Care Quality Commission

Subhir Sen Lochun

High Dene

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

This inspection took place on 2 June 2015 and was unannounced.

At our last inspection we found that the service had breached Regulations 10, 17, 18,19, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the service was not carrying out appropriate background checks on staff, had not provided staff with training relevant to their role and the tasks they were to perform and did not provide care for people in a manner that promoted their dignity and respect. The provider had failed to carry out effective quality and safety monitoring of the service. They also failed to listen and respond to the complaints or concerns that people had expressed.

The service is registered to provide care for up to 15 people. On the day of our inspection there were 14 people living in the service, some of whom were vulnerable because of their situation.

On the day of our inspection the service did not have a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There were insufficient staff on duty to provide people with the care they required. This meant that people were

Summary of findings

left for long period without personal interactions and staff did not complete required documentation appropriately. Staff had not received appropriate training. On the day of our inspection we observed inappropriate and incorrect practice taking place. Appropriate background checks were not always carried out before staff commenced employment.

Risks to people were not managed. Risk assessments had been carried out but where a risk had been identified no actions had been taken to mitigate the risk.

The building was found to be dirty and poorly maintained. Corridors and communal areas were cluttered with odd pieces of furniture which presented a hazard to people with reduced mobility.

Medicines were not managed safely. Training for staff who administered medicines was not up to date and medicines administration was not recorded accurately.

Care plans were generic and did not demonstrate that the person or their representative had been involved. They did not contain information about people's likes and dislikes to enable staff to meet their needs. Where people were unable to make decisions staff were not aware of the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards which ensures that decisions are made appropriately. This put people at risk of having their liberties unlawfully restricted and physical harm.

Care plans had not been reviewed and updated regularly to ensure that they reflected a person's current care needs.

People were not supported to maintain a nutritious diet. Care plans did not identify people's nutritional needs and records of what people had eaten or drunk were not completed appropriately. Where people required support to eat or drink this was not always provided in a dignified manner whilst ensuring people ate and drank a sufficient amount.

Mostly care staff demonstrated a caring attitude. However, this was mostly instinctive and was not supported by the provision of training or procedures in the service. The care provision was task led and we saw that the task sometimes took precedence over the care.

People were not supported to carry on activities they had engaged in before moving into the service. Social engagement between people living in the service was minimal.

People's health, welfare and safety was compromised because the provider did not have in place a robust quality assurance process that identified issues in service provision and potential risk to people. The provider's quality and safety monitoring had failed to identify the shortfalls we found at this inspection.

The service did not have an effective complaints procedure to monitor and investigate complaints.

Open communication was not encouraged by the service. No recent residents meetings, staff meetings, or quality assurance surveys had taken place.

The service did not have links with local or national organisations to ensure that the care provided reflected up to date practices and guidance.

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 was not safe.

There was not sufficient staff to provide the care people needed.

The service did not carry out adequate background checks to ensure the suitability of new care staff.

Risks were not managed effectively.

Medicines were not managed safely.

Is the service effective?

Inadequate

Staff were not adequately trained and this was demonstrated in their practice and approach to care.

Staff did not understand the Mental Capacity Act 2005 and Deprivation of Liberty safeguards.

People were not supported to maintain their independence by the physical environment they lived in.

Medicines were not managed safely. This meant people did not receive their medicines as prescribed.

Is the service caring?

Inadequate

The service was not caring

Staff interactions with people were mainly around a task that was being performed.

People's privacy and dignity were not promoted and respected.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans were not up to date and did not reflect people's current needs

People were not supported to follow their interests and hobbies.

The service did not have a complaints procedure.

Is the service well-led?

Inadequate

The service was not well-led.

The service did not promote an open person centred culture which listened to people's views.

Quality assurance processes were not in place to monitor the quality of the service provided and address any identified shortfalls.

There were no methods to measure the delivery of care against current guidance.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. This inspection was also done to check that improvements to meet legal requirements planned by the provider following our inspection of 26 January 2015 had been made.

This inspection took place on 2 June 2015 and was unannounced.

The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert on this inspection had experience of caring for a person with dementia.

Before our inspection we reviewed all information we held about the service. This included events we had been notified about and any comments or complaints we had received.

During the inspection we spoke with six people who used the service and one relative. We also spoke with the manager, three members of care staff, the cook, the cleaner. We looked at nine care plans. We also looked at records relating to the management of the service including care plans, staff records and audits and management information. We observed the care being provided throughout the day.

Is the service safe?

Our findings

Our inspection of 26 January 2015 found that there were insufficient numbers of staff to keep people safe.

At this inspection we found that the provider had continued to fail to provide numbers of sufficiently qualified and suitable staff to meet people's health. The provider did not have a systematic approach to determine the number of staff and range of skills required in order to meet the needs of people and keep them safe at all times.

Staff told us that four people required two staff to support them when moving. During the day there were three care staff on duty. We observed that it was service practice to put everybody who was up and about into one room so that when a person needed support with mobilising one member of staff could stay in the lounge and the other two staff members could support the person to move. However, we observed that this arrangement did not work when one member of staff was not available and people with complex care needs were left unsupported. For example, if a carer was on their break or if a carer was required to carry out other duties such as the dispensing of medicines. The manager told us that they were supernumerary to staffing numbers and were available to support staff if required. However, on the day of our inspection they were working as the senior carer and they also told us that they worked two or three days a week as senior carer meaning there was not a supernumerary person available. This lack of staff meant that carers had no time to interact with people other than carrying out tasks such as supporting with personal care. We observed one person left in a chair with no interactions from staff for two, two hour periods. We also observed that records relating to people's care were left blank as staff did not have time to complete them. For example, one person had been assessed as at high risk and had chronic pressure ulcers. There was a chart in their room to record when they were repositioned. We inspected this chart at 3.45 pm and saw there was no record of them being re-positioned since 6am that morning.

Our inspection of 26 January 2015 also identified that insufficient checks were carried out on staff backgrounds before they commenced employment. At this inspection we saw that staff were still being employed with insufficient background checks. The service was not obtaining a full employment history before employing a person and where references had been obtained it was not clear if these were from a previous employer or were from a friend. We asked the manager what their understanding was of the checks they should carry out before employing a person. They told us that they should check a person's employment history for the past 10 years and obtain two references. They confirmed this had not been done.

This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe living in the service. One member of staff was unsure if they had received training in safeguarding adults from the risk of abuse. Other members of staff told us that they received safeguarding training as part of their yearly update training or as part of external training. Staff were able to give a basic explanation of what constituted abuse. All staff told us if they suspected abuse they would report it to the manager or the owner.

However, our observations showed that people were not protected from abuse and avoidable harm including breaches of their dignity and respect which could result in avoidable harm. One person told us, "I don't like the lounge, I don't like the people in there as they can be unkind, not the nurses they are nice." During our inspection we observed one person being forcibly moved by staff twice against their will. This was done in front of other people with no attempt by staff to protect this person's dignity. Staff were not supporting this person appropriately, they did not demonstrate and put into practice positive actions when dealing with this difficult situation that could potentially cause harm and compromise this person's safety.

This was a breach of Regulation 13(4) (b) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to individuals were not dealt with effectively. For example seven people's care plans showed their risk of falls had been assessed as high. Care plans did not detail how the risk was to be managed or any record of actions to guide staff put in place to mitigate the risk to people's safety.

Risks throughout the service were not monitored effectively. Policies and procedures for risks such as fire, food safety, gas safety and the monitoring of accidents to people were all dated 2013 and had not been reviewed to ensure they were up to date with current circumstances in

Is the service safe?

the service and recognised procedures and practice. Audits associated with these risk assessments such as hand hygiene methods were not up to date. The manager told us that there were no arrangements in place to continually review such matters as accidents or the occurrence of pressure ulcers to make sure that themes were identified and any necessary action taken. The manager cited the fact that they had only been promoted to manager from senior carer three weeks prior to our inspection as the reason for this.

The service was not clean or well-maintained. On entering the service there was a distinct unpleasant smell. Bathrooms were found not to be clean. For example in the first floor bathroom at the front of the service the ceiling was cracked and the paintwork chipped. Taps were heavily coated with lime scale where bacteria could multiply. This room had a large sash window and a high ceiling. The only heating in the room was a heated towel rail. When asked about heating in this bathroom one carer replied, "It can be a bit cold." The toilet seat in the staff/visitors toilet was stained brown on the underside. Floors in two bathrooms and the dining room were sticky when walked on. In one person's bedroom the taps to the sink were heavily coated in lime scale. A commode and urine bottle were found stored in the ensuite together with a caution wet floor sign. The ensuite had an unpleasant smell, there was not toilet paper on the roll and the handles on the toilet support were grubby. Another person's ensuite was used for storage of a foot spa, packs of incontinence pads and a metal pole for a hoist. The floor was sticky to the soles of the shoe, the toilet bowl was stained and discoloured brown and the taps were coated in lime scale.

We observed corridors were cluttered with equipment such as a commode, hoist, odd pieces of furniture and slippers. One person's care plan recorded, under their mobility assessment, that staff were to remove or clear hazards that can cause trips or falls, another person's mobility assessment recorded that staff should make sure there were no hazards or obstructions to their mobility. The cluttered corridors increased the risk of these people falling and sustaining and injury.

We saw that net curtains in people's bedrooms which had originally been white were now grey and carried a heavy coating of dust. In the dining room the centre of the curtain was hanging off of the hooks. We asked the manger if there were any plans to clean the curtains. They told us that they were planning to do this but due to their short time as manager they had not had time to do so. We had identified at the beginning of our inspection that there was a light bulb missing in the dining room making the room quite gloomy on a dull day. We pointed this out to the manager at the beginning of our inspection. The bulb had not been replaced by the end of our inspection meaning people were eating meals and some were reading in this room with insufficient lighting.

We spoke with the cleaner. They told us they completed regular records of their cleaning but that these had never been checked and the quality of their cleaning had never been questioned by the management of the service. We asked the manager if they checked that the service was clean and well maintained. They told us that they walked around the service during their shift but had not identified any problems. They did not keep a record of this check and were not able to provide any examples of anything they had found which needed attention.

This was a breach of Regulation 15(1) (a) (d) and (e) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they received their medicines when they needed them. However, we found that documentation was not always completed correctly. For example, one person who was at high risk of pressure ulcers was prescribed a cream and a spray to be applied regularly to reduce the risk of pressure ulcers developing. The care plan referred to a cream that had not been prescribed and the medication record showing that cream and spray had not been applied at all for one day in the previous two weeks and the cream only being applied in the morning for six days during the preceding two weeks.

This was a breach of Regulation 12(g) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Is the service effective?

Our findings

People were not supported by staff who had the necessary knowledge and skills to provide effective care. The manager told us that staff received all mandatory training in February. This training, which included moving and handling, safeguarding and mental capacity, was covered in half a day. Training was not effective as during our inspection we observed staff handling a person unsafely and not in accordance with the Mental Capacity Act. There was no system in place for checking when staff required updates to their training or if their training had expired. One member of staff told us that their medicines administration training had expired and that they were still administering medicines. We were unable to check this as there was no method of monitoring training received.

Staff told us they received had one to one meetings with a manager or senior carer however they could not recall when these had taken place or how regular they were. We could see no record of these meetings in the staff files. The manager confirmed this was where these meetings should be recorded. This meant that development needs were not recorded and followed up.

This was a breach of Regulation 18(2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Consent to care and treatment was not always sought in line with legislation and guidance. Staff told us they had received training in the Mental Capacity Act 2005 (MCA) at their yearly half day training. The manager told us that one person living in the service was subject to a Deprivation of Liberty Safeguard (DoLS) which had been authorised by the local authority and was due to be reviewed. They told us that they were seeking support from the local authority with regard to this as they were unsure of the requirements of the Act. Staff we spoke with were not able to effectively explain the requirements of the MCA. One member of staff told us, "It means you have to be more patient with them." Another carer told us, "(Person) cannot speak so I make the choice for them." We observed practice which demonstrated that staff were not putting into practice the requirements of the MCA. For example interactions between a person living with dementia and a member of staff where the interaction was not supportive and did not recognise the person's needs and another person who was exhibiting challenging behaviour which not was dealt with effectively by staff.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always supported to have sufficient to eat and drink. People who could speak with us told us they received a choice of meals and that the food was good. However, our observations and care records did not demonstrate that people's nutritional needs were being met. Two people's weight records showed that they had lost weight in the last two months. Their care plans did not evidence that this weight loss had been identified and action taken to address the risk of malnutrition . The service was recording the food intake of one person who had lost weight. No entries had been made on this food chart on the day prior to our visit. In another case the GP had visited and recorded that the person should be encouraged with fluids and observed to ensure they were hydrated. Fluid charts for this person showed a very low daily fluid intake with gaps as long as seven hours between drinks. We did not observe that this person was offered regular drinks during our inspection.

Another person was unable to communicate with us. Their care plan recorded that they should be offered a high protein and high calorie diet. The care plan did not contain details of what foods this person should be offered to meet these requirements. The care plan also stated that the person liked to eat independently with the assistance of specialist equipment. Our observations during this inspection and our previous inspection of January 2015 concluded that this person could not eat independently. Staff told us that this person now required a pureed diet since they had recently returned from a stay in hospital. The care plan did not record that they now required this type of diet or the reasons that they now required their food to be pureed.

Records showed that the service used the Malnutrition Universal Screening Tool (MUST) to assess people's nutritional needs. We found that in four cases the MUST was not being used correctly. Where the MUST required the process to be repeated within a specific timescale this was not taking place and where it showed that actions should

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be taken such as fortifying food or referral to a dietician this was not taking place. This meant that, as demonstrated above people, were losing weight and the appropriate action was not being taken to address this.

We observed the lunch time meal. We saw that people were not supported in a way which encouraged them to eat and enjoy their meal. For example a carer was supporting one person to eat their meal with a desert spoon. The carer placed a heaped desert spoon of food into the person's mouth and then held another full desert spoon heaped with food close to the person's mouth despite the still chewing the food in their mouth. When it was time for desert the carer said, "Do you want some desert?" and immediately spooned desert into the person's mouth before they had time to reply. The person was not allowed to eat at their own pace, no verbal encouragement was given and the meal was conducted in silence. In another example a carer who was supporting a person to eat was seated on a low stool to the side of the person which meant that to eat the person had to turn their head almost sideways to reach the food offered.

We observed one person who had been identified as at high risk on their MUST. Staff told us they were eating little. There was not plan in place to support them to eat more and reach a healthy weight. We saw that they had eaten little of their lunch. We asked a member of care staff how much the person had eaten and they told us that the person had eaten all of the meal, another member of care staff told us that the person had eaten all of their meal and the cook said they had eaten hardly anything. We checked the nutritional record for this person and found that nothing had been recorded on it. The MUST assessment in their care plan showed they were at risk of malnutrition. There was no plan in place to support them to gain weight or any evidence of referral to a dietician. This meant that the person was at risk of malnutrition as they were not being supported to eat sufficiently.

During our observations of lunch we saw that food that was brought for people who required a pureed diet did not show a contrast in colours being all dark green, it did not resemble the food that had been pureed from. We asked the cook if they pureed people's meals individually. They told us that they puree it all together as it took too long to prepare if it was pureed individually. Food served in this way did not take account of national guidance and did not promote people's dignity and aid their visual enjoyment of their meal.

This was a breach of Regulation 14(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they received support to access health services. One person said, " I have a lovely doctor who comes on Friday." Another person told us how staff had supported them on a recent hospital visit. People's records showed that they were visited by other healthcare professionals. However, we could not always see from people's records why the visit had taken place. For example one person's record showed that the incontinence nurse had visited to carry out a pad assessment. This person's care plan recorded that they were 'able to toilet independently.' There was no record that this person's continence needs had changed or why the incontinence nurse was visiting.

Is the service caring?

Our findings

People's records were not kept securely. We observed that people's care plans containing information about their care and support and other personal information were not kept securely. Records were kept in an unlocked cabinet in the dining room. During our inspection we saw that people were alone in this room with no member of staff in attendance meaning that they could access the records held in the cabinet.

This was a breach of Regulation 17(1) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff mostly demonstrated a caring attitude towards people. One person told us, "The carers are lovely, I get absolutely spoilt and they cannot look after you enough." However, our observations showed that most interactions between people and staff were based around a task the carer was performing and relied heavily on the caring nature of the staff member rather than input from the service. For example, in the morning all but one person was seated in the lounge. People were moved and seated by staff who acted in a caring and compassionate manner. However, people who were not able to verbally communicate were not given a choice of where to spend their time as it suited the service for everybody to sit together in the lounge. This was because of the staffing levels discussed previously.

During the afternoon we observed a carer sitting in the lounge engaged in administration. We observed that the person sitting next to them was trying to attract their attention but the carer ignored them so they hit the carer. The carer did not respond to this and left the room shortly after without speaking to the person. On another occasion staff were taking around drinks. Some people were offered drinks others were not. The support to people who needed help with drinking was brief. One person who was given a drink dipped their biscuit in their drink and offered it to somebody without a drink. This person ate the biscuit. Care staff were in the room and saw this but did not offer a drink to the person without one. This did not demonstrate a concern for people's wellbeing in a meaningful way, responding quickly to people's needs.

People living with dementia did not always get information and explanations they needed at the time they needed them in the way the needed them. For example we saw that two people came into the dining room and requested a cooked breakfast at 10.45am. Care staff told them it was too late for a cooked breakfast and they could have cereal or toast. Shortly after a member of care staff returned with plain buttered toast. The conversation between the two people demonstrated some confusion with what they were eating. Shortly after they had eaten their toast they were brought a cooked breakfast despite being told they could not have it earlier.

Our inspection January 2015 identified that people did not feel listened to or valued because changes were not implemented as a result of their feedback. The example given was that people had been waiting for over a year for a shower to be fitted. This inspection found that a shower had still not been fitted. The provider has told us that they have applied for planning permission to fit a shower but this could not be confirmed. We saw that no residents meetings had taken place to allow people to be involved in planning the care the service provided. The manager told us they planned to hold meetings but to date had not had time to do this.

When speaking amongst them and to us staff did not always demonstrate a respectful attitude to people living in the service. For example when speaking about what activities were provided the manager said, "When we do bingo we do all of them." This lack of respect demonstrated by the manager was seen throughout the staff team with staff frequently referring to people as, 'them' and ignoring requests for assistance.

Is the service responsive?

Our findings

Our inspection of January 2015 had found changes in people's health and welfare needs had not been reviewed and their up to date care needs recorded in their care plan, therefore, care plans did not reflect people's needs. This inspection found that, although the service had made changes to some people's care plans, they were not accurate in reflecting what people needed to provide care and support which met their current needs and preferences.

Not everybody we spoke with was aware of, or had been involved in writing their care plan. One person said, "Care plan, what is that?" There was no evidence in the care plans that people had been involved with writing them and they did not contain any background history of the person to enable staff to provide care which met their needs and preferences.

Care records were brief and often did not reflect people's current needs as they had not been reviewed or updated. For example one person's care plan stated they could mobilise with a frame. This person did not have a frame available and our observations concluded that they could not mobilise with a frame. This put the person at risk as if care staff followed the care plan and allowed them to mobilise they could fall and sustain injury. We observed that another person had advanced dementia and displayed behaviour that challenged. There was no care plan in place which supported staff to manage the behaviour or records which may show what triggered this behaviour. We observed staff dealing struggling to deal with this person's challenging behaviour. Their behaviour had escalated since our last inspection but professional advice had not been sought.

Care plans did not contain information about people's preferences on how they wanted their care delivered. For example one person's care plan stated, 'I am unable to do all my personal care so I require assistance from staff.' There was no explanation of what the person could do for themselves or what assistance they required and how they wanted that assistance provided.

Care we observed in the communal areas was tasked based and not centred on the needs of the person. For example the majority of interactions we observed were centred on a task which needed to be performed such as giving out drinks. We saw that if carers were involved in a task, such as writing up care notes, in the communal areas people's needs were ignored.

People were not supported to pursue their interests and take part in social activities. One person said, "My relative and I play snakes and ladders, I don't do anything else." Another person said, "Not done much in the last year, the choir used to come in every month." A relative told us, "[Relative] used to go to church in her wheelchair up until a year ago." There was no schedule of organised activities displayed in the service. During the morning of our inspection we saw that the television was on in the main lounge. There were five people in the lounge but only one person was watching the television which dominated the room. We asked the manager how the service supported people to develop relationships and avoid social isolation. They told us that there was one to one time for staff and people and that the service did bingo. They also said people watched television and one person had a newspaper delivered. We queried with the manager how the staffing levels allowed staff time for one to one's with people and if these were recorded. We were told these were not recorded and the reply regarding staff time was not specific. People's care records did not show what one to one time they had received from staff.

This was a breach of Regulation 9(1) (b) and (3) (a) (b) (c) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The reception hallway of the service had a complaints and concerns poster displayed. The poster directed people to raise a concern with staff and if this was not satisfactory to contact the manager. It went on to state if the response of staff was not satisfactory to contact the manager and gave an e mail address and telephone number. We asked the manager if the e mail address was that of the service. They told us that it was their personal e mail address and not that of the service. The poster did not detail the system for investigating complaints. We asked the manager for a copy of the procedure but they told us there was not one. A complaints policy was not listed in the service index of policies and procedures.

This was a breach of Regulation 16 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Is the service well-led?

Our findings

The service was not well-led. Our inspection of January 2015 had identified that systems were not in to place regularly monitor the quality of service provided. This inspection found that there were still nothing in place to monitor the quality of the service.

There was no registered manager in place. The manager who was in place at our last inspection had left and a member of staff had been promoted to this position. However, they told us that at the moment they were not able to work full time as the manager as they were still required to work as a senior on the care team two or three days each week. The new manager had not as yet applied to the CQC to be registered as the manager. The manager was receiving little support from the provider to move into a managerial position. The manager told us that the provider visited the service approximately once a month but no records of the visit were kept to demonstrate what checks and audits were carried out by the provider. They told us that if they needed support this would be via telephone or e mail.

We looked at the record of audits carried out by the manager. No recent audits of the service had been carried out to ensure the quality of the service carried out and identify areas for improvement. For example the last record of an infection control audit was dated 24 April 2014, bedroom assessments had been carried out in March 2014, and an assessment of the kitchen was dated January 2013. The manager told us that they carried out regular checks on the care plans but these were not formalised and no records of the checks were kept.

The service did not encourage open communication with people using the service. When asked if there had been any recent residents meetings one person replied, “Not that I know of.” The manager told us they had not organised any meetings. The manager told us they were in the process of producing a quality assurance survey for residents but as yet this had not been sent out. We asked staff if there had been any recent staff meetings to feedback their views or concerns. Staff we spoke with said they had attended a staff meeting but could not remember when it had taken place. When asked if the meeting had been constructive and used to gain their view of the service and how care be could be improved one carer replied. “They tell you what has to be.” The manager was unable to provide any minutes from the meeting.

This was a breach of Regulation 17 (2) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager was unable to demonstrate that they were aware of the risks faced by the service. They were aware of the breaches of regulations following our previous inspection from reading the previous report but told us they had failed to take action due to their short time in post as manager. They also said they had not had time to read materials recommended following a meeting with CQC the week previous to the inspection. They were not aware of or familiar with the changes to the care regulations. There was no system for the service to keep up to date with current guidance on the provision of care. The service did not have contact with local or national organisations which supported services to maintain good practice.

During our inspection we observed that the culture of the service was not person-centred. For the majority of the time staff were engaged with care tasks and did not engage with people and in some cases ignored requests for assistance. The service did not have any links with the local community. Visits from a choir had lapsed. The leadership in the service did not inspire staff to provide a quality service and senior staff were observed using inappropriate methods to move people and inappropriate phrases when referring to people living in the service.