Mr Alan Morris

Montagu Court Residential Home

Inspection report

49-51 Edgar Road, Cliftonville,
Margate, Kent CT9 2EQ
Tel: 01843 223648
Website: www.**montagucourt**.co.uk

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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 responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Overall summary

This inspection was carried out on 14 and 15 April 2015 and was unannounced.

Montagu Court Residential Home provides accommodation for up to 30 people who need support with their personal care. The service provides support for older people and people living with dementia. The service is a large, converted property. Accommodation is arranged over four floors. A shaft lift and stair lifts are available to assist people to get to the upper floors. The service has 20 single bedrooms and five double rooms, which couples can choose to share. There were 9 people living at the service at the time of our inspection.

A registered manager had not been employed at the service since August 2014. A registered manager is a person who has registered with the Care Quality Commission to manage the care and has the legal responsibility for meeting the requirements of the law. Like registered providers, they are 'registered persons'.

Summary of findings

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. As the provider is an individual he is not required to have a registered manager unless he is not going to be in day to day charge and manage the service.

We last inspected Montagu Court Residential Home in November 2014. At that inspection we found the provider had not taken action to meet regulations that they were not meeting at our inspections in December 2013, March and June 2014. The regulations breached related to the care and welfare of people who use services, supporting staff, and assessing and monitoring the quality of service. We are currently in the process of taking enforcement action against the provider.

The service lacked leadership and direction. The provider had been managing the service since the acting manager had left in January 2015. A nurse advisor had been employed as a consultant to support the provider and visited the service approximately once a week. The lack of leadership and oversight by the provider had impacted on all areas of the service. Staff were demotivated and did not feel supported by the provider. They lacked confidence in the provider to respond to concerns and issues and because of this they said that they no longer raised their concerns with the provider.

The provider did not operate a system to make sure there were enough staff available to meet peoples' needs at all times. Staff did not have time to spend with people and people received little interaction from staff during the day. Cover for staff sickness and vacancies was provided by other staff members. Staff had taken on additional responsibilities for management tasks as they recognised that if not, the management tasks would not get completed and people would be left at risk. Senior staff had taken it on themselves to manage people's medicines and people were receiving their medicines effectively. This had increased staff's workload. Some staff told us they were tired because of the number of hours they were working each week.

Staff knew the possible signs of abuse; however they did not know how to report possible abuse. Guidance was not available to staff about how to respond to safeguarding concerns and possible abuse. Staff had struggled to obtain information about how to report a recent allegation of abuse.

Emergency plans, such as emergency evacuation plans were not detailed and specific about the support people needed to remain safe. Staff did not have the skills and experience to keep people safe in the event of a fire. Action had not been taken to minimise the risks to people from the building and equipment. Bath equipment and the garden both posed risks to people.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards. The provider and staff were unaware of their responsibilities under Deprivation of Liberty Safeguards (DoLS). The provider did not have arrangements in place, as the managing authority, to check if people were at risk of being deprived of their liberty and apply for DoLS authorisations. Staff assumed that people were able to make decisions for themselves and supported them to do this.

Staff recruitment systems did not protect people from staff who were not safe to work in a care service. The provider had not obtained information about and checked staff's previous employment. Disclosure and Barring Service (DBS), criminal records checks, had been completed.

Staff were not supported to provide quality good care. Staff had completed basic training but had not retained all of the information they had been given. Staff did not have opportunities to develop in their role, learn new skills and keep up to date with best practice. Staff did not have the opportunity to meet with a senior staff member of a regular basis to discuss their role and practice and any concerns they had. Staff were not clear about their responsibilities and were not sure who they were accountable to for the care they provided.

Changes in the care people needed had not been assessed and care had not been planned to keep them safe and well. This included changes in people's mobility and the amount they ate and drank. Staff tried to meet people's needs in the best way they could but there was a risk that the care was inconsistent and was not the best way to meet people's needs.

People had choices about the food they ate but told us that they did not particularly like the food.

Summary of findings

Food was prepared to meet some people's specialist dietary needs but additional calories were not added to foods to support people at risk of losing weight. People had not always been referred to appropriate health care professionals when they lost weight.

People were offered choices in ways that they understood. Staff listened to people and responded appropriately to support them and reduced any anxiety they had. Most staff treated people with respect and maintained their privacy and dignity. People told us they felt that some staff did not like them.

People were not supported to continue with interests and hobbies they enjoyed. A programme of activities was on display but not all of the activities happened.

People and their relatives were not encouraged and supported to raise concerns and complaints about the service. Information about how to make a complaint was displayed; however, this was not written in a way that people could easily understand.

The provider was not aware of the shortfalls in the quality of the service we found at the inspection and did not understand the risks these posed to people. They described the shortfalls to us as 'minor misdemeanours'. Systems were in place to check the safety of the building but not the quality of the care people received. The provider had not obtained information from people and staff about their experiences of the care.

Records were kept about the care people received and about the day to day running of the service. Some records were not accurate and did not provide staff with the information they needed to assess people's needs and plan their care. Systems were not in place to make sure that records were retained securely and records could be located promptly when they were required.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We took enforcement action and cancelled the provider's registration.

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.

Staff knew the signs of abuse but had not received guidance about how to respond and report possible abuse.

There were not enough staff with the right skills and experience to meet people's needs at busy times of the day and to provide basic care such as baths.

Robust emergency plans were not in place. The grounds were not safe for people to use.

People received their medicines safely but staff competency in medication administration had not been checked this year.

Is the service effective?

Inadequate 

The service was not effective.

The provider did not assess people's ability to make decisions. Arrangements were not in place to check if people were at risk of being deprived of their liberty.

Appropriate action had not been taken when people were not eating and drinking well. People were not encouraged and supported to drink enough.

Staff had not received the training and support they needed to provide safe and appropriate care to people.

Is the service caring?

Requires improvement 

The service was not consistently caring.

Staff did not always speak to people respectfully. People felt that some staff did not like them as this was the impression the staff gave them.

Staff knew people well and treated them with kindness and compassion.

People's privacy and dignity was maintained. People were supported to wear what they wanted to and to maintain individual styles.

Is the service responsive?

Inadequate 

The service was not responsive.

People's needs had not been assessed and their plans of care had not been updated when their needs changed.

People were not supported to take part in activities they enjoyed, inside and outside of the service.

Summary of findings

People and their families were not encouraged to make complaints or raise concerns. Information about how to make a complaint was not written in a way that people could easily understand.

Is the service well-led?

Inadequate

The service was not well-led.

The provider did not have a clear set of values, including people's involvement, equality and safety for the service.

There was no leadership and staff were demotivated and felt unsupported. Staff were not clear about their roles and responsibilities.

Checks on the quality of the service had not been completed. People, their relatives and staff had not been asked about their experiences of the care.

Records about the care people needed and received were not accurate and up to date.

Montagu Court Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 14 and 15 April 2015 and was unannounced. The inspection team consisted of one inspector, a specialist professional advisor, whose specialism was in the care of older people 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.

We looked at previous inspection reports and notifications received by CQC. Notifications are information we receive from the service when a significant events happen, like a death or a serious injury. We spoke with the local authority case managers who had met with some of the people living at the service before our inspection.

During our inspection we spoke with all nine people, 1 person's relatives, six staff and the registered provider. We looked at the care and support that people received. We looked at people's bedrooms, with their permission; we looked at care records and associated risk assessments for four people who needed a lot of care and support. We observed medicines being administered and inspected nine medicine administration records (MAR). We looked at management records including six staff recruitment files, training and staff support records, health and safety checks for the building, and staff meeting minutes.

We last inspected Montagu Court Residential Home in November 2014. At this time we found that accidents and incidents were not analysed so patterns and trends were not picked up that may reduce further accidents and incidents from happening. Changes in people's needs were not always reflected in their care plans and risk assessments. The culture within the service was one of mistrust between the staff and the management team. Staff did not feel supported or listened to and felt undervalued by the provider. Staff did not receive regular one to one meetings and had not received appraisals. Audits of different aspects of the service had not always completed. We found the same issues and shortfalls at the inspection of 14 and 15 April 2015.

Inadequate

Is the service safe?

Our findings

People told us they felt safe at the service. One person told us, “Staff always come in and check on me at night.” Another person told us, “Staff come fairly quickly when I ring the bell”.

The provider did not have a process to help them decide how many staff were required to keep people safe and meet their needs. The number of people using the service had reduced recently and the provider had reduced the number of staff working between 8 am and 11 am because of this. The provider had not considered the layout of the building, rooms in use, or people’s needs when deciding how to deploy staff. Eight of the 25 bedrooms were in use and these were across three floors of the building which meant staff took time to get to people’s rooms.

Cover for staff sickness and vacancies was provided by other staff members and the provider. Some staff told us they were tired because of the number of hours they were working each week. Many staff told us they had not had a holiday for a long time. Staff told us they felt bullied by the provider into covering vacant shifts. They said they felt guilty when the provider told them people would not get the care they needed if they did not work.

At times during our inspection, all the care staff were providing care in people’s bedrooms and bathrooms and the provider and their wife observed people in the lounge. The interaction between the providers and people during these times was limited. Staff told us that the provider and his wife rarely stepped in to help them unless staff specifically asked them for support and help. The provider’s support was not available at busy times of the day such as when people got up because the provider was not at the service when people got up in the morning or when people went to bed. Shifts were not planned and staff were not allocated specific important tasks, such as supporting people at meals times. Some people did not get the support they needed at lunchtime as staff were completing other tasks or were taking a break.

Staff did not have time to spend with people and several people received little interaction from staff during the day. Not everyone using the service received regular baths or showers, as staff did not have the time to help people. During our two day inspection two people received a shower or bath. One person told us, “This is different from last week. They were short staffed so we couldn't have a bath”. One person’s care plan stated, “likes a bath once a week or more”, they had not received regular baths. Another three people had not received a bath for several months. Staff told us, “The three people who need hoisting do not get a bath. We do not have the time. There are three staff on the shift. “

Some people chose to spend time in their rooms, staff completed regular checks to make sure the people were safe. No equipment, like call bells, was in place for people in the lounge or dining room to call staff if they needed them.

The registered provider had not taken action to make sure there are sufficient numbers of staff to meet people’s needs and keep them safe at all times. This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff knew the signs of abuse, such as bruising or a person being withdrawn. The provider had not instructed staff on the action they needed to take when they thought that someone may be at risk of abuse or harm. Staff told us that as a manager was not working at the service they did not know who to inform of concerns they had. They were not confident that the provider would know what action to take if they reported to him. Before our inspection staff had identified that a person may have come to harm. They had taken some action to get the support and advice they needed to keep the person safe. However, the staff member did not take immediate action as they had to research how to contact professionals outside of the service for support and advice. They then had to search for the relevant forms to complete. This caused a delay in the allegation being reported to the local authority safeguarding team. Following this incident the provider had not taken action to ensure that all staff knew how to raise safeguarding concerns appropriately and without delay in the future.

Most staff had completed safeguarding training, however one senior carer who was responsible for leading shifts, in the absence of a manager and the provider, had not received the training. Staff’s understanding of the training they had completed had not been checked to make sure they had the knowledge they required to keep people safe.

Inadequate

Is the service safe?

The provider did not operate effective systems and processes to immediately respond to allegations or evidence of abuse. This was a breach of Regulation 13(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A fire evacuation plan was in place, including the use of equipment to help people to escape safely. Staff had not been trained to use the equipment and did not know how to use it. Staff had not practiced the evacuation plan. During the day or at night and there was a risk that staff would not know how to keep people safe in the event of a fire. We reported our concerns to the local fire and rescue authority.

The provider did not have plans in place to respond and manage emergency situations such as fire. This was a breach of Regulation 12(3)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Accidents involving people were recorded. A nurse specialist employed by the provider as a consultant reviewed these to see if there were any patterns or trends. They found that one person was falling frequently at night and action had been taken to support the person to get up when they woke up as they were an early riser. .

The consultant employed by the provider reviewed people's risk assessments and made any necessary changes when they visited approximately once per week but on occasions less often. No action was taken to review the risks to people when their needs changed between the consultant's visits. We observed two staff help a person to transfer from an armchair to a wheelchair. The person was very anxious, grabbed the staff and leant backwards making the situation risky for both them and the staff. One staff member told us, "Last week they were walking, it's very sad." The change in the person's needs had not been reassessed and care had not been changed and planned to keep the person and staff safe.

A process was not in operation to ensure that all staff were informed of the changes in the way risks to people were managed. Staff relied on 'word of mouth' to share the information. There was a risk that staff would not be aware of changes in the risks to people and the action they needed to take to keep people safe.

The provider had failed to assess and mitigate risks to people. This was a breach of Regulation 12(1)(2)(a)(b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A garden was available for people to use at the rear of the property. Our inspection took place on a warm sunny day. The garden had not been maintained and was not safe for people to use. The garden was accessed by a wooden ramp from the dining room, the wooden ramp looked rotten and the surface of the ramp was uneven. Handrails were not provided to support people to use the ramp independently and to prevent people from falling off the edge. The paved area of the garden was uneven and posed a trip hazard to people. Equipment in the garden, such as the washing line also posed risks to people because it hung just below head height and could get caught around someone's neck. The service was free from unpleasant odours. The premises were secure and the identity of visitors was checked before they entered the service.

The only accessible bath was on the top floor, a long way from communal areas and people's bedrooms. A bath seat and an overhead hoist were provided to assist people in and out of the bath. The bath seat was very dirty and needed cleaning. The seat had several small splits in it and people using it were at risk of being pinched by the seat, especially as some people had fragile skin.

Maintenance and refurbishment plans were not in place for the building, grounds or equipment. Staff told us, "What breaks gets replaced"; however we found that items such as the bath seat had not been replaced. A handyman was available and repaired identified faults. Regular checks on equipment had been completed.

The provider had failed to maintain the grounds and this posed a risk to people. Suitable arrangements were not in place to maintain and renew the premises and equipment. This was a breach of Regulation 15(1)(e) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff recruitment systems did not protect people from staff who were not safe to work in a care service. The provider had failed to obtain sufficiently detailed information about staff's previous employment, including a full employment history and the reasons for any gaps in employment. Staff conduct in previous social care employment had not been checked. Disclosure and Barring Service (DBS) criminal records checks had been completed for staff. Information

Inadequate

Is the service safe?

about applicant's physical and mental health had been requested. This had not been reviewed and further information had not been obtained from applicants to make sure they were fit to fulfil their role. Other checks including the identity of staff had been completed.

A process was not in place to make sure that staff had the skills, knowledge and experience they needed to fulfil their role when they were appointed or promoted. Job descriptions were in place for each role but these were not used as part of the staff selection process. The provider asked some staff to 'act-up' and take on senior roles, the provider had not reviewed staffs' skills and experience when offering staff 'acting up' opportunities.

The provider had not established and operated effective procedures to ensure staff were of good character, had the necessary qualifications, competence, skills and experience and were fit to perform their work. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People received their medicines safely from trained staff. People were given their medicines at the time they required them. The necessary checks, such as checking people's blood pressure or blood sugars were completed before people were given their medicines. Each staff member who gave people medicine had only been observed administering medicines once in 2014 to check they were competent to complete the task. No competency checks had been completed in 2015 so the provider could not be sure that staff were still competent in administering medicines.

None of the people were responsible for taking their own medicines so staff administered all medicines. Systems were in place to make sure that regular medicines were ordered on time and returned to the chemist if they were no longer needed. Records were kept of the medicines people received. No one was prescribed medicines only given on a 'when needed' basis. (PRN). People's medicines were stored safely.

Inadequate

Is the service effective?

Our findings

People were offered choices in ways that they understood. Staff responded to the choices people made. People were able to choose where they spent their time and who with.

Some people were able to make decisions for themselves about all areas of their life, and staff supported them to do this. Other people were not able to make complex decisions. General assessments of people's capacity to make decisions had been completed but assessments relating to specific decisions had not been completed. The provider did not have a system in place to assess people's ability to make specific decisions, when they needed to be made. People's relatives and professionals had been involved in making decisions with the staff in people's best interests.

Most staff had completed training about the Mental Capacity Act 2005 but did not apply this in practice. The provider and many staff did not know who could lawfully make decisions on a person's behalf or when they needed to make decisions, with others, in the person's best interests. One person's relative told us that they made decisions about their relative's care, with the staff in their relative's best interests. Records were not kept of the decision making process to demonstrate that they had been taken lawfully.

People had been asked to give their consent for several things, including having vaccinations. These decisions had not been reviewed to make sure that people remained happy with their decision. The consent people had given for vaccinations had not been reviewed each year before they were given their annual flu vaccination.

People, including those living with dementia, made choices for themselves when they were able to, such as where they spent their time and what they ate. Staff assumed that people were able to make decisions for themselves and supported them to do this, as required by the Mental capacity Act 2005.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). The service was not meeting the requirements of DoLS. Staff were unclear about their responsibilities under DoLS. Assessments of the risk of people's liberty being restricted unlawfully had not been completed; six of the nine residents required an assessment as their liberty was restricted and this had not happened. The remaining three people were able to come and go freely without risk.

The provider had failed to assess the risk of people being unlawfully deprived of their liberty. This was a breach of Regulation 12(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When staff first started to work at the service they received an induction to get to know the people and the care and support that they needed. Staff promoted to new roles had not completed an induction to ensure they knew and understood their new roles and responsibilities. Promoted staff had not had the support to develop the skills their new role required.

The provider did not have a system in place to ensure staff received the training they needed to perform their duties. Most staff had completed basic training including moving and handling and infection control, but not all staff had completed this training. Staff told us the training was basic and repetitive and did not update them about any changes in regulations, guidance or best practice. They told us they watched the same DVD's and answered the same questions each time. They told us that the training was not specific to the needs of the people living at the service or to the provider's processes and systems. Staff's skills, knowledge and competence had not been checked following the training to ensure staff applied the skills they had learnt.

Three staff had enrolled on 'Diplomas in Health and Social Care' courses and eight staff had achieved this Diplomas or equivalent qualifications. The provider had not ensured that sufficient staff with leadership skills and qualifications worked at the service.

The provider had not followed their procedures to support staff, including supervisions and appraisals. Staff told us they did not feel supported by the provider to deliver safe and effective care. Staff had not met with the provider or senior staff regularly for supervision to talk about their role and the people they provided care and support to. Development plans were not in place to support staff to develop their skills, knowledge and experience. Staff were not supported to identify areas where their practice required improvement. Steps had not been taken by the provider to support staff to develop the attitudes and

behaviours they needed to complete their role and to provide good care. Before the manager left in Jan 2015 she had invited staff to appraisals but these appraisal meetings had not happened.

Staff had not received appropriate support, training, professional development, supervision and

appraisal as was necessary to enable them to carry out the duties they were employed to perform. This was a breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to see health care professionals such as their GP and community nurses. When they were able, people visited their GP at the surgery on their own. An optician and dentist visited occasionally and a chiropodist visited approximately every six weeks. People were able to choose if they saw these professionals.

People told us they did not particularly enjoy the food at the service. One person said, "I have a salad most days because it's about the only nice thing to have". Another person said, "It's like workhouse food". One person commented, "The pudding is nice and better than the main course". Two cooks were employed to prepare lunch and tea. People told us the quality of the meals depended on which one of the cooks was working.

People were offered a choice of food at each meal and staff knew what people preferred. The cook offered people choices in a way they understood and people were not rushed. If people did not like the choices offered the cook prepared an alternative of their choice. A variety of main courses and puddings were prepared each day. People were able to choose their pudding from a dessert trolley containing at least five options. Many of the meals were homemade such as puddings.

The cook understood the different diets people needed to keep them healthy. Low sugar varieties of the puddings were on offer, such as sugar free custard. Some people needed 'fortified' food with additional calories as they were at risk of losing weight. Milk was fortified with additional skimmed milk powder and some foods such as custard were fortified with cream for people who needed them. Staff, including the cook, had not received information or training about the fortification of food. The calorie content of foods was not always maximised for people who needed it. Staff told us they had made a fortified milkshake, under the guidance of the consultant, for one person who was at risk of losing weight. They told us that the person had enjoyed the shake and had drunk all of it. They had not continued to prepare and offer more shakes for the person when they had refused meals and snacks and the person had continued to lose weight.

People's weight was recorded and monitored. Some people had been referred to a dietician when they had lost weight. One person had lost weight recently and was not eating or drinking well. The provider and staff were unclear if the person had been referred to a dietician. The provider thought a referral had been made approximately one month ago whilst other staff said a referral had not been made. Staff found that a referral had not been made and the person's GP was contacted on the second day of our inspection.

Records of what the person ate and drank were kept and showed the person had eaten and drunk very little on some days. Action had not been taken to review what the person had consumed and to take action to support the person to eat or drink more the following day. This increased the risk of the person becoming dehydrated or malnourished. The person's care plan stated they were to be offered 'snack pots' between meals and additional snacks and puddings. This did not happen during the two days of our inspection. There was no oversight of the person's care and action had not been taken to maintain the person's health in relation to eating and drinking enough. Action had been taken to support another person to have a healthy diet when they were not able to make informed choices about the food they needed to keep them healthy. On this occasion action had been taken in accordance with the Mental Capacity Act 2005 to keep the person well.

People had their breakfast when they got up. Lunch was offered at 1pm and afternoon tea at 5pm. Supper was offered to people before they went to bed. Staff told us that snacks were offered to people between meals but this did not always happen. No system was in place to ensure that snacks were regularly offered to people. People were offered biscuits with their morning drink but no snacks were offered to people in the afternoon. Jugs of squash were available to people who could help themselves. Only one of the five staff members working during our inspection supported and encouraged people to drink throughout the day. People who could not pour their own drinks were at risk of not drinking enough.

Inadequate

Is the service effective?

People who had difficulty swallowing or were at risk of choking were offered soft or pureed food. Foods were pureed separately and presented in an appetising way so that people were able to taste the flavours of each food. People were able to choose where they ate their meals and staff knew their preferences about where they liked to sit. The atmosphere in the dining room, where most people ate their lunch was relaxed and people chatted to each other and any staff present.

People's nutrition and hydration needs had not been regularly assessed and reviewed and action had not been taken to respond to people's changing needs in good time. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service caring?

Our findings

People and their relatives told us that most staff were very nice, and were 'kind' and 'polite'. Staff knew a lot about people, their likes and dislikes and how they liked things done. We observed staff and people in the lounge and dining room, staff spoke and joked with people individually and people laughed and smiled back.

Most staff listened to people and responded to them. Some staff took people's feedback about the service personally and became upset. People told us they thought that some staff did not like them. One person told us, "Sometimes X (staff) and Y (staff) are rude to us." Another person said "X (staff) is not very nice to us, sometimes they are quite rude and sharp." We informed the provider of people's concerns during our inspection. People had not been supported to express their views about the care and support they received and had not been given the opportunity to share their views about staff with the provider. The provider did not have a rapport with people and did not chat to them when in their company.

People were generally treated with kindness and compassion by staff and appeared relaxed in their company. People, and their relatives, had been asked for information about their life before they moved into the service. Staff knew about people's histories and chatted to people about their life and family. People enjoyed chatting to staff about their life. Staff used the information about people's histories to talk to them and make them feel secure and this reduced their anxiety. Staff worked at people's pace and did not rush them. Several people with dementia told staff they wanted 'to go home'. Staff gently distracted them and sat and spoke with them individually.

Staff treated people with respect. People were asked quietly about personal matters, such as using the toilet. Staff sat next to people while supporting them to eat a meal and chatted to them as they helped them. People were provided with information about what they were eating and were asked how they would like their support to be provided. One staff member apologised when they had to leave a person they were supporting to eat, to complete other tasks, as no other staff were available in the dining room.

People told us they were offered choices about all areas of their life and were involved in making day to day decisions where they could. People were able to get up and go to bed when they wanted. Staff knew where people liked to spend their time and respected their choices. Three people told us they chose what they wore every day. Some people wore jewellery that matched their clothes and this was noted in their care plan and supported by staff. Staff paid people compliments about how they looked including after they had visited the hair dresser. People told us they were supported to buy their clothes online. One person told us, "We see them on a machine and staff get them for us."

People's privacy was maintained. Staff described to us how they maintained people's privacy when they provided personal care. Screens were used to maintain people's privacy in communal areas when people were being hoisted from one seat to another. People received care and treatment in their bedroom. Staff knew if people preferred staff not to go into their bedroom when they were not there and respected this. Personal, confidential information about people and their care and health needs included in their care plans was kept securely. Staff wrote notes in people's care plans and put them away when they had been completed. People's personal information was not accessible to other people and visitors to the service.

People were supported to speak to their care manager when they asked to. Information about other advocacy services, especially for people who did not have a care manager, had not been provided to people. There were no restriction on people's family and friends visiting the service. People and their relatives told us that they visited often.

Inadequate

Is the service responsive?

Our findings

People told us they knew that plans had been written about the care they needed when they moved into the service. People had not been offered the opportunity to look at their care plans and did not know if they had been reviewed or updated. We asked one person if we could look at their care plan, they replied, "Is that my care plan? Is it good?"

People had a wide range of needs. Some people were independent and required minimal support from staff. Other people required support from staff to meet all of their needs including eating and drinking, keeping clean and moving around the service. People, who were able to, told staff what support they required and how they would like to be supported, remained as independent as they could. Other people who had difficulty communicating or had dementia were not involved in planning their care or in saying how they would like to be supported. People's relatives and others who knew them well had not been involved in planning people's care when the person was not able to do this for themselves.

Everybody was happy with the support they received from staff and accepted what staff did for them. One person's relative told us they and their relative had not been involved in developing the person's care plan and had not seen it. They said they had been at the service for several years. They told us that the person's needs had changed since they moved in but they still had not been involved in any care plan review. Some people's plans had been signed by them in 2013 but they had not signed to say they had seen it or agreed with it since this date. People's assessments and care plan had been written by the previous manager and had been reviewed by the consultant in 2015.

Assessments of people's needs had been carried out before they moved in to the service. Information had been obtained from other service providers or commissioners before people were offered a care service. No one had moved into the service for approximately 1 year because following previous inspections the provider agreed not to admit new people. Some further assessments had been completed once people began to receive a service but changes in people's needs had not always been identified and recorded so care had not been planned to reflect the changes. One person's ability to walk had reduced and they needed support to move around. A new moving and handling assessment had not been completed. Care had not been planned to meet the person's needs and guidance had not been given to staff about how to move the person safely.

Guidance was provided to staff about how to provide people's care and support to help them remain as independent as possible, however this had not been updated when people's needs changed. Staff told us that they did not have time to read the care plans and relied on information from other staff and their experience of working with the people to provide their care safely.

There was no process in operation to regularly review people's care plans to ensure they remained current. Action had not been taken when people's needs had changed to amend their care plan and inform all staff about the changes. Systems were not in place to review the care people had received to identify risks and changes quickly.

People using the service and the person who is lawfully acting on their behalf, were not involved in an assessment of their needs and preferences. Assessments had not been reviewed regularly and whenever needed. Care plans had not been kept up to date with any changes in people's needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had little opportunity to follow their interests or take part in social activities. Staff told us that people needed more stimulation and things to do but they did not have the time to spend with people. A programme of activities was on display. The activities scheduled for the first day of our inspection did not happen and people spent the day in the lounge with the television on. People did not appear to be watching or be interested in what was on the television. Many people spent their time doing nothing. An activities coordinator worked at the service on three mornings a week and spent time chatting to people on the second day of our inspection. People from the local church visited regularly and chatted to people.

A staff member told us, "There is always a gap after lunch when we could take people out just for an airing but the provider is not happy to have suggestions from staff. The garden area is not suitable. We cannot take people out there as it is uneven and not really safe." Another staff member did not know if people were 'allowed' to go out

Inadequate

Is the service responsive?

with the support of staff. They said that they would like to take people out to the seafront, a short walk away, or to the local shops. One person was able to go out alone and another was taken out often, other people had not been offered the opportunity to go out. Activities were not available for people to participate in when they wanted to and people relied completely on staff to keep them occupied and stimulated.

Information about how to make a complaint was displayed; however, this was not written in a way that people could easily understand. The provider had not taken action to encourage and support people and their families to raise concerns, make complaints and give feedback about the service. Some people had raised concerns they had with staff about issues such as the quality of the food and staff being rude to them. These had not been recorded and action had not been taken to address people's complaints to their satisfaction. Other people did not feel comfortable to raise concerns they had. A process to respond to complaints was in place; however the provider had not recognised that people were unable to use the process.

The registered provider had not established an effective and accessible system for identifying, receiving, recording, handling and responding to complaints by service users and others. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

The provider told us they were managing the service as they had not replaced the manager when they left in January 2015. The provider did not have a vision and set of values for the service. Values such as involvement, compassion, independence and respect were not central to everything the service did. One staff member told us, "The service just drifts along".

A manager was not employed to lead the staff team and manage the service on a day to day basis. The provider had not taken on or delegated management roles and responsibilities when the previous manager had left the service in January 2015. Many management responsibilities including monitoring people's care and leading and supporting staff were not being completed. Staff were not always clear about their roles and responsibilities. Staff told us that they had taken on additional responsibilities when the manager left as important tasks such as ordering medicines would not be completed unless they did it themselves. Systems were not in place to allocate staff specific duties during each shift. Staff were not held accountable for care and support that was not provided, such as supporting people to eat at mealtimes as the staff were not monitored or directed. The provider was present in communal areas of the service throughout the first day of our inspection but did not show any leadership or support to staff.

Staff did not feel supported and appreciated by the provider. They did not receive feedback about their work and were not motivated by the provider to deliver a good quality service to people. Staff told us that they were motivated by the people they cared for and worked together as a team to support each other and provide the best care they could. The consultant visited the service approximately once a week. Staff said the consultant was supportive and they felt confident to contact them for advice about people's care.

The provider did not have the required oversight and scrutiny to support the service. They had not taken action to monitor and challenge staff practice to make sure people received a good standard of care. Staff did not have the confidence to question the practice of their colleagues or report concerns they had to the provider, including practice that might put people at risk of harm. Several staff told us that when they had raised concerns with the provider, the provider had failed to address their concerns and had 'swept them under the carpet' or dismissed them as 'a misunderstanding'. They told us that they no longer told the provider about situations that concerned them. Some staff felt they were not treated equally by the provider and other senior staff said, "There is one rule for one and one rule for another". They explained that this meant that some staff chose what tasks they completed and when they took a break.

People were not involved in the day to day running of the service. Systems were not in place to obtain the views of people and staff to improve the quality of the service. People had not been asked for their views about the service they received or for suggestions about how the service could be improved. Staff had not been given an opportunity to tell the provider their views about the quality of the service they delivered or make suggestions about changes and developments. Staff told us that when they identified small changes that would improve the service they implemented these without consultation with the provider. Two people's relatives had responded to a questionnaire sent to them by the provider asking them about the quality of the service. The provided had not taken action to gather the views of other relatives or visitors to the service.

Systems and processes were not in place to ensure that the service was of a consistently good quality. The provider had not made it clear to staff what good quality care looked like and how it would be provided. They were not aware of the shortfalls in the quality of the service found at the inspection. Systems were in place to assess the safety of the building and equipment. Some checks had not been completed consistently and actions identified had not been addressed. Three of the four actions required following a check of the kitchen in October 2014 had not been completed. Further checks had not been completed and the risks remained. Checks on the quality of the care people received had not been completed. The provider relied on the consultant to monitor the quality of the service and did not know what checks they had completed. The consultant's job description was not clear about their responsibilities and stated, "'Controlling and monitoring, all auditing'.

Staff were not supported by the provider to keep up to date with changes in the law and recognised guidance. The provider and staff were not aware of recent changes in

Is the service well-led?

health and social care law or the way that CQC inspected services. Polices and guidelines for staff were available in the service, however staff had not been prompted to read and use them. The provider had not reviewed their policies to ensure they were up to date and provided staff with the guidance they needed.

The call bell system was able to give the provider detailed information about how quickly call bells were answered. The provider had not reviewed this information to make sure that people did not have to wait for the support they needed.

The provider did not have systems and processes in operation to assess, monitor and improve the quality and safety of the service. Feedback on the service provided from relevant persons had not been obtained by the provider so they could use it to continually evaluate and improve the service. This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Accurate and complete records in respect of each person's care had not been maintained. Records of what people had eaten and drunk were not accurate, and could not be used to plan their care. One person's records showed that they had eaten a slice of toast and drunk a cup of tea for breakfast on the first day of our inspection. The person did not eat and drink anything for breakfast that day. Staff were not available to support them and the person's breakfast went cold and was cleared away by staff. A new hot breakfast was not provided and the record was not an accurate record of what the person had for breakfast.

Decisions made about people's care were not consistently recorded. Night time checks for one person had been reduced; however, the reasons for the change had not been recorded. Records regarding the checks gave staff contradictory guidance about the support the person needed to remain safe at night. The change had not been communicated to staff quickly and the additional checks had continued, which resulted in disturbing the person's sleep for a further 2 days.

A system to archive records so they could be retrieved easily was not in operation. Old records relating to all areas of the service were muddled and had not been filed; some were stored on the floor under a desk in the office. The provider did not know if they were registered as a data controller with the Information Commissioner's Office (ICO). Every organisation that processes personal information is required to register with the ICO.

The provider did not have systems and processes in operation to maintain an accurate and complete record in respect of each service user, including of decisions taken in relation to their care. This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered provider had not taken action to make sure there are sufficient numbers of staff to meet people's needs and keep them safe at all times. Staff had not received appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform.

The enforcement action we took:
Cancellation of registration

Regulated activity	Regulation
	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not operate effective systems and processes to immediately respond to allegations or evidence of abuse.

The enforcement action we took:
Cancellation of registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not have plans in place to respond and manage emergency situations such as fire. The provider had failed to assess and mitigate risks to people. The provider had failed to assess the risk of people being unlawfully deprived of their liberty.

The enforcement action we took:
Cancellation of Registration

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The provider had failed to maintain the grounds and this posed a risk to people. Suitable arrangements were not in place to maintain and renew the premises and equipment.

The enforcement action we took:
Cancellation of Registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The provider had not established and operated effective procedures to ensure staff were of good character, had the necessary qualifications, competence, skills and experience and were fit to perform their work.

The enforcement action we took:
Cancellation of Registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs People's nutrition and hydration needs had not been regularly assessed and reviewed and action had not been taken to respond to people's changing needs in good time.

The enforcement action we took:
Cancellation of Registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

This section is primarily information for the provider

Enforcement actions

People using the service and the person who is lawfully acting on their behalf, were not involved in an assessment of their needs and preferences. Assessments had not been reviewed regularly and whenever needed. Care plans had not been kept up to date with any changes in people's needs.

The enforcement action we took:
Cancellation of Registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The registered provider had not established an effective and accessible system for identifying, receiving, recording, handling and responding to complaints by service users and others.

The enforcement action we took:
Cancellation of Registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have systems and processes in operation to assess, monitor and improve the quality and safety of the service. Feedback on the service provided from relevant persons had not been obtained by the provider so they could use it to continually evaluate and improve the service. The provider did not have systems and processes in operation to maintain an accurate and complete record in respect of each service user, including of decisions taken in relation to their care.

The enforcement action we took:
Cancellation of Registration