Kesh-Care Limited

# The Old Hall Residential Care Home

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

The Old Hall Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. The home is registered to provide accommodation for up to 25 people, including older people and people living with dementia.

We carried out a first comprehensive inspection of the home in August 2015. At this inspection we found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (HCSA). This was because there were shortfalls in the monitoring of service delivery. We rated the service as Requires Improvement.

In January 2017 we undertook a second comprehensive inspection. We found the quality of service had deteriorated and people were not receiving the safe, effective, responsive and caring service they were entitled to expect. We found six breaches of the HSCA. This was because the registered 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 registered provider had failed to establish systems and processes 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 registered provider had failed to notify us of issues relating to the safety and welfare of people living in the home. Following our inspection, we issued a Warning Notice requiring the registered provider to be compliant with the requirements of the HSCA Regulation 17 – Good governance by 31 July 2017. The rating of the service remained as Requires Improvement.

We conducted this third comprehensive inspection of the home on 5 and 7 December 2017. The inspection was unannounced. There were 25 people living in the home on the first day of our inspection.

At this inspection we found the registered provider had not achieved compliance with our Warning Notice and was in continuing breach of four of the seven breaches of regulations identified at our previous inspection. This was because the registered provider was still failing to properly assess and mitigate risks to people's safety; to respond effectively to people's need for greater mental and physical stimulation; to notify us of significant incidents and to assess, monitor and improve the quality of the service. We also found one further breach of the HSCA. This was because of the registered provider's continuing failure to ensure all staff had the training and supervision necessary to support people safely and effectively. In areas including medicines management, the provision of mental and physical stimulation and organisational governance the registered provider had failed to secure the necessary improvement for three consecutive inspections.

The overall rating for the home is 'Inadequate' and the home is therefore in 'Special Measures'.

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 details of the action we have taken at the back of the full version of this report.

In some areas the registered provider was meeting people's needs.

Staffing levels had been increased and were sufficient to meet people's care and support needs; action had been taken to improve the promotion of rights to privacy and dignity and staff reflected the requirements of the Mental Capacity Act 2005 in their practice. Although further work was required in each of these areas, legal requirements were now met.

Staff worked well together in a mutually supportive way and communicated effectively, internally and externally. Staff knew people as individuals and supported them to have choice and control over their lives. Staff were kind and considerate in their approach and provided end of life care in a sensitive way. People were provided with food and drink of good quality which met their individual needs and preferences. The provider maintained a rolling programme of refurbishment.

Care plans were well-organised and provided staff with guidance on how to meet people's individual care needs and preferences. Staff worked closely with local health and social care services whenever this was required. Staff knew how to recognise and report any concerns to keep people safe from harm. Any concerns and complaints were managed effectively. There was evidence of some organisational learning from significant incidents and events.

The home had a registered manager in post. A registered manager is a person who has registered with 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.

The registered manager had a hands-on style and was liked by everyone connected with the home. However, some people expressed concerns about the way the service was managed under her leadership.

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 been granted a DoLS authorisation for one person living in the home and was waiting for a further two applications 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?

**Inadequate**

The service was not safe.

Some aspects of the premises remained unsafe.

Systems to prevent and control infection remained ineffective and unsafe.

Some people's medicines were still not managed safely.

There were sufficient staff to meet people's care needs.

Staff knew how to recognise and report any concerns to keep people safe from harm.

There was some evidence of organisational learning from significant incidents.

### Is the service effective?

**Requires Improvement**

The service was not consistently effective.

Staff were still not receiving training and supervision in line with the provider's policy requirements.

Staff reflected the requirements of the Mental Capacity Act 2005 in their practice.

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.

The provider had taken steps to promote people's privacy and dignity but further action was required to ensure a fully consistent approach.

Staff were kind and caring in their approach.

Staff encouraged people to maintain their independence and to exercise choice and control over their lives.

## Is the service responsive?

**Inadequate**

The service was not responsive.

People still did not receive sufficient physical and mental stimulation.

People's individual care plans were well-organised and kept under regular review by senior staff.

Staff provided compassionate care for people at the end of their life.

People were confident that the provider would respond effectively to any concerns or complaints.

## Is the service well-led?

**Inadequate**

The service was not well-led.

The provider had failed to comply with the requirements of the Warning Notice issued following our previous inspection of the home.

The provider had failed to take effective action to address many of the areas for improvement highlighted at previous inspections.

The registered manager was liked by everyone connected with the home. However, some people expressed concerns about the way the service was managed under her leadership.

Staff worked well together in a mutually supportive way and communicated effectively, internally and externally.

# 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 5 and 7 December 2017. On the first day our 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.

In preparation for our visit we 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 contracting and safeguarding teams.

During our inspection 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 eight people who lived in the home, three visiting family members, the registered manager, the deputy manager, the cook, three members of the care staff team and two health and social professionals who were visiting the home at the time of our inspection.

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

Inadequate

# Is the service safe?

## Our findings

On our first full inspection of the home in August 2015 we identified concerns with the management of some people's medicines and told the provider that improvement was required.

On our next inspection of the home in January 2017 we identified continuing concerns with medicines management and a number of additional safety concerns relating to cleanliness and infection control; premises and equipment; individual risk assessment and staff recruitment. Reflecting these multiple shortfalls, we found the provider to be in breach of Regulation 12 of the Health and Social Care Act 2008 (HSCA) due to a failure to properly assess and mitigate risks to people's safety. Following our inspection, the provider wrote to us and told us that immediate steps would be taken to address the breach of regulations. However, on our inspection of 5 and 7 December 2017, we were concerned to find that the provider had failed to take effective action to address all of the risks to people's safety and welfare highlighted at our previous two inspections.

When we reviewed the storage, administration and disposal of people's medicines we found, for the third consecutive inspection, the provider was failing to manage people's medicines in line with good practice and national guidance. For example, although we had highlighted it as a specific concern at our last inspection, we found that 'controlled drugs' (medicines which are subject to special storage requirements) were still accessible to staff who were not trained or authorised to handle medicines. We also found that senior staff were routinely signing people's medicine administration sheets to record that their prescription creams had been applied, despite the fact that the administration of these creams was undertaken by care staff and had not been witnessed by the senior staff member who had signed the record. The medicines fridge was kept in the hairdressing salon, a room that was unlocked and readily accessible to people living in the home, visitors and staff. On the first day of our inspection we were concerned to find the fridge was unlocked, despite the fact that it was being used to store powerful prescription medicines which had the potential to cause significant harm if not administered correctly. Additionally, staff told us that the monthly delivery of new medicines was sometimes kept under a desk in the manager's office for several days before being transferred to the medicines storage cupboard. There were no medicines stored in this way at the time of our inspection. However, we noted that the manager's office was often left unoccupied and unlocked, creating an increased risk, if medicines were stored in this room, that they could be accessed inappropriately.

In response to our last inspection the provider had introduced a revised cleaning schedule and laid new floor coverings in some of the toilets and bathrooms to make them easier to keep clean and reduce the risk of cross-contamination. However, despite these changes, the provider's approach to infection prevention and control remained ineffective and unsafe, creating an enhanced risk to people's health and welfare. For example, on the first day of our inspection we saw that both the hand towel and hand sanitizer dispensers in one person's ensuite toilet were empty, increasing the risk of poor hand hygiene by staff who provided the person with personal care. Similarly, on the second day of our inspection, we found no hand towels in two of the communal toilets in the home, both of which we were advised were used primarily by staff. This was despite a 'How to Handwash' poster in one of the toilets which stated, 'Dry hands thoroughly with single use

towel'. Furthermore, although soiled laundry was placed in special red bags which were washed separately, there were no bins in people's rooms to store the red bags securely. One member of staff told us that the red bags were left on the floor in people's rooms before they were removed to the laundry, increasing the risk of cross-infection should they leak or be trodden on. Additionally, the laundry basket used to collect the red bags from people's rooms was also used, at other times, to collect general laundry, creating a further cross-infection risk. We reviewed the record of staff training and saw that for over 25% of staff there was no record of them ever having received training in infection control, despite this having been identified as mandatory by the provider. Additionally, no infection control training was recorded as having been provided to staff since our last inspection, despite the concerns we identified in this area at that time.

Following our last inspection, the provider had taken steps to address some of the safety concerns we had identified in relation to premises and equipment. For example, the heating and hot water systems had been repaired and safety barriers had been installed on one of the patios. However, the provider had failed to address all of the potential risks to people's safety we had highlighted at our last inspection. Although the cracked paving stones on the footpath at the front of the home had been repaired, the unprotected raised edge remained. This presented a continuing risk to people using the path, whether on foot or in a wheelchair. This was compounded by the fact that part of the path was unlit, increasing the risk of an accident during the hours of darkness. Similarly, the provider had installed a gate at the foot of the main internal stairway, replacing the heavy wooden bar we had identified as a concern on our last visit. However, a similar bar remained in place at the top of the stairway. The bar provided only very limited protection against the risk of someone accessing the stairs without staffing support and, because it could be easily removed, presented an additional risk of injury. Discussing this issue, one member of staff commented, "[The bar] was just left there. I thought they would get a gate put here [as well as at the bottom of the stairs]. It's precarious."

Taken together, the provider's ongoing failure to implement effective systems to manage people's medicines safely, minimise the risk of infection and make the premises safe for people to use was a continuing breach of Regulation 12 of the HSCA.

More positively, since our last inspection we found the provider had taken action to improve the safety of staff recruitment. We reviewed staff personnel files and saw that references had been obtained. Disclosure and Barring Service (DBS) checks had also been carried out to ensure that the provider had employed people who were suitable to work with the people who lived in the home.

When we looked at people's care records we found that the provider had also taken action to ensure potential risks to people's safety and wellbeing had been considered and assessed. For example, one person had been identified as being at risk of developing pressure sores. Specialist equipment had been obtained and instructions given to staff detailing the actions they were to take to address the risk. The deputy manager reviewed and updated people's risk assessments on a monthly basis to take account of any changes in their needs.

On our January 2017 inspection we found the provider was in breach of Regulation 18(1) of the HCSA due to a continuing failure to deploy sufficient staff to meet people's individual needs and to ensure their safety. On this inspection, most people we spoke with told us that the provider employed sufficient staff to meet their care needs without rushing. For example, talking about the way staff provided personal care, one person told us, "The staff … never hurry or flurry." Another person's relative said, "The staff …. take their time." Commenting on the response to call bells, another person said, "I think the staff respond ok to the buzzers." Following our last inspection, the provider had taken action to increase staffing levels on the afternoon shift to ensure more support was available to people at the busy tea time period. Commenting positively on this

change, one member of staff told us, "One on teas and two on the floor [makes it] a lot easier." Another staff member said, "Three on [at] tea time makes all the difference." The registered manager told us she continued to keep care staffing levels under regular review and was currently seeking to recruit another part-time member of staff to provide additional support at lunchtime.

In the light of the increase in care staffing levels and people's generally positive feedback we were satisfied that that the provider had taken sufficient action to address the breach of Regulation 18(1).

Since our last inspection, most staff had received training in safeguarding procedures. Reflecting this training, the staff we spoke with were aware of how to report any concerns relating to people's welfare, including how to contact the local authority or CQC, should this ever be necessary. In response to feedback from our inspector, the registered manager added advice on how to contact these external agencies to the information pack given to people when they first moved into the home.

The provider maintained a log of accidents and incidents which had occurred in the home. In some cases there was evidence that senior staff had reviewed what had happened to identify if there were any lessons that could be learned to reduce the risk of something similar happening in the future. However, this approach had not been followed consistently in every case and, for the future, the registered manager agreed to strengthen and extend this process of organisational learning to include all significant incidents and events in the home.

Requires Improvement

# Is the service effective?

## Our findings

On our last inspection of the home in January 2017 we identified shortfalls in the provision of staff induction and training and told the provider that improvement was required. However, on this inspection we found that the provider was still failing to ensure that all staff had the necessary skills and knowledge to support people safely and effectively.

On our January 2017 inspection we identified that new employees were not receiving moving and handling training as a core part of the provider's induction training, increasing the risk that people might not be supported safely in line with best practice. On this inspection, we reviewed the provider's 'new employee induction form' and saw that there was still no requirement to complete this important training as part of the induction process. Reflecting this continuing omission, we found that one new recruit had only received formal moving and handling training nine months after she had started working in the home. Discussing the provider's approach to her induction, this member of staff told us, "Even though I'd been shown moving and handling [techniques] I wanted the training. I'm glad I've [now] done it. [It's] obviously very important." Acknowledging the delay in providing moving and handling training to this individual, the deputy manager told our inspector, "You're right. The training was very late."

On our last inspection we also identified significant backlogs in the provision of some of the training the provider had identified as mandatory for all staff. On this inspection the registered manager told us she had organised a variety of training courses in recent months and that mandatory training was now "mostly up to date". However when we reviewed the record of staff training maintained by the registered manager (the 'training matrix'), we saw that mandatory training was still far from up to date, with worrying gaps in a number of areas. For example, for over 25% of staff there was no record that they had ever received health and safety training and for 43% of staff there was no record of them receiving fire safety training. The gaps for first aid and food hygiene training were 48% and 43% respectively and, as noted elsewhere in this report, there was also a significant gap in infection control training. Over 50% of staff had no record of having received training in dementia awareness and for 81% there was no record of them having received training in end of life care. This was despite a written assurance in the information booklet given to people when they first moved into the home that, 'All staff have … extensive training in dementia and End of Life care'. We were also concerned that staff appeared unaware of the specific training that was required for their role. For example, one member of staff told us, "I've done all of my mandatory training." However, there was no record of this person having completed training in infection control, fire safety, first aid, dementia awareness, the Mental Capacity Act, end of life care or equality and diversity. All of which were courses specified as mandatory on the provider's training matrix.

On our last inspection we also identified shortfalls in the provision of staff supervision. This increased the risk that people would not receive safe, effective care and we told the provider that improvement was required. On this inspection we noted that the provider's 'personal supervision' policy still 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, when we reviewed the provider's record of staff

supervisions in 2017 we saw that supervision was still not being provided six times a year in accordance with the provider's policy requirement. With only three weeks left until the end of the year, the record indicated that less than 10% of staff had received six supervisions in 2017. Some had received only two supervisions in that period and the average number per employee was three, half the number specified by the provider. Commenting on the lack of regular supervision, one staff member told us, "[My last supervision was] six or seven months ago. I am not sure of the frequency [and] there is nothing booked."

Taken together, the ongoing failure to ensure staff received training and supervision in line with the provider's own policy requirements was a breach of Regulation 18(2) of the HSCA.

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, we identified a continuing failure to ensure staff acted in accordance with the requirements of the MCA and found the provider in breach of Regulation 11 of the HSCA. Following our inspection, the provider wrote to us and told us that immediate steps would be taken to address the shortfalls identified. On this inspection, we were pleased to find that the provider had taken sufficient action to address the breach of Regulation 11.

Since our last inspection, most staff had received training in the MCA. Reflecting this training, staff had an understanding of the Act and understood the importance of obtaining consent before providing care or support. For example, describing their approach in this area, one staff member said, "People have a right to have a choice. You can't force them [to do things]. I couldn't put my head down to sleep [at night] if we forced people."

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 been granted a DoLS authorisation for one person living in the home and was waiting for a further two applications to be assessed by the local authority.

Senior staff made use of best interests decision-making processes to support people who had lost capacity to make some significant decisions for themselves. For example, one person had lost the capacity to give consent to aspects of their personal care and the deputy manager had taken a decision to continue to provide this support and documented it in the person's care record. Talking about her improved knowledge of the requirements of the MCA, the deputy manager told us, "I had the training as well. I used to find [it] confusing [but] now I have a better understanding." Although we were satisfied that people's rights under the MCA were properly protected, the registered manager agreed to amend the documentation used to record best interests decisions to make it clear exactly what decisions were in place for each person.

Staff had access to a range of publications and other information sources to help them keep up to date with any changes to good practice and legislative requirements. For example, senior staff responsible for administering people's medicines had access to recent guidance on the use of medicines guidance in care homes. The registered manager also received regular updates from an employment law specialist which she said she found helpful in maintaining her knowledge in this area.

People told us they were satisfied with the food and drink provided in the home. For example, one person said, "You can have a good meal. There's always two choices at lunchtime and there are sandwiches at teatime." People had the choice of a cooked or continental breakfast. Discussing one person's regular breakfast request, the cook told us, "What they want they can have. [Name] has eggs and bacon." At lunchtime, people had a choice of two main course options, although alternatives were available if requested. Discussing the additional options she could provide, the cook told us, "I can do fishcakes, fish fingers. I sometimes do egg on toast. One person [sometimes] has vegetables with cheese on top. She doesn't like meat." The cook also told us that she baked homemade cakes and puddings on a daily basis. On the morning of the first day of our inspection she said, "I am baking jam roly poly today. Nothing is brought in. I make them all."

The cook had access to a comprehensive 'resident food profiles' folder which detailed people's individual nutritional preferences and requirements and which she used to guide her menu planning and meal preparation. For example, one person's profile read, '[Name] dislikes …onions, leeks [and] kippers." Another person's stated that they liked tea without sugar and wanted a jug of juice to be placed in their bedroom every day. The cook was aware that one person was allergic to cheese and that another person who had recently moved into the home was living with diabetes. Talking of this person, the cook told us, "I am waiting for some diabetic jam to make her some jam tarts."

From talking to people and looking at their care records, we could see that their healthcare needs were monitored and supported through the involvement of a broad range of professionals including GPs, district nurses and therapists. Talking of the support they received from care staff and external professionals, one person told us, "I feel well cared for." Another person's relative said, "The care is consistent." Commenting positively on their relationship with the care staff, a visiting healthcare professional told us, "They are proactive in getting in touch [and] certainly follow my advice. I have not come across any issues."

Staff from the various departments within the home also worked well together to ensure the delivery of effective care and support. For example, describing her relationship with the cook, one member of the care staff told us, "Just today for example. [I could see] you were keeping the cook busy [interviewing her as part of the inspection]. So I did two breakfasts so that people didn't have to wait. I think we make a good team." Another member of staff said, "We all communicate well. Everything that needs to be done gets done. We all work well as a team."

Since our last inspection, the provider had made some improvements to the physical environment and equipment in the home to ensure they remained suitable for people's needs. For example, new carpets and windows had been installed in the dining room and an adjoining bedroom. Tablecloths had been replaced and an additional hoist purchased. The provider had prepared a schedule for further improvements to be completed in 2018 which included the redecoration of several communal areas of the home.

Requires Improvement

# Is the service caring?

## Our findings

On our last inspection of the home in January 2017 we identified a continuing failure to promote and maintain people's privacy and dignity and found the provider in breach of Regulation 10 of the HSCA. Following our inspection, the provider wrote to us and told us that immediate steps would be taken to address the shortfalls identified. On this inspection, we found that the provider had taken sufficient steps to address the breach of Regulation 10, although further action was required to ensure a fully consistent approach in this area.

In contrast to our previous inspection, people told us that staff respected their right to privacy in their bedroom. For example, one person said, "The staff are all courteous and polite and knock before entering. Always." Describing their approach, one member of staff told us, "I always knock. My colleagues knock. Sometimes if I go in with a tray, I say 'knock, knock'!" Bedroom doors were lockable and the deputy manager told us that one person had asked for a key which had been provided. To safeguard the confidentiality of people's personal information, computers were password protected and the provider had provided staff with guidance on their use of social media platforms. People's individual care plans were stored in an office which opened onto the main corridor of the home. However, this office was frequently left unlocked and unattended which meant people's private information could be accessed by people and visitors passing in the corridor. We raised this concern with the registered manager who told us she would take steps to ensure people's care plans were stored more securely in the future.

Again, in contrast to our previous inspection, we observed that, with one isolated exception, staff no longer used the undignified term "feeds" to describe people who needed support to eat. Describing the change in this area, one member of staff told us, "When I first started, the word [we used] was 'feeds'. Now we get in trouble if that word is said." We saw that people were also supported in a more dignified way at lunchtime. For example, people who required staff assistance to eat were now provided with one-to-one support rather than the one-to-two support we had observed on our previous inspection. However, as described in the Responsive section of this report, at other times of day the pressures on care staff to meet people's physical support needs meant they often lacked time to sit and talk with people for meaningful periods and meet their needs for emotional support.

People told us that staff were caring and kind in their approach. For example one person said, "The girls are lovely. No problem there." Another person said, "They are all kind to me." Reflecting this feedback, during our inspection we saw individual members of staff supporting people in kind and thoughtful ways. For example, we observed a member of staff had removed a decorative Christmas snowman from outside the front door and placed it inside, in one of communal corridors instead. Explaining her actions the staff member told us, "I brought it in because one of the residents said he [the snowman] was too cold outside." Discussing her approach to helping people celebrate their birthday, the cook said, "I make different birthday cakes. Chocolate, plain [depending on people's preference]. I decorate them up. I call it tipperating. Candles and flowers. But not [flowers] for the men. I bring in Smarties and Maltesers for them."

Staff also understood the importance of promoting choice and independence and reflected this in the way

they delivered people's care and support. For example, one person told us, "I had a bath last night. I can have a bath any time." At lunchtime on the first day of our inspection, one person said that she would prefer to have her medicines after her meal. This choice was accepted readily by the member of staff who was administering medicines. Describing their approach to encouraging people to exercise as much choice and control as possible, including those who had lost the capacity to make some decisions for themselves, one member of staff said, "[Name will] never say yes or no [when choosing what to eat]. If I can't get her to make a choice I will offer a little bit of everything. That's a kind of choice." Later that day we saw the member of staff supporting this person to have lunch. As the staff member had described, the person was unable to indicate her choice of dessert so she escorted her to the sweet trolley to have a look at them all. The staff member put a little of each of the desserts on a plate saying, "There you are my darling. You can have a little bit of everything."

Senior staff were aware of the role of lay advocacy services and the deputy manager told us that one person living in the home currently had the support of a local service. Lay advocacy services are independent of the service and the local authority and can support people to make decisions and communicate their wishes.

Inadequate

# Is the service responsive?

## Our findings

On our first full inspection of the home in August 2015 we identified concerns about the amount of stimulation being provided to people living in the home and told the provider that improvement was required. On our next inspection of the home in January 2017, no improvement had been made and we found the provider to be in breach of Regulation 9 of the HSCA due to the continuing failure to meet people's individual needs and preferences in this area. Following that inspection, the provider wrote to us and told us that immediate steps would be taken to address the breach of regulations. However, on our inspection of 5 and 7 December 2017, we were concerned to find that the provider had failed to take any effective action to address the shortfalls highlighted in our previous two inspections.

For the third consecutive inspection people told us of their concern and frustration at the continuing lack of mental and physical stimulation provided in the home. One person said, "There's absolutely nothing to do." Another person said, "We don't do anything here really. It would be nice though. I do get fed up with sitting around." Another person told us, "There's nothing to do. They put the residents in the front [hall] and leave them until the next mealtime. It's really no life at all sitting …all day long. There's no stimulation. It's just very frustrating." Another person said, "They could do a lot more really. It would be nice to get out a bit. To the shops and that." Commenting on the lack of activities and other forms of stimulation, one staff member said, "I would like the entertainment side of things [to be] better. It would send me insane sitting every day with nothing to do." Another member of staff said, "The residents haven't got enough to do. I have been here three years and not seen anything different." Describing the negative impact on the health and well-being of the people living in the home, another member of staff told us, "Activities. That's the thing that lets [the home] down. People are unsettled [as] they [are] not stimulated enough. Especially if they've got dementia. They sit out all day, every day. They've got to a stage that they don't want to do anything as that's what they are used to. It's very hard to engage with [some people]. They have become institutionalised."

Reflecting this feedback during both days of our inspection, exactly as we had done on our previous inspection, 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. As they had done previously, one person spent much of their day pacing up and down the corridors of the home. A 'Daily Activities Board' was on display in the dining room, unchanged since our last inspection. It detailed a varied programme of communal activities and events including gardening, arts and crafts, film club, wartime nostalgia, keep fit to music and karaoke. However, at no point on either day of our inspection did we see these, or any other activities, take place. Talking about the daily activities board, one member of staff said, "I've never seen it used."

Following our last inspection, the provider told us an activities coordinator would be appointed to take the lead in the facilitation of activities and other forms of physical and mental stimulation for the people living in the home. The registered manager told us that someone had been identified to take on this role. However, they had not yet commenced their employment, almost a year since we had been assured that recruitment to this post was in hand. In the meantime, the registered manager told us "We are all filling in with activities until the person starts." However, the care staff we spoke with told us that they did not have time to facilitate activities or interact socially with the people living in the home, other than when providing personal care or

other forms of direct support. For example, one member of the care staff team said, "The activities list is never used. As carers we feel pressed to make time for them personally. We sit and try to talk to them as much as we can. But [we have to do] everything else. It's very difficult." One person told us, "The staff just don't have the time to sit and talk to me like I would like. There's no stimulation at all." Reflecting this feedback, when we reviewed the 'client activity sheets' that staff had completed in the three months prior to our inspection we found only 11 recorded activities, an average of one every six days and exactly the same frequency we had identified at our previous inspection, some 10 months earlier.

Over two years since we had first highlighted our concerns in this area, the provider's ongoing failure to respond effectively to people's need for greater mental and physical stimulation was a continuing breach of Regulation 9 of the HCSA.

More positively, since our last inspection the provider had taken action to review and update people's individual care plans. We reviewed people's care plans and saw that they were well-organised and provided staff with guidance on how to respond to each person's care requirements and preferences. For example, the plan of one person who lacked the ability to communicate verbally advised staff that if they became agitated this usually meant that they wanted to use the toilet. Another person's plan stated that they would like staff to ensure that the water jug in their bedroom was always kept topped up. Staff told us that they found the care plans useful, particularly when somebody first moved into the home. One member of staff said, "The care plans are helpful. You can find out about [a person's] history, any allergies, likes and dislikes. If something changes we report it [to senior staff]. It helps [when they] review the care plan." The deputy manager reviewed each person's plan on a monthly basis to make sure it remained up to date. Many of the people living in the home were funded by a local authority and the deputy manager told us that these people were invited to participate in an annual review of their care plan, organised by their social worker. For the future, the registered manager and the deputy manager agreed to extend this process of annual review to people who were not in receipt of local authority funding.

Staff understood people's individual needs and preferences and reflected this in their practice. For example, talking about some of the people they supported, one member of staff said, "[Name] likes the crusts off her sandwiches. And [name of another person] doesn't like watching TV." Despite their lack of training detailed elsewhere in this report, this person-centred approach was also reflected in the way staff supported people at the end of their life. Describing her approach in these difficult situations, one staff member told us, "I try to have a warm heart [and] give them all the comfort possible." The registered manager told us that she had good links with the local Marie Curie and Macmillan nursing teams. She also stressed the importance of providing support to family members telling us, "I invite them to come in and stay overnight [if they wish]. We can put a [temporary] bed in the person's room [as] they wouldn't want to leave them. If there is no family, I sit with them to the very end. [At] weekends and in the middle of the night. It doesn't make any difference. If [they] have no one to sit with them, I do."

People we spoke with knew how to raise concerns or complaints and were confident they would be addressed promptly by the provider. The registered manager told us that formal complaints were rare as she spent time with people and their relatives and was often able to resolve issues informally. Confirming this approach, one person's relative told us, "Any niggles I have had have been dealt with efficiently and effectively." The registered manager kept a record of any formal complaints that were received and ensured these were managed correctly in accordance with the provider's policy.

Inadequate

# Is the service well-led?

## Our findings

On our last inspection in January 2017 we identified that we had not been notified of significant issues relating to people living in the home that the provider is required by law to tell us about. As a result, we found the provider to be breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. Following this inspection, the provider wrote to us and told us that immediate steps would be taken to ensure all notifications were submitted as required. At this time, the provider also told us that if senior staff were unsure if an issue was notifiable or not, they would seek advice from their CQC inspector.

On our inspection of 5 and 7 December 2017, we were therefore disappointed to find that the provider had failed to inform us of two significant incidents that had occurred since our last inspection, both of which were required to be notified under Regulation 18. A person had sustained a serious injury requiring hospital treatment and the lift which serviced the first floor bedrooms had been out of action for several days. On neither occasion had senior staff contacted CQC to clarify whether a notification was required.

The provider's ongoing failure to submit notifications as required by law was a continuing breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

On our last inspection of the home we were also disappointed to find that the provider had failed to make any of the improvements identified as necessary at the first full inspection of the home in August 2015. In the 17 months between these two inspections the quality of the service had deteriorated and people were not receiving the safe, effective, responsive and caring service they were entitled to expect. Reflecting this shortfall in organisational governance we found the provider to be in continuing breach of Regulation 17 of the HCSA, due to an ongoing 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. Following our inspection we issued a Warning Notice requiring the provider to be compliant with this regulation by 31 July 2017.

On our inspection of 5 and 7 December 2017, we were extremely disappointed to find that the provider had failed to achieve compliance with our Warning Notice. As detailed elsewhere in this report, the provider had taken insufficient action to deliver the improvements required in medicines management; the safety of the premises; infection prevention and control; staff training and supervision; the provision of mental and physical stimulation to meet people's needs and the notification of significant issues. Some improvements had been made in respect of staffing; compliance with the MCA and the promotion of people's privacy and dignity. However, the provider remained in continuing breach of three regulations and was newly in breach of another. In areas including medicines management and the provision of mental and physical stimulation, the provider had failed to secure the necessary improvement for three consecutive inspections.

In response to our last inspection, the provider had reviewed the approach to auditing and monitoring of service quality in the home. Although a more comprehensive suite of audits was now in place, this was still not consistently effective and, for the third inspection in a row, improvement was required. For example, although monthly medicines and infection control audits were conducted by senior staff, they had failed to

pick up some of the issues relating to the prevention of infection and the management of people's medicines identified on our inspection. Similarly, monthly internal and external environmental safety audits were conducted but these had not picked up the ongoing safety hazards detailed elsewhere in this report. The provider conducted an annual customer survey to seek feedback from the people living in the home, relatives and professionals about their experience of living in or visiting the home. However, no survey of people and their relatives had been undertaken in 2017 meaning an important opportunity to gain people's views about the quality of the service had been missed. Acknowledging this shortfall, the registered manager said, "It's yearly [but] I have still got to do the questions. We've got professionals [but] I am a bit late in sending out resident and family [questionnaires]." Although senior staff organised regular meetings with the people living in the home, the registered manager was unable to provide any examples of when action had been taken in response to people's feedback at these meetings.

Taken together, the provider's persistent failure to effectively assess, monitor and improve the quality of the service provided and to mitigate risks relating to people's health, safety and welfare was a continuing breach of Regulation 17 of the HCSA.

The registered manager had been in post for many years and was clearly liked by everyone connected with the home. For example, describing her relationship with the registered manager one member of staff said, "I like her. She's funny." Another staff member told us, "[The registered manager is nice. [She is] approachable [and] if I ask for help [she] comes." Describing her hands-on style, the registered manager told us, "I don't want [people] to think I am stuck in an office all day. If I am passing a bell and it is ringing I will knock and ask if I can help you. When you work in a care home it doesn't matter what position you have. If a job needs doing, it needs doing." However, despite their personal fondness for the registered manager, some of the people we spoke with expressed concerns about the way the home was managed under her leadership. For example, one person said, "Sometimes the leadership leaves a lot to be desired. We need a motivator to organise things." Expressing their frustration at the continuing shortfalls in the provision of activities and other forms of stimulation described elsewhere in this report, one member of staff told us, "I think it is recognised by [the registered manager] that we need an activities coordinator. Putting it into action is the issue. Not just with that, most things. It's very difficult to get her to change." Describing the provision of plastic aprons, paper towels and other personal protective equipment required for the safe provision of people's personal care, another member of staff said, "[No one] is allocated to [ensure supplies of ] hand towels, gloves and red bags [are topped up]. I don't think it was done today. It .. needs more organisation. It would be better if someone gave more direction." Talking to us about her knowledge of the HSCA regulations she was required by law to comply with, the registered manager said, "I should be aware of the regulations. [I have] downloaded [them].12 pages. [But] I've not read them yet." Similarly, discussing the failure to notify us about the inoperative lift, the registered manager told us, "I don't know what the regulation is."

Despite their frustrations with some aspects of the administration of the home, staff told us they worked together in a well-coordinated and mutually supportive way. For example, one staff member told us, "It's a good place to work. My second home. [We've got] a good team. [It's a] very good atmosphere." Team meetings, communication logs and shift handover sessions were used to facilitate internal communication. Commenting positively on their experience of attending staff meetings, one member of staff said, "[We meet] with [the registered manager and her deputy]. We put things on the table and talk about them. I can talk freely." Systems were also in place to ensure effective external communication with people's relatives and the professionals involved in their care. For example, we saw a written comment from a local healthcare professional which stated, "Staff are polite [and] professional. I am always made to feel welcome." Describing the staff team's proactive approach to communication, a relative told us, "They keep me well-informed."

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<br><br>The provider's ongoing failure to notify CQC of significant incidents. |

**The enforcement action we took:**

We issued a Fixed Penalty Notice in the sum of £1250.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>The provider's ongoing failure to respond effectively to people's need for greater mental and physical stimulation. |

**The enforcement action we took:**

We imposed an additional condition on the provider's registration to prevent the admission of any service user to The Old Hall Residential Care Home without the prior written agreement of the Care Quality Commission.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider's ongoing failure to implement effective systems to manage people's medicines safely, minimise the risk of infection and make the premises safe for people to use. |

**The enforcement action we took:**

We imposed an additional condition on the provider's registration to prevent the admission of any service user to The Old Hall Residential Care Home without the prior written agreement of the Care Quality Commission.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider's persistent failure to effectively assess, monitor and improve the quality of the |

service provided and to mitigate risks relating to people's health, safety and welfare.

**The enforcement action we took:**

We imposed an additional condition on the provider's registration to prevent the admission of any service user to The Old Hall Residential Care Home without the prior written agreement of the Care Quality Commission.

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The provider's ongoing failure to ensure staff received training and supervision in line with the provider's own policy requirements. |

**The enforcement action we took:**

We imposed an additional condition on the provider's registration to prevent the admission of any service user to The Old Hall Residential Care Home without the prior written agreement of the Care Quality Commission.