the requirements of the Mental Capacity Act 2005.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider's failure to properly assess and mitigate risks to people's safety.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider's continuing failure to deploy sufficient staff to meet people's individual needs and to ensure their safety.

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's continuing failure to establish systems and processes to mitigate risks relating to people's health, safety and welfare and to assess, monitor and improve the quality of the service provided.

The enforcement action we took:

Warning Notice regarding the continuing failure to establish systems to mitigate risks relating to people's health, safety and welfare and to monitor and improve service quality.