Care Quality Commission

Lancam Nursing Care Limited

Lancam Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires improvement**
Is the service well-led?	**Inadequate**

Overall summary

Lancam Nursing Home provides accommodation and nursing care for up to 16 people. Its services focus mainly on caring for adults of all ages including those with physical disabilities and people with dementia. There were seven people living in the service at the time of this inspection.

We carried out an unannounced comprehensive inspection of this service on 13 and 17 October 2014. Breaches of legal requirements were found. We served enforcement warning notices on the provider in respect of two breaches that had the greatest impact on people, in the areas of safeguarding and quality assurance.

We carried out an unannounced focussed inspection on 07 January 2015. We found that a number of breaches of legal requirements continued to occur, including breaches in relation to our warning notices. This put people using the service at significant risk of receiving inappropriate or unsafe care and treatment.

We undertook this unannounced focused inspection, of 05 May 2015, to check on the progress the provider had made with plans they sent us following the January inspection, and to check on the standard of care and treatment people using the service were receiving. We inspected the service against four of the five questions we ask about services: Is the service safe, effective, caring

Summary of findings

and well-led? This report only covers our findings in relation to these questions. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for this service on our website at www.cqc.org.uk

Whilst we found evidence to demonstrate that some aspects of the provider's plans had been followed, we found that other parts had not been addressed. We found that a number of breaches of legal requirements were occurring. This continued to put people using the service at significant risk of receiving inappropriate or unsafe care and treatment.

At this inspection, we found that the passenger lift had not been working for seven days. This followed people being stuck in the lift for a short period of time on two occasions. There were no records of these incidents made available to us on request. Whilst there was evidence of contracted professionals being called to fix the lift, this process lacked urgency, and meant two people using the service had not been able to come downstairs safely during this period.

We found that the fire alarm system was displaying fault signals. When we asked for the system to be tested, to show that it would activate when needed, devices to test it could not be located. We found other concerns about fire safety such as a fire door being wedged open which would not help to prevent the spread of fire. We raised our concerns with the local fire authority, who promptly visited the service and required the provider to keep them updated on actions being taken.

The provider's system for assessing and monitoring the quality of services remained ineffective. Whilst there had been audits at the service, these were not comprehensive and action had not been taken to address all the identified shortfalls in service delivery. Despite there being records of occasional incidents of behaviours by people that challenged the service, there continued to be no record of auditing incidents so that learning could take place with the aim of minimising the risk of harm to people using the service and staff. This ongoing inability to address the shortfalls identified and breaches of the regulations meant that the provider continued to fail to protect people using the service and staff against the risks of inappropriate or unsafe care and treatment.

Whilst improvements had been made to the consistency of the staff team's skills and support in their work, we found that the provider had further reduced staffing levels despite a previous breach of regulations and concerns being raised by members of the staff team. We found a further occasion where staffing arrangements were not promptly made to cover staff sickness. This continued to compromise the health, safety and welfare of people using the service.

We found that care and treatment risks to people using the service had been reviewed, and that the care provided to people was aimed at meeting their needs. For example, people were safely supported to eat, and the service was paying attention to people's skin integrity so that pressure sores did not develop. However, the service had not taken prompt action to address two requests for the results of a health procedure for one person, which compromised the effectiveness of their treatment from a visiting healthcare professional. We also found delays in acquiring a new charger for the weighing equipment after reports that the previous charger had been lost, which meant people's weight had not been monitored effectively for five weeks.

Whilst action had been taken to address our previous concerns about people being treated with respect, we found different ways in which people were improperly treated. This included insufficient attention to supporting people with their appearance, and cases of not listening to people in respect of support requests and refusals.

There was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. We cancelled the registration of the previous manager due to ongoing breaches of regulations at the service which put people using the service at risk of inappropriate or unsafe care and treatment. A new manager had been appointed since our last inspection, whom we met during this inspection. They had started the process of applying to be the registered manager. However, due to the many concerns that we found including some that were evident at the previous inspection, we did not have confidence in the manager and provider's oversight of quality and risk at the service, and concluded that the service was still not well-led.

Summary of findings

We found overall that people using the service continued to be at risk of receiving inappropriate or unsafe care. We found several breaches of the new Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following this inspection we continued with our enforcement action. The action we took was to serve notices proposing to cancel the registration of the provider and manager. Due process was followed and we served a Notice of Decision to cancel the provider's registration which meant that Lancam Nursing Home was closed by the Care Quality Commission on 31 July 2015.

Summary of findings

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 remained unsafe. Whilst action had been taken to address many of our previous safety concerns, some safety matters had not been addressed, and we found other ways in which the safety of people using the service was compromised.

There were further premises matters that compromised the safety of people. The passenger lift was not working, and had malfunctioned a number of times since our last inspection, including two occasions that resulted in people being stuck for short periods in the lift.

The fire alarm system was found to be displaying faults for a week without sufficient action to rectify matters. The system could not be demonstrated as able to activate in the event of a fire. This failed to safeguard the health, safety and welfare of people using the service.

We found that there continued to be occasions where there were insufficient numbers of skilled and experienced staff working with people.

We found that the service's new manager was working at the service, albeit not directly with people using the service, in advance of the provider receiving an appropriate criminal records check for them.

Some improvements had been made. For example, all staff had now been training on how to safeguard people from the risk of abuse. Care and treatment risks to people using the service had been reviewed and updated.

Is the service effective?

Inadequate

The service remained ineffective. Action had been taken to address many of our previous concerns. For example, people were safely supported to eat, and the service was paying attention to people's skin integrity so that pressure sores did not develop. Staff supervision systems had been re-established.

However, we found that sufficient action had not been taken in response to two requests from a community healthcare professional which compromised the effectiveness of their treatment of someone using the service.

Monitoring of most people's weight had not occurred for five weeks because a fault in the weighing equipment had not been promptly fixed.

Is the service caring?

Requires improvement

The service continued to not be consistently caring. Whilst action had been taken to address our previous concerns about people being treated with respect, we found other ways in which people were improperly treated.

Summary of findings

We found that some people received insufficient support with their appearance. Whilst staff interacted with people in a patient and friendly manner, there were cases of staff not listening to people in respect of support requests and refusals. Insight into what people were experiencing was not always demonstrated.

Is the service well-led?

Inadequate

The service continued to not be well-led. Despite the appointment of a new manager, we found a number of ways in which the action taken to address concerns from our previous inspection had not been effective and for which the provider was still in breach of regulations. This continued to fail to protect people using the service and staff against the risks of inappropriate or unsafe care and treatment.

The provider had carried out a whole-service audit since our previous inspection. However, it had not been completed, and we found a number of service shortfalls identified in it had not been addressed, which compromised the safety and welfare and people using the service.

Despite there being records of occasional incidents of behaviours by people that challenged the service, there continued to be no record of auditing incidents so that learning could take place with the aim of minimising the risk of harm to people using the service and staff.

There were inaccuracies in some records about people's care and the management of the service.

We had not been promptly notified of the malfunctioning of the fire alarm, and were not notified of the malfunctions of the passenger lift at the service.

Lancam Nursing 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. We undertook this unannounced focused inspection of Lancam Nursing Home on 05 May 2015. The inspection was to check that the provider had addressed the legal requirements that they were in breach of after our 07 January 2015 inspection. The inspection team comprised of two inspectors and a specialist professional advisor on nursing care. The team inspected the service against four of the five questions we ask about services: Is the service safe, effective, responsive and well-led? This was because the service was not meeting some relevant legal requirements in those areas.

We used a number of different methods to help us understand the experiences of people living in the service. We observed care in the communal areas of the service and met some people in their rooms. We used the information we gathered to track that the care people experienced matched what was planned in their records. We checked aspects of the physical environment used at the service.

The manager told us that there were seven people using the service at the time of our visit. We spoke with six people using the service. We interviewed members of the management team and four staff members. We looked at five people's care records, duty rosters, and various records used for the purpose of managing the service.

Inadequate

Is the service safe?

Our findings

At our previous inspection of 07 January 2015, we found occasions when there were no staff working who had had safeguarding training, and occasions when the provider's planned staffing levels were not met. An audit of recruitment checks had identified some shortfalls but no action had been taken to rectify them. One person's room had a strong smell of sewage but no action had been taken to permanently rectify this or move the person to a vacant room. This all failed to safeguard the health, safety and welfare of people using the service. This meant the provider was in breach of regulations 11, 15, 21 and 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At this inspection, we looked at the actions taken by the provider in respect of addressing the breaches of regulations 11, 15, 21 and 22. We found that the provider had addressed the breach of regulation 11, and action had taken place to address the breaches of regulations 15, 21 and 22. However, we found that there continued to be occasions where there were insufficient numbers of skilled and experienced staff working with people. This breach of regulation 22 was continuing and was now a breach of regulation 18 of the new Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 [The 2014 Regulations]. There was a further breach of appropriate recruitment checks. This continuing breach was now a breach of regulation 19 of The 2014 Regulations. There were further breaches of the safety of the premises. This continuing breach was now a breach of regulation 12 of The 2014 Regulations.

At this inspection, we did not notice any lingering offensive odours in the premises. This showed that the provider had taken action to address the specific matter from our previous inspection about a strong smell of sewage in one person's room. However, we found other concerns with the safety and maintenance of the premises. The last electrical wiring certificate for the premises expired on 19 March 2014. We were shown a letter from a professional contractor dated 2009 indicating that the electrical wiring standards were satisfactory, however, it had no expiry date. This meant that the safety of the electrical wiring in the premises at the time of our visit had not been approved as satisfactory by a competent professional. On 13 May 2015, the new manager told us that an electrical engineer had checked the electrical wiring following our inspection visit, that a copy of their report would be sent to us, and that all necessary works would be carried out. As of 18 May 2015, we had not received that report.

At this inspection visit, we found that the fire alarm control panel had flashing warning lights for "general fault" and "sounder", and its display recorded faults including "Fault smoke detector zone 2" and "Fault loop sounder zone 1." A staff member told us that this had occurred as a result of recent refurbishment of the premises about three weeks previously. The weekly fire alarm test had identified that the system was malfunctioning on 29 April 2015, as the record of the test had recorded that the panel was flashing, which matched what we saw. The service's 'fault log' book recorded this fault as being reported to the contracted fire professionals on 29 April 2015. However, the fault had not been rectified on the day of our inspection.

When we asked for the fire alarm system to be tested, to show that it would activate when needed, the device to test it and the reserve device could not be located. We told the new manager and the provider's representative to send us documentation within one day that the fire system would activate. The manager emailed us the next day to say that their contacted fire professionals had told them the system was safe and fully functional, however, they would not be visiting until 07 May 2015, which subsequently did not occur. We consequently informed the local fire authority of this safety concern. They visited the service, and informed the new manager that the fire alarm system had to be fully serviced with a copy of documentation about this to be forwarded to them, which we also requested. The new manager informed us on 12 May 2015 that a fire professional had checked the fire system but was now needing to contact the manufacturer of the panel. As of 18 May 2015, we had not been provided with a professional report that the fire alarm system was working. Therefore, for a period of at least 20 days, the fire alarm system could not be demonstrated as being safe for use, which put people using the service and others at avoidable risk to their safety and welfare.

We found a fire door held open by a fire extinguisher at the top of the stairs on the first floor, close to three people's bedrooms, two of whom were using their rooms during the day. This would not help to prevent the spread of fire. There was a sign on the door about not wedging it open, and there was a fire-closure safety device on the door that

Is the service safe?

would allow it to be held open but to close if the fire alarm sounded. The premises and equipment in this respect were not being used in a safe way, which put people using the service and others at avoidable risk to their safety and welfare.

The passenger lift in the service had an 'out of order' sign on it during our inspection visit. Staff fed-back two incidents of the lift having stopped working with people stuck in it for short periods, the latter resulting in the lift being stopped from use and the sign being placed on it. These incidents compromised people's safety. There were no records made available on request of these two incidents, to document what happened, the impact on people, and actions taken to prevent reoccurrence. The service's 'fault log' book recorded the lift being out of action from 28 April 2015. The manager informed us the lift was restored to working order on 13 May 2015. It was therefore failing to operate for a period of 16 days. This compromised the safety and autonomy of three people using the service who had upstairs rooms. One person said, "The lift's broken all year." Another person told us they used the stairs with staff support, however, we saw that they ordinarily used a frame to walk about. We found that one person remained upstairs until the day of the inspection when they had a health appointment, contrary to their usual routine of being downstairs during the day.

There were entries in the service's 'fault log' book of the lift malfunctioning on 21 April 2015, 16 March 2015, 28 February 2015, and 27 January 2015. The 21 April 2015 entry was that the lift had to be switched off and on to make it work. The 28 February 2015 entry was resolved via lift engineers on 04 March 2015. We saw a record of a professional check of the lift dated 31 March 2015 to ensure its safety, and one dated 15 April 2015 leaving the lift working after being called out because of malfunction. However, the repeated occurrences of lift malfunction, the length of time taken to fix the latest malfunction and consequent impact on some people using the service, and the lack of records of the two incidents of people being stuck in the lift, failed to demonstrate the lift as being safe for use. This put people using the service and others at avoidable risk to their safety and welfare.

The above evidence demonstrates a breach of Regulation 12(1)(2)(d)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection of January 2015, the planned staffing levels at the service were two care workers and one nurse working 8am to 8pm, and one care worker and one nurse working 8pm to 8am. Additionally, the Head of Care worked 9am to 5pm weekdays but with authority to provide care support if needed, a chef worked 9am to 2pm seven days a week, and a cleaner worked 9am to 2pm on weekdays. There were nine people using the service at that time.

At this inspection, when seven people were using the service, records of staff signing in and out for May 2015 showed that one of the two care workers was working until 6pm instead of 8pm, and the Head of Care worked only in the role of a care worker, no longer on a 9am to 5pm basis. The new manager explained that the previously-registered manager was now working in an "office assistant" role and so the Head of Care role had transferred to care working. However, records of staff signing in and out of the service between 29 April 2015 and 14 May 2015, a period of 15 days, showed the previously-registered manager to be at the service on seven occasions, in comparison to the previous Head of Care role being ordinarily five days a week. This meant that this change of staffing arrangement had reduced staffing numbers in practice.

The new manager explained that the provider had made the 6pm finishing time alteration when the number of people using the service reduced to seven on 03 April 2015, as "most of the 'demanding work' would have been completed by that time." We saw minutes of a staff meeting of 31 March 2015 raising concerns that staff felt having a staff member leave at 6pm would be unsafe. The new manager was at the meeting, and was recorded as stating that they would investigate. However, the 6pm finishing time remained in place, and so staffing numbers were reduced in practice.

At our inspection of January 2015, we found a disorganised approach to arranging adequate staffing when a staff member had phoned in sick the night before that inspection visit. At this inspection, when we checked records that were available from 29 April 2015 of staff signing in and out of the service, there was evidence that one staff member had worked from 8am on 30 April 2015 to 8am on 01 May 2015. The manager explained that the scheduled night care worker failed to attend. They were called and found to be sick at 9pm, and so a day care worker volunteered to work the night shift as no other arrangements for staffing cover could be found. This

demonstrates a further disorganised approach to arranging adequate staffing, and by working twenty-four hours, there was an increasing risk of the staff member providing unsafe care.

We asked to be provided with a copy of the staff signing in and out records for April 2015, by 08 May 2015. We received payroll timesheets for staff on 18 May 2015. These showed staffing cover as above, including that the second care worker finished at 6pm from 04 April 2015 onwards. However, on three occasions, of 14, 15 and 24 April 2015, both care workers were recorded as leaving the service at 6pm, indicating that only one staff member, the nurse, was present at the service between 6pm and 8pm. This failed to demonstrate that sufficient numbers of suitably skilled and experienced people were working at the service on these occasions.

The new manager had informed us they had been on leave between 01 and 22 April 2015. They told us that representatives of the provider's company had managed the service during this period. This coincided with further malfunctioning of the lift and insufficient action being taken in response. This failed to demonstrate that sufficient numbers of suitably skilled and experienced people were managing the service during this period.

Records available to us indicated that the provider had taken action to ensure that more staff were recruited and that the previous reliance on a care staff member with significant language difficulties was no longer occurring. A cleaner was also now consistently working on weekdays, although their hours of work had dropped from five to four daily.

Our overall findings of concern at this inspection, in conjunction with the above evidence of reduced staffing numbers between 6pm and 8pm, and the occasion of replacement staffing arrangements being disorganised, mean that the provider has continued to fail to demonstrate that sufficient numbers of suitably skilled and experienced staff were working to safeguard the health, safety and welfare of people using the service.

The above evidence demonstrates a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our January 2015 inspection, we found that there was not satisfactory evidence of conduct in previous care employment for two staff members, which put people using the service at unnecessary risk of unsafe care and treatment. At this inspection, we checked the recruitment records of two new staff members and found that appropriate recruitment checks had taken place, for example, criminal record checks, identification checks, and written references. However, the recruitment file of the new manager did not have evidence of a criminal record check. The provider's representative told us that they had seen this check but a copy was not kept. We established that this criminal record check was from 2012, as the manager told us it was the check they had used when previously applying to register with us at a different service. Criminal record checks have limited portability, ordinarily three months although up to a year in certain circumstances, however, the provider had accepted a criminal record check that was over two years old. The provider's representative had informed us on 20 February 2015 that they had "appointed a (sic) experienced home manager… to provide leadership." The new manager informed us following the inspection that "I was invited to apply to become the registered manager …..on 3 March 2015. I accepted the challenge." However, the provider did not have a current criminal record check for the new manager until 01 May 2015. The provider accepted a criminal record check that was over two years old, which was not sufficient to demonstrate the new manager's good character.

The above evidence demonstrates a breach of Regulation 19(1)(a)(3)(a) schedule 3 part 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records indicated that further safeguarding training had been provided to staff. Training documents indicated that all staff now had up-to-date training in this respect. Staff feedback demonstrated knowledge of what could constitute abuse. This helped to ensure that people using the service were kept safe from the risk of abuse.

Our checks of two people's care files found up-to-date risk assessments relating to a variety of people's individual needs, for example, in respect of the risk of falling, nutritional needs, and the management of skin integrity. Care plans had been updated in respect of these assessments and reflected people's individual needs and preferences, for example, in terms of the cultural dietary needs of one person. Staff showed awareness of people's specific needs and how these were addressed, along with safe practice such as for ensuring that people's call-bells were within reach.

Inadequate

Is the service effective?

Our findings

At our previous inspection of 07 January 2015, we found that some people failed to have health concerns recognised and addressed. Applicable people's individual mental capacity assessments for specific care and treatment decisions had not been reviewed to act in accordance with the Mental Capacity Act 2005. Staff supervision was not being provided at the frequency set by the provider. This did not support staff to be equipped to meet people's needs consistently. This meant the provider was in breach of regulations 9, 18 and 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At this inspection, we looked at the actions taken by the provider in respect of the breaches of regulations 9,and 23. We found that the provider had addressed these breaches. However, we found breaches of regulations 12 and 15 of the new Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in respect of liaison with a community healthcare professional and the maintenance of health monitoring equipment.

Records and feedback demonstrated that the service had taken action to address the care and treatment concerns we previously found for one person's feet. Appropriate healthcare professionals had been involved in the treatment, and the person was now wearing appropriate footwear. There was a care plan in place for the treatment. Other skin integrity issues had been identified by the service at an early stage and action had been taken to minimise health risks.

People received sufficient support at lunch relative to their needs. For example, we saw one person being supported to eat lunch in an unhurried manner. When the supporting staff member was called away, another staff member stepped in. Drinks were available to everyone with their meals, and people had equipment to support them to drink where needed. People had specific nutritional care plans that reflected their assessed needs, and there was evidence of action in response, such as weekly blood glucose monitoring and health professional appointments.

However, we found that one person was not being sufficiently supported with their physiotherapy treatment. The physiotherapist visited during our inspection and asked for results of an X-ray requested 15 days previously.

We were told that at their previous visit eight days previously, the service had not acquired the results as requested, which was put to senior staff for action. During this visit, the nurse in charge incorrectly reported on the results, which the physiotherapist challenged, after which a record of the results could not be found. This resulted in the physiotherapist providing treatment to the person for a second time without the results of the X-ray that they had twice asked the service to provide. Appropriate action had not been taken to ensure that the service worked together with the physiotherapist to ensure that the person received safe and effective care and treatment.

The above evidence demonstrates a breach of Regulation 12(1)(2)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we checked people's weight records, we found that four out of five were out of date, for example, a last entry dated 20 March 2015. Previous entries were recorded monthly. A staff member told us they wanted to support one person to be weighed weekly, but the weighing equipment for more dependent people had not been working for a while. A record of daily checks in the service included the weighing equipment, which showed that it had not been working since 01 April 2015. However, the service's 'fault log' book first had an entry about this on 22 April 2015, that a new charger was needed, and then on 28 April 2015 that a charger had been ordered. It had not arrived at the time of our inspection. This meant timely action had not been taken to maintain this equipment, which failed to enable checks of people's weight so as to support people to maintain good health.

The above evidence demonstrates a breach of regulation 15(1)(c)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our January 2015 inspection found that staff supervision was not being provided at the frequency set by the provider, particularly for nursing staff. This was not adequate to support staff to be equipped to meet people's needs consistently. Records at this inspection demonstrated that most staff had received two supervision sessions in 2015, which met the frequency set by the provider. We saw records of occasional staff meetings, and were told by the manager of regular informal meetings at the service. There was evidence of further training being provided to staff, such as for medicines management, care planning, and dignity in care. The new manager could also

Inadequate

Is the service effective?

demonstrate that work had started to review and update staff members' skills in line with the new Care Certificate that had been introduced nationally from 01 April 2015. This better enabled staff to carry out the duties they were employed to perform.

Requires improvement

Is the service caring?

Our findings

At our previous inspection of 07 January 2015, we found that doors were not always knocked on to gain permission for entry. We saw one person being rushed to eat their meal which put them at risk of choking. The broken blinds in one person's bedroom that we found at the previous inspection of October 2014 had still not been fixed. This showed a lack of respectful treatment of people using the service. This meant the provider was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At this inspection, we looked at the actions taken by the provider in respect of the breach of regulation 17. We found that the provider had addressed the specific matters described above; however, we found other ways in which people were not treated with dignity and respect. This breach of regulation 17 was continuing and was now a breach of regulation 10 of the new Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Three of the six people we spoke with fed-back positively about the approach of staff members, for example, "The staff are caring" and "New staff ask how I feel." However, the feedback and our observations did not demonstrate a consistently caring approach. One person told us that, as at the previous inspection, they still experienced instances of their curtains being closed when they did not want this. "This upsets me," they said, explaining that they could not then access items on their windowsill such as their television remote-control. Whilst we saw that a care plan had been recently set up that referenced this preference, that person told us that the problem still occurred.

At this inspection, we saw and heard staff knocking on people's doors and asking permission to enter. We saw people being supported in a respectful manner with eating. The blinds in one person's room that were previously broken had now been fixed. This showed that the provider had taken action to address specific examples from our previous inspection around how people were treated. We also saw that staff interacted with people in a patient and friendly manner, and gave people time to respond when needed. One person confirmed that staff gave them time to respond relative to their changing abilities during the day.

Care records were respectful and aimed to enable people's choices and preferences. The last meeting for people using the service emphasised their entitlement to choice and autonomy.

However, we saw other ways in which people were not treated with dignity and respect. We noticed that, following a drink at supper, someone in the lounge had a wet top. An hour later, they still had a wet top. At that time, they were asking to get changed, however, the staff member was trying to distract them, explaining that it was too early for bed. This meant the person had not received support with their appearance to uphold their dignity, and their autonomy was not being respected.

When we spoke with another person after lunch, we noticed their clothing was food-stained. They asked staff for support to get changed, which was responded to, however, as we saw that they received support with lunch, it meant that staff did not provide immediate support with their appearance to uphold their dignity.

A third person told us of being unhappy with "second hand clothes." When we looked at clothes in their wardrobe, we saw there was evidence of old clothing. One top, for example, was stretched out of shape, and we noticed food stains on it. We also saw the pillow for their unmade bed had a number of holes in its fabric. We showed this to the management team, who consequently arranged for new pillows to be put in place. This person's bed had not been made by mid-afternoon, and we noticed that they spent some of the day in their room. When we asked staff about this, we were told this always happened. These matters amounted to a failure to treat this person with dignity and respect.

We saw an accident report from two days before our inspection, in which a staff member recorded that when they had tried to support a person to get changed during the night, the person had been aggressive towards them. They recorded that the person did not want to be disturbed as they were sleeping. There was no record of action taken by the staff member to diffuse the situation, for example, by asking the other staff member working at night to provide support instead or by giving the person time to orientate themself. When we asked the manager about this incident, they told us they had not been informed of it. The manager contacted us after the inspection to inform us that after discussing with the staff member, they felt the staff member had acted in the person's best interests. However,

Requires improvement

Is the service caring?

whilst the person may have needed support with personal care, insight into what the person was experiencing was not demonstrated. These matters amounted to a failure to treat this person with dignity and respect.

The above evidence demonstrates a breach of Regulation 10(1)(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At our previous inspection of 07 January 2015, we found little evidence that effective action had been taken to address the most significant concerns arising from our previous inspection of October 2014. For example, there had not been a whole-service audit since our previous inspection despite our previous concerns and enforcement work. This continued to fail to protect people using the service and staff against the risks of inappropriate or unsafe care and treatment.

This meant the provider was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At this inspection, we looked at the actions taken by the provider in respect of the breach of regulation 10. We found a number of ways in which the action taken to address our previous concerns had not been effective and for which the provider was in breach of regulations. This continued to fail to protect people using the service and staff against the risks of inappropriate or unsafe care and treatment. This breach of regulation 10 was continuing and was now a breach of regulation 17 of the new Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was also a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009, as we had not been notified of the malfunctioning of the fire alarm and the passenger lift.

A new manager had been appointed since our last inspection, following the cessation of the previously-registered manager's registration. The new manager informed us they had started working at the service on 12 February 2015 as a consultant, stating, "I am fully confident that the home can be turned round and service rendered safe and effective." We were formally notified of the change of manager at the service on 23 April 2015. That notification included the statement that the new manager "was appointed as caretaker manager, to respond to the last CQC inspection report and provide a plan of action to deal with the various breaches of regulations, which was forwarded to CQC on 4 March 2015." Information from the new manager assured us that they had taken reasonable action to apply for registration as manager of the service.

The new manager told us at this inspection that the provider was now in receipt of a criminal records check for them, and hence he could now work unrestricted in the service. The manager confirmed this by email after the inspection, stating, "I confirm that I have been officially appointed as manager from 1st May 2015 and acted only as a caretaker previous to that, with limited clinical duties." He told us the role had, until then, focused mainly on staff training, recruitment and record-keeping.

We noted that the manager had been on leave for three weeks during April 2015. We were told that members of the provider organisation provided managerial cover during this time.

Our findings, as outlined below, demonstrate that despite changes in the management of the service, required improvements have not been consistently made and a number of breaches of regulations identified at the last inspection remained. This continued to fail to protect people using the service and staff against the risks of inappropriate or unsafe care and treatment.

We found that the quality assurance and audit processes at the service remained ineffective. When we asked to see what audits had taken place since our last inspection, the new manager told us he had not been involved in any formal auditing. This was despite communication on behalf of the provider in February 2015 that the new manager would be taking responsibility for quality monitoring and auditing.

We were shown the audit file. Since our last inspection on 07 January 2015, it contained two medicines audits including the findings of an external pharmacist, along with recorded evidence of action being taken to address findings. There were three undated audits of the care files of people using the service, and one dated 09 February 2015, as undertaken by the previously-registered manager.

The only other audit in the audit file since our last inspection was an undated 'Three Month Nursing Home Audit' that identified some shortfalls in service delivery standards but which was not fully completed. For example, the sections on enquiries, accidents and complaints had not been filled in and scored, unlike all other sections. A copy of the audit was sent to us after the inspection visit. It now contained a date of 07 April 2015 and was signed by the previously-registered manager under the "Home Manager" heading. This was despite the cessation of that

person's role as registered manager on 13 March 2015, and communication being sent to us in February 2015 that the provider recognised that this person lacked the skills and experience to ensure effective quality monitoring would take place.

The audit had no plan of action, and we found that some matters identified in the audit had not been addressed. For example, section 14.13 of the audit stated that the annual assessment of risk "needs doing." Section 8.03, for risk assessments in respect of maintenance, was recorded as "fully met." When we asked the manager and the provider's representative to see risk assessments in respect of the service, none were supplied. These might have included, for example, hazards around the premises that had been identified and control measures put in place to minimise risk. We had also identified that no such risk assessments were available at our previous inspection. This was not effective assessment, monitoring and mitigation of the risks relating to the health, safety and welfare of people using the service and staff.

Section 14.01 of the audit, for the five-yearly electrical installation check, had been recorded as 'fully met.' However, the last records made available to us for electrical wiring at this inspection dated from 2009, six years ago, and so were out-of-date, in contrast to the audit. This was not effective assessment, monitoring and mitigation of the risks relating to the health, safety and welfare of people using the service and staff.

Section 9.11 of the audit, for fire drills being up-to-date, was left blank. Records showed the last fire drill took place on 08 August 2014, with a statement that further training was needed for new staff. The stated ordinary frequency of fire drills within the fire file was six-monthly, and so given the outcome of the last drill, a further drill might reasonably have taken place sooner than six months. However, the last drill was now almost nine months old, and the audit had not identified this concern. This was not effective assessment, monitoring and mitigation of the risks relating to the health, safety and welfare of people using the service and staff.

Section 6.03 of the audit, for the management of staff sickness and absence, was left blank. Following the inspection, we asked the manager to clarify who had worked a night shift at the end of April. The reply explained that a staff member rostered to attend had not turned up for work, for which they had to be called to establish that they were reporting sick. Someone who worked the day shift agreed to work the night shift instead. This showed ongoing concerns with the management of staff sickness, which we reported on at our previous inspection. The audit had not identified this concern, which was not effective assessment, monitoring and mitigation of the risks relating to the health, safety and welfare of people using the service and staff.

The only entry against section 4 of the audit, for accidents, was a statement, "1 present in book, where are the rest kept" (sic). We asked the manager about whether there had been any other accidents since our last inspection other than the one we found in the accident book from two days before our visit, and noted that there was no clear system showing where accident records removed from the accident book had been filed. We received no reply, which indicated that there was no system of tracking the filing of accident records. The audit had identified this concern, but action had not been taken to resolve it. This was not effective assessment, monitoring and mitigation of the risks relating to the health, safety and welfare of people using the service and staff.

The report of our inspection of 07 January 2015 stated that a November 2014 catering audit included a check that "All grades staff attended Food Hygiene Training within the last 12 months" was partially met. We noted that the staff training matrix showed seven out of 16 staff as not having had food hygiene training. Whilst training records at this inspection demonstrated overall improvement in staff training, food hygiene training had only occurred for one of the seven identified staff members. Three of these staff continued to work in care roles at the service without having had food hygiene training, which put people using the service at avoidable risk to their health and welfare. This was not effective assessment, monitoring and mitigation of the risks relating to the health, safety and welfare of people using the service and staff.

We noted that there were now daily checks documented for a number of key service standards. This helped to demonstrate, for example, that people's call-bells were working and accessible, as we also found when we checked people's rooms. However, this system had identified that the charger for the weighing equipment was missing from 01 April 2015. Despite this, there was no record of this in the service's 'fault log' record until 22 April

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2015, and no record of a new charger being ordered until 28 April 2015. This was not effective monitoring and mitigation of the risks relating to the health, safety and welfare of people using the service and staff.

The report of our inspection of 07 January 2015 stated that there was no record of audit of incidents that occurred at the service, so that learning took place with the aim of minimising the risk of harm to people. This continued to be the case at this inspection. This was despite us finding evidence of four incidents during the inspection visit. Two incidents were fed-back by staff that the lift had stopped working on two occasions with people stuck in it, the latter resulting in the lift being stopped from use. The other two incidents were recorded as occurring within the previous week, of behaviour from people that challenged the service. However, the manager confirmed he had not seen these records. He was aware of one incident but not that there was alleged physical aggression as was recorded, and so he had not investigated. The staff member who made the record told us they had not had the incident-reporting system explained. We noted that they were new to the service, and that their service induction records showed their induction had not been completed. This was not effective assessment, monitoring and mitigation of the risks relating to the health, safety and welfare of people using the service and staff.

During the inspection visit, we heard a continuous buzzing noise in the upstairs hallway. When we spoke with staff about this, they identified that it was coming from the device fixed to one person's bedroom door that allowed the door to be safely held open but to close should the fire alarm activate. However, the device was not able to hold the door open and staff confirmed that the noise was to notify that the battery was low and needed replacing. A staff member confirmed that this was not the first day they had heard the noise. The person using the service grimaced when we asked them about the noise, and demonstrated that they had turned their television volume up to counter the noise. However, there was no record of malfunction of the device, for example, on the daily checklist for the service, staff handover sheets, the fire file, or the service's 'fault log' book. When we asked what checks were made of fire doors, staff told us this was part of their weekly checks of the fire system. However, that record was only specific to the fire alarm system. The section of the fire file for fire door checks was blank. We also found that the service's fire safety risk assessment was dated November 2013 and was therefore over a year old without having been reviewed to ensure its accuracy. This was not effective assessment, monitoring and mitigation of the risks relating to the health, safety and welfare of people using the service and staff.

The service's 'fault log' book included an entry on 28 April 2015 of the toilet seat in the upstairs bathroom needing to be repaired. When we checked it, the toilet seat was only secured by one of the two hinges. There was no sign indicating the risk of the faulty toilet seat, although staff informed us that no-one using the service accessed the toilet independently. However, seven days after reporting the concern, action had not been taken to ensure that the toilet seat was properly maintained. This was not effective monitoring and mitigation of the risks relating to the health, safety and welfare of people using the service and staff.

Following our inspection visit, we found that the provider was listed on the Health and Safety Executive's website as having been issued with five improvement notices on 05 March 2015 following a health and safety inspection visit. The circumstances that resulted in these notices being issued was not effective assessment, monitoring and mitigation of the risks relating to the health, safety and welfare of people using the service and staff.

Our inspection of October 2014 had highlighted the ineffective use of monthly audit forms at the service. Our January 2015 inspection found that these were no longer being used. At this inspection, we asked for a copy of the provider's quality auditing policy, to clarify what audits were to take place, however, the policy was not supplied. This failed to demonstrate that there were established systems to audit quality and ensure good governance of the service.

The above evidence demonstrates a breach of Regulation 17(1)(2)(b)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Communication on behalf of the provider in February 2015 informed us that a meeting for people, using the service and their relatives took place on 02 February 2015. It stated that people said at this meeting that they were happy with the care provided in the service. When we checked the minutes of this meeting, we found no comments on the quality of care provided. When we spoke with people at this inspection, two people were happy with all aspects of the

service, two were happy with most aspects but had a specific issue they wanted improving, and two were not happy with the services provided. Comments ranged between, "It's a very good service" and "The staff are no good."

Two people were unhappy with activity provision, telling us for example, "I'm fed up and bored." During the inspection visit, we saw little evidence of activity provision for people, although one person was supported to walk in the garden as per their recorded preferences and one person had a copy of a daily newspaper to read. When we looked at records of activity provision for people, we found one person's record ended on 30 April 2015, and another's on 31 March 2015. A staff member told us that they found it difficult to motivate people, and that investment in equipment to support activities had not recently occurred.

Communication on behalf of the provider in February 2015 informed us that the activities programme had been improved on and that a 24-hour activity plan had been mapped out for each person based on their preferences. Further communication informed us of weekly trips out and visiting entertainers. However, feedback and records at the inspection visit did not support these claims. We asked the new manager to provided evidence of these improvements. The response showed further activity plans for May 2015 within a newsletter, but did not provide evidence of what had taken place before our visit. We could not therefore conclude that people were experiencing improved activity provision, which failed to demonstrate that there were effective systems to assess, monitor and improve on the quality of the services provided in respect of people's experiences of activities.

The above evidence demonstrates a breach of Regulation 17(1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that accurate records were not consistently maintained in respect of people using the service and the management of the service, which failed to support the effective governance of the service. In respect of the four incidents above, there were no records available on request for the two occasions of people being stuck in the lift. Staff handover sheets back to 01 April 2015 did not document these incidents. The incident of physical aggression was not accurate as the staff member who witnessed it had not made the record and consequently the record overstated the extent of the physical aggression according to feedback we received during the inspection. Additionally, there was no record of the incident in the daily record of care of the person using the service who experienced the aggressive incident.

We saw that the care delivery grid, used to chart the care and treatment provided to each person using the service, was incomplete in two people's cases. The record was not completed between 1800 hours on 01 May 2015 to 1500 hours on 04 May 2015 for one person. There was a day's gap between 03 and 04 May 2015 for another person. These records were not maintained accurately.

The above evidence demonstrates a breach of Regulation 17(1)(2)(c)(d)(ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the provider had not informed us of certain events at the service that they are required by law to inform us of. The fire alarm control panel had flashing warning lights during our inspection visit, and its display recorded faults. The weekly fire alarm test had identified that the system was malfunctioning on 29 April 2015, as the record of the test had recorded that the panel was flashing. The service's 'fault log' book recorded this fault as being reported to the contracted fire professionals on 29 April 2015. However, we had not been notified of the malfunction of this fire safety device before our inspection visit. We only received a formal notification about the malfunction on 14 May 2015. As of 18 May 2015, we had not been informed of the fire alarm control panel being restored to full functionality. The failure to promptly notify us of this safety event in the premises did not demonstrate a well-led service.

The passenger lift in the service had an 'out of order' sign on it during our inspection visit. Two incidents were fed-back by staff that the lift had stopped working on two occasions with people stuck in it, the latter resulting in the lift being stopped from use and the sign being place on it. The 'fault log' book for the service recorded the lift being out of action from 28 April 2015. The new manager informed us the lift was restored to working order on 13 May 2015. It was therefore failing to operate for a period of 16 days. There was also an entry in the 'fault log' of the lift malfunctioning on 28 February 2015, with repair taking place on 04 March 2015, a period of five days. These failure events meant that people with bedrooms upstairs could not safely move between floors. However, we had not been notified of these malfunctions of the lift before our

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inspection visit. At of 18 May 2015, we had still not received formal notifications about these matters despite reminding the new manager and provider of the requirement to do this, both at the inspection visit and by email on 11 May 2015. The failure to notify us of this safety event in the premises did not demonstrate a well-led service.

The above evidence demonstrates a breach of Regulation 18(1)(2)(g)(iv) of the Care Quality Commission (Registration) Regulations 2009.

We formally asked, as part of this inspection, to be provided with information in relation to a number of aspects of the management of the service and the care and treatment of people using it. Whilst much of what we requested was responded to by the new manager, certain requests were not. This included information on accidents in the service, and evidence of recent activities provided to people using the service. We did not receive copies of policies we requested on safeguarding, quality auditing, risk management, and health and safety. This meant we could not robustly check on certain aspects of the service.

We asked to be provided with a copy of the staff signing in and out records for April 2015, by 08 May 2015. On 12 May 2015, the new manager informed us that the provider's representative had informed him that these records were still "at payroll and will be forwarded to you in due course." These records were provided to us on 18 May 2015, which compromised our ability to promptly check on whether sufficient numbers of staff were working at the service during April 2015. This did not demonstrate a well-led service.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The registered person did not ensure that service users were treated with dignity and respect.** Regulation 10(1)(2)(b)

The enforcement action we took:
We served a Notice of Proposal on the Registered Provider to cancel their registration in respect of the regulated activities that they are registered for. The Registered Provider appealed against the Notice but after consideration we decided to proceed to a Notice of Decision to cancel the Registered Provider's registration, which took effect on 31 July 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person did not ensure that care and treatment was provided in a safe way to service users.** Regulation 12(1)(2)(d)(e)(i)

The enforcement action we took:
We served a Notice of Proposal on the Registered Provider to cancel their registration in respect of the regulated activities that they are registered for. The Registered Provider appealed against the Notice but after consideration we decided to proceed to a Notice of Decision to cancel the Registered Provider's registration, which took effect on 31 July 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **The registered person did not ensure that premises and equipment used at the service was properly maintained and suitable for purpose.** Regulation 15(1)(c)(e)

The enforcement action we took:
We served a Notice of Proposal on the Registered Provider to cancel their registration in respect of the regulated activities that they are registered for. The Registered Provider appealed against the Notice but after consideration we decided to proceed to a Notice of Decision to cancel the Registered Provider's registration, which took effect on 31 July 2015.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered person did not ensure that systems and processes were established and operated effectively to ensure compliance with the relevant regulations.** Regulation 17(1)(2)(a)(b)(c)(d)(ii)(f)

The enforcement action we took:
We served a Notice of Proposal on the Registered Provider to cancel their registration in respect of the regulated activities that they are registered for. The Registered Provider appealed against the Notice but after consideration we decided to proceed to a Notice of Decision to cancel the Registered Provider's registration, which took effect on 31 July 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The registered person did not ensure that sufficient numbers of suitable qualified, competent, skilled and experienced persons were deployed in order to meet the relevant regulations.** Regulation 18(1)

The enforcement action we took:
We served a Notice of Proposal on the Registered Provider to cancel their registration in respect of the regulated activities that they are registered for. The Registered Provider appealed against the Notice but after consideration we decided to proceed to a Notice of Decision to cancel the Registered Provider's registration, which took effect on 31 July 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The registered person did not ensure that persons employed for the purposes of carrying on the regulated activities were of good character.** Regulation 19(1)(a)(3)(a) schedule 3 part 3

The enforcement action we took:
We served a Notice of Proposal on the Registered Provider to cancel their registration in respect of the regulated activities that they are registered for. The Registered Provider appealed against the Notice but after consideration we decided to proceed to a Notice of Decision to cancel the Registered Provider's registration, which took effect on 31 July 2015.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **The registered person did not notify the Commission without delay of any event which prevented, or appeared to threaten to prevent, the registered person's ability to continue to carry on the regulated activities safely or in accordance with the registration requirements.** Regulation 18(1)(2)(g)(iv)

The enforcement action we took:

We served a Notice of Proposal on the Registered Provider to cancel their registration in respect of the regulated activities that they are registered for. The Registered Provider appealed against the Notice but after consideration we decided to proceed to a Notice of Decision to cancel the Registered Provider's registration, which took effect on 31 July 2015.