Little Heaton Care Limited

Little Heaton Care Home

Inspection report

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Ratings

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

Overall summary

Little Heaton Care Home is registered to provide personal care and accommodation for up to 25 people who do not need nursing care.

We carried out this inspection following a safeguarding concern regarding medications and whistleblowing alert that stated training, staffing ability and food provision were of concern. Following the inspection visit we also received information from a whistle-blower regarding complaints they had made and medication concerns.

This unannounced inspection took place on 25 September 2015 and 1 October 2015

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

Peoples view's about the service they received were mixed. While some people were very happy, others were not as happy. In addition, our observations and the records we looked at did not always match the positive descriptions some people had given us.

During the inspection, we spoke with nine people living at the service, two relatives, eight staff and the registered

Summary of findings

manager. 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.

The service was not consistently respecting and involving people who use services in the care they received. For example all the care plans viewed did not show the person's choices and personal preferences. The care plans did not involve the person or their relative when they were written and their views were not reflected in the care plans. People told us they had no input into the menus or activities.

Staff members were not always following the Mental Capacity Act (2005) for people who lacked capacity to make decisions. For example people's mental capacity was not assessed and there was no information available in the service for the staff that helped them support a person with fluctuating capacity. We saw inconsistent approaches from staff with some staff explaining to people before they undertook a care action, other staff failed to give the person any information about the care and support they were about to deliver.

We saw that people's health care needs were not accurately assessed and that risks such as poor nutrition were not assessed. People's care was not planned or delivered consistently. In some cases, this put people at risk and meant they were not having their individual care needs met. Records regarding care delivery were not consistently accurate or up to date leaving people at risk of not having their individual needs monitored or met.

Neither the registered manager nor the registered provider identified, investigated or responded to people's complaints. Complaints were not recognised or addressed by the service.

Staff members were inconsistent in their approach for safeguarding with some staff able to explain in detail how they reported any safeguarding concerns. When we looked at how staff put this into practice, we saw that three safeguarding concerns had not been dealt with or reported to social services and CQC. The lack of reporting safeguarding concerns appropriately potentially placed people who lived in the service at risk. We asked the registered manager to report the safeguarding concerns identified at the inspection to the local authority and to CQC appropriately.

People who lived in the service did not consistently receive their medicines in a safe manner that met their individual needs. Staff did not have the correct information or training to give medicines when needed and this meant that people would not be able to receive their medicines safely when needed.

Staff training was underdeveloped with large gaps in the training of staff particularly around dementia care needs, medicines training, mental capacity, moving and handling and safeguarding. The majority of staff had been appropriately checked before starting work with the exception of one member of staff who had not been checked for their suitability to work in the service before undertaking voluntary work.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We found that where required, DoLS applications had been made and the manager understood when an application should be

made and how to submit one.

The arrangements that the provider had in place to check the quality of the service were not in place as such the providers' arrangements meant service users' views or their relatives did not influence the service provided and complaints were not appropriately addressed or responded too.

Overall, we found significant shortfalls in the care provided to people. We identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Care Quality Commission is considering the appropriate regulatory response to resolve the problems we found. We will publish what action we have taken later. Where regulations have been breached information, regarding these breaches is at the end of this report.

As the overall rating for this service was 'Inadequate' and the service is therefore in 'Special measures'. The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's

Summary of findings

registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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.

People who used the service were being put at risk because medication was not given correctly. Safeguarding concerns and complaints were not appropriately dealt with.

There were limited arrangements for people to be involved in the decisions about their care.

The service had no arrangements in place to manage infection control.

Is the service effective?

Inadequate

The service was not effective.

We found that care plans did not accurately reflect people's individual health and social care needs. . As a result people did not always receive care that met their personal needs.

Staff did not have up-to-date training and on-going planned supervision, Staff practice was inconsistent with some staff responding to people's better than others able to respond to people's needs better than others. People who had fluctuating capacity and were less able to make a decision did not have arrangements in place to assist them to make appropriate decisions.

People's views about the food were not consistent. Some stating that the food had improved others stating that it was frequently cold and not of their choice.

Is the service caring?

Requires improvement

The service was not always caring.

We found that staff's approach to people did not always take their individual needs into account. People's views varied about the care they received with the majority feeling happy and well cared for.

People who lived in the service were asked were staff kind to them comments. The majority stating that most staff were with the exception of one or two. The service did provide support to people at the end of their lives but staff had not received any training for this.

Is the service responsive?

Inadequate

The service was not responsive.

We saw that care plans did not always reflect up to date information for staff to be able to meet people's needs. Information about people's preferences, choices and risks to their care were not consistently recorded. As a result some of the people had not received care that met their individual needs.

Summary of findings

The service did not manage complaints that had been raised. People we spoke with did not know how to make a complaint or raise a concern.

There were not enough meaningful activities for people to participate in as groups to meet their social needs; so some people living at the home told us they felt bored.

Is the service well-led?

Inadequate 

The service is not well led

People were put at risk because systems for monitoring quality were not effective. One audit had been completed that had not identified concerns. Communication to the manager was not effective and actions were taken by staff that the manager was not made aware of.

The registered manager had not received any supervision or visits to the service from the provider since they commenced in post 4 months previously.

The culture of the service was not centred on the person but was more around the tasks that the staff had to achieve each day. This approach did not support people's individual needs.

Little Heaton Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. 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 25 September and 1 October 2015 and was unannounced. The inspection team consisted of an inspector. During the inspection we spoke with nine people living at the service, two relatives, eight staff and the registered manager.

We observed care and support in communal areas and also looked at the kitchen and the majority of the bedrooms. We reviewed a range of records about people's care and how the home was managed. We looked at the care for eight people this included looking at care records, risk assessments, food and fluid records, turn charts, daily records, professional visits records, diary records, menus, medication administration records and care plans.

We looked at a variety of staff records including training, induction and supervision for all staff and recruitment records for a sample of four staff employed at the home. We looked at other records within the service including quality assurance audits available at the inspection.

Inadequate

Is the service safe?

Our findings

Relatives told us, "It's a lovely place staff are very nice". Those relatives we spoke with told us they thought that was because staff really did try to care for their relative.

One person living in the home told us, "One person on nights is not very nice". When asked who they explained who this was. We reviewed the person's records there was no record of the concern raised. A member of staff confirmed that this had been reported to them and they passed the information on to the registered manager. In discussion with the registered manager they had been made aware of the concern. The registered manager had spoken to the person who had been in the registered manager's opinion, "reluctant" to identify the member of staff and the registered manager had made the decision not to refer this as a potential safeguarding concern. The registered manager agreed to make a safeguarding referral following this inspection.

A member of staff reported to us following the inspection that a controlled drug for a service user had not been given at the correct dose. The registered manager confirmed that this was correct and that a safeguarding referral had not been made. The registered manager agreed to make a safeguarding referral following this inspection.

Prior to our inspection we received a notification that a serious injury had occurred which we later received information from the Local Authority Safeguarding Team. The safeguarding alert was with regard to a person living in the service not receiving the correct medicines on return from hospital. The registered manager and Deputy Manager confirmed that the person had not received the correct medicines because they had not read the discharge letter which stated that some medicines had been discontinued. This error meant that the person had required readmission to hospital for further treatment.

The Local Authority contacted us regarding a safeguarding alert received by them regarding unexplained bruising. We discussed this with registered manager who had not notified CQC regarding this. The registered manager informed us that this was now resolved as the bedrails were now covered but had not undertaken any investigations to determine the causes of the bruising. The registered manager stated that they assumed that the unexplained bruising was in relation to bedrails on the person's bed, but was unable to confirm that this was the cause.

At the inspection we were given a file that the registered manager informed us contained all the records regarding safeguarding notifications to CQC. We saw that there was no records of the services own investigations or lessons learnt in relation to safeguarding alerts.

Personal finances for two people living in the service were not managed safely in order prevent financial abuse. Both people had legal representatives that sent money for personal allowances to the registered provider. The money was then deposited in the companies' accounts not in an account specific to the individual. The company then sent a cheque made out to the registered manager. The registered manager then had to obtain the cash through their own personal account in order to make the payment to the service users. This did not protect people's finances from potential abuse or the registered manager from potential allegations.

Discussion with staff told us that they were aware of how to inform the registered manager of safeguarding issues but they had not received up to date safeguarding training, The records regarding training shown to us did not record that any staff had received training in safeguarding vulnerable adults.

We were informed by the registered manager that a person had also fallen on the stairs in the service and this had resulted in a temporary hospital admission. However there were no records regarding an investigation of this incident in order to prevent a reoccurrence.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the service did not have an effective system in place that recognised potential abuse or took appropriate action when concerns were identified.

A further exploration for an incident in early August 2015 which was reported to us by a member of staff following the inspection detailed that two people living in the home had been referred to safeguarding due to concerns. , We called the registered manager the day after the inspection

who explained that this was reported to them. The registered manager explained that it was reported to the Local Authority as a safeguarding however a safeguarding concern was not notified to CQC

An incident was reported to us by the manager that they were dealing with as they arrived in post. This related to a potential theft and a police investigation. This was not notified to CQC, the registered manager said that a police investigation was on-going at the time of the inspection.

One person also had developed a pressure ulcer that was being attended to by the district nurses. This had not been notified to CQC or reported as a safeguarding concern. The registered manager agreed to refer this is a safeguarding concern following the inspection.

We have asked the provider to check that they have made all the correct notifications to CQC and to make any that they may have missed to us.

This was a breach of Regulation 18 Care Quality Commission (Registration) Regulations 2009 as incidents that resulted in changes to the structure of a person's body, any abuse or allegations of abuse or investigation by the Police must be notified to CQC without delay.

We looked at how the service managed medications and found that people were not getting their medications as they should. We saw medicines could not be provided at night as none of the staff overnight had received training. As a result for people on, "as needed medicines" would not be able to access their medicines from 8pm until 8 am in the morning. This means that medication which should be spread evenly such as antibiotics were all given between 8 am and 6 pm less than 10 hours potentially reducing the effectiveness of the antibiotics.

Staff told us that they commenced a medicines round at 8 am, although all morning medicines were recorded as being given at 9 am. They anticipated that this would take up to an hour and half meaning that they finished their medicines round at approximately 9.30 am. They did confirm that it could be up to 10.00 am on occasions. The lunchtime medicines were given at 12.30. This meant that medicines would have a potential gap of a maximum of 3 hours. Several of the medicines for people required a four hour gap between doses as a result people were placed at risk of harm by receiving their medicines too close together.

Antibiotic therapy was not always correctly given in one example we saw that the service had received 14 doses of antibiotic but recorded that they gave 15. In another case we saw that they received 21 doses but completed the course having given 19 doses. As such, the service had not given the antibiotics as prescribed placing people at risk of harm.

There was no information available in the service for people who had medication prescribed "as needed" (PRN). Care staff did not have the instructions they needed to give this safely. On the second day of the inspection, the registered manager had written PRN guidance but this was still in their office and not within individual records. As such, staff did not have access to the instructions they needed to make sure they gave PRN medication safely.

On admittance into the care home families and people brought in the medicines that the person had at home. The service did not check if this was the most current medicines or whether all the medicines that needed to be taken were available. The policy for the service regarding admitting people to the service did not mention this safety check. Without checking that the medicines are the most current it is possible that staff could not receive vital medicine or could be give an incorrect medicine. The service was subject to a safeguarding alert in recent months were medicines that had been discontinued were given when the person returned to the service.

Records regarding medicines were not clear as such on some occasions it was unclear if the correct medicines were given at the correct time. We also saw that people who managed some of their own medicines did not have risk assessments in place to check if this was safe and monitor support that they needed to continue to do this safely.

A review of care records showed that the service did not have nutritional risk assessments that monitored individual weight loss or gain. The lack of assessments meant that there was a laborious process looking back over peoples weights for several months in order to determine a potential nutritional risk. When potential weight loss was identified limited action was taken. As an example one person showed a weight loss of 9kgs in one week. No action was taken and the inspector suggested that the person be re weighed as the loss seemed excessive. The individual was re weighed and had lost 0.5kgs the weight of

the person had initially been recorded incorrectly. However this potential weight loss was not actioned or investigated to make sure that it was a recording error as opposed to an actual significant weight loss.

Risk assessments for the development of pressure ulcers had not been undertaken. A person had developed a grade 3-4 pressure ulcer and had specific equipment in use. There was no care plan in place to reduce the risks of further damage or promote healing. Staff and the district nurse confirmed that further deterioration of the pressure ulcer occurred since it was initially discovered. We observed the person to be in bed from 1 pm until 5 pm on the second day of the inspection. They remained in the same position for the four hours and there were no records in place to monitor that staff were reducing any risks to the person by altering their position.

The service has received an action plan for improvements for the last two infection control audits undertaken by an external government body. We observed appropriate usage of plastic aprons and gloves during inspection. We saw that disposable hand towels were available for all the sinks in the service and that the commodes in use had all been cleaned appropriately. The service did not have any of its own infection control audits and was not aware of the Health and Social Care Act 2008 Code of Practice for health and adult social care on the prevention and control of infections and related guidance.

We asked for but were not shown a fire risk assessment that identified and addressed any fire risks. 14 fire doors were noted not to close into the rebate thereby ensuring the smoke seals were effective at the inspection on our second day of the inspection six of the doors were fixed and eight were awaiting repair. The second day of inspection was seven days later within that seven days risk assessments had not been put in place to manage the fire risk in the interim.

People's records showed that moving and handling risk assessments were not updated and did not contain clear information that would inform staff how to appropriately move and handle people safely.

Where risks to people were identified these were not reflected in the care records. As an example two people were detailed by the registered manager and staff as requiring input for behavioural needs. Neither person had risk assessments in place to manage the risk for the people and others, neither had care plans in place to assist staff to reduce and manage any potential risks. This meant that people living in the service and staff were placed at risk of potential harm.

There were no environmental risk assessments in place that make sure the service was safe for people who lived in the service. As an example we saw that the service had one outdoor space which was also the car park for a local church. On the day of the inspection, we observed both staff and people who used the service to be seated in this area. There were no assessments of this risk and the area contained rubbish that could present a trip hazard such as unused television cabinets.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider was failing to ensure that care. and treatment was provided in a safe way.

We looked at how many skilled staff were employed in the service to meet people's needs. People who lived in the service told us that there was enough staff on duty, they stated, "Plenty of staff", "I never have to wait long for help." And "I do a lot myself, but they are on hand if I need them".

We spoke to the registered manager who informed us that there was no means to determine the amount of staff available that was based on people's assessed needs. The registered manager also explained that at present staffing levels were suitable on a day to day basis. Staff spoken with also confirmed that in general they thought that there was sufficient staffs available to meet the needs of people living in the service.

We observed staff available throughout our inspection. On the last day of the inspection we observed the manager reprimanded three members of staff who had congregated in the kitchen leaving no staff available in service user areas.

We reviewed the records regarding staff recruitment and spoke to staff about their recruitment. We saw that care staff were checked prior to their recruitment as suitable to work in the service. Additionally all staff had a record of their initial interview and a copy of their application available. This was undertaken by the registered manager in order to make sure that all staff was recruited fairly and those with the correct backgrounds were employed to work in the service.

Inadequate

Is the service effective?

Our findings

People we spoke with had differing views about the food and its quality, comments included, "marvellous", "It's alright" and "No, I don't like the food here it's always cold".

Records showed that night staff have no medication training leaving service users unable to access medicines for over 12 hours a day. Staff who gave out medicines had received training and a competency assessment. We saw that an assessment of staff competency had been completed once in most cases and no further assessments had been undertaken. The registered manager explained that competency assessments could be six monthly however this had not occurred. The registered manager also explained that half the staff had received supervision in the last four months. There was no policy in place as to how often supervision was to take place, the registered manager told us that this could be three monthly and more frequently for new staff. Without supervision, staff may not be appropriately supported to undertake their job role.

Prior to our inspection we were informed that staff had not received up to date training. We spoke with the registered manager; staff employed and reviewed the training records. This confirmed that not all the staff had training in place to make sure they had the appropriate training to undertake their job role. There was no training plan in place that monitored staff training and planned for the training that they needed to remain up to date.

The induction into the service for new staff was brief and completed in one day. A new member of staff has started working and did not have moving and handling training staff had been informed not to ask undertake any moving and handling activities. The registered manager confirmed that there were no arrangements in place to make sure that the member of staff received appropriate moving and handling training.

Observations during the inspection showed that whilst staff talked to people in a caring manner and demonstrated a caring attitude they were not all able to effectively communicate with people who required additional communication input such as people with dementia care needs. Staff were disorganised in their approach and often shouting across the room to each other for instructions. One member of staff asked a person living in the home the same question three times. The person was unable to respond appropriately and the staff member was heard to say, "It doesn't matter I know what you like". This demonstrated a lack of ability on behalf of the staff member to effectively communicate with the person.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have sufficient arrangements in place to ensure that that staff were suitably qualified, competent and skilled in order to meet the needs of people living in the service.

Mental capacity assessments to determine if somebody had fluctuating capacity and to determine the best time and way to support them were not in place. Information about people's mental capacity and how to support them to make decisions or give consent was not included in people's care records. The home provided support to people living with dementia. There was a lack of appropriate arrangements for supporting people with fluctuating capacity as the service did not have arrangements in place to make sure that people living with dementia had their mental capacity needs met.

We observed how staff approached people with variable mental capacity in order to involve them in their care and gain consent. We saw that staff were not consistent in their approach. For example, some staff explained to people the meal available that day, others gave people the food without any explanation. We also saw that this inconsistent approach was in place in other interactions; staff did not always gain people's consent or permission before they moved them around the service or placed protective clothing on them for meals. We discussed with staff their understanding of how to support people who lacked capacity and their understanding of the law to support this such as the Mental Capacity Act 2005 and its associated codes of practice (MCA). Staff member's understanding was also inconsistent with some staff being able to explain clearly how to support people whilst others demonstrated a limited understanding particularly in relation to people living with dementia.

We observed practice on at least two occasions were staff made decisions for people. One person lack capacity and staff decided they would like a certain meal as they knew, "what they liked". There were no records that determined if the choice the staff member made was meeting the person's wishes and choices. A further person had their

Is the service effective?

food chosen for them by a staff member as the staff member asked the individual three times what they would like the person was unable to answer the question. In discussions with the registered manager the person did not lack capacity but were hard of hearing. The staff member had not effectively communicated with them to obtain their agreement.

We saw that two people had a copy of lasting powers of attorney. Lasting powers of attorney is a legal arrangement that supports the relatives of people to make decisions on their behalf. The lasting powers of attorney information and the decisions allowed were not reflected in people's care records.

Two people had Do Not Resuscitate (DNAR) arrangements in place. This was recorded as being discussed with the person who agreed with this. The staff and the registered manager explained to us that both people did not have capacity to agree to a DNAR. One member of staff explained that they had discussed the DNAR with a family member but had not recorded this. As such this significant decision had been made without making sure that a best interests meeting had been held to make sure that the person's best interests were discussed and their rights were maintained.

Some of the records viewed such as agreements for managing money were signed by relatives for people who did not lack capacity and had no legal standing to agree to actions on behalf of their relatives.

There were no policies and procedures related to consent that would support staff to make sure that they provided the correct level of support. There was an overview of the MCA but this did not detail how staff were to make sure that they meet the principals of the MCA. Additionally the registered manager and the staff reported that they had not received training in gaining appropriate consent

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of people who lived in the home.

We looked at how the service supported people to eat and drink and what arrangements they had in place to meet people's nutritional needs.

We observed people during the lunchtimes over two days and saw that support to eat meals was inconsistent. There was no information for people to assist them to make choices about the food they wanted. People's views regarding the food varied. Some of the people living in the service told us that they though that the quality was better and improving others stated that significant improvement was still needed. Both of the mealtimes were not well organised with peoples food being put in their seating place long before they sat down as such in some cases their food was going cold before they ate it. Some people on some tables were served food long before others and others sitting at the table were heard to be asking why they waiting so long. Some people waited up to 20 minutes before they received a meal.

Staff reported that it was difficult to serve all the meals and for them to remain hot. We spoke to three people who complained that their food was cold. The registered manager explained that they had asked the provider to supply equipment that would keep food hot and been informed that this would be several months before it was available.

The cook had recently left the service as a result care staff were cooking the meals. The service was in the process of recruiting a new cook/ We asked how the menu in place had been created and were informed by two staff that they put it together based on what they thought people living in the service liked to eat. Both were unaware if the meals were suitable for people needing a diabetic diet or those who required a fortified diet. We saw that two people were prescribed supplementary drinks but there was no arrangements in place to make sure that the calories they needed was available within their diet. Neither had food monitoring arrangements in place in order to make sure that they were receiving an appropriate calorie intake. However on reviewing weight records both had lost a minimal amount of weight over the last 3 months.

A person needed a diabetic diet care records stated that their diet needed to be monitored. When we looked at diet records this person was not getting their diet monitored and was not being provided with a menu that could help them determine what food was suitable for them to eat.

Inadequate

Is the service effective?

A further person on a diabetic diet was gaining weight. Staff explained that the person did not wish to stick to a diabetic diet. This was not reflected in any of the records within the service and advice from a diabetic specialist had not been sought to assist the person.

We asked the staff who had developed the menu what had been done to make sure that the food provided was nutritionally suitable. They informed us that they were not aware of any assessments on the nutritional value of the food being provided.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider did not ensure that people's individual nutritional needs were met.

The dining room lighting was low and as an internal room with no windows this made the room dark. People living in the service told us that they found it difficult to see the food served.

The environment had been adapted to meet people's needs with appropriate bathroom facilities and ramps as needed.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We found that where required, DoLS applications had been made and the registered manager understood when an application should be made and how to submit one. The registered manager also had arrangements in place to monitor the order and to make sure that if a renewal was needed appropriate applications would be undertaken.

Requires improvement

Is the service caring?

Our findings

Feedback from people about the attitude and nature of staff was mixed. Some people spoke positively about the care provided by staff. Comments included, "Can fault them, they are lovely", "Absolutely fabulous can't do enough for me and I'm comfortable living here because they look after me." One person told us, "they are not all as good as each other particularly at night".

We saw that interactions between people living in the service and staff were not always consistent.

Some interactions appeared task-focused. At these times staff gave no information about what was happening and did not engage people in conversation. We observed that people in wheelchairs were moved without explanation, reassurance or commentary whilst being moved We also observed one member of staff spend a long time sitting with a person discussing their life with them and offering reassurance when they were upset, they settled rapidly and were soon eating their meal. This however was not consistent the same person had been upset for several minutes prior and some staff had not responded to the distress of the person. When this was discussed with staff they explained the person generally became upset in the afternoons.

We observed that people were not told what the meal was unless they requested information. We saw that in one area of the service there was a notice board that was blank we asked what this was for and told it was for stating what the meals were that day. It was blank on both days we inspected.

We observed the televisions were turned on by staff with no consultation with people as to what they wanted to watch or listen to. When we asked two people whether they had input into the choice of programme they told us they did not and the remote for the television was not within reach for any of the people living in the home.

We asked people whether they felt that the staff listened to them. Most told us they did. We asked had they been involved in any "residents and relatives meetings", one person told us "I don't think so." Three other people could not remember attending a meeting. One relative told us no one in the home has asked them their opinion as to how the home was run. We saw that there was a record of one residents meeting which took place within the last four months. The minutes of this meeting were handwritten had not been distributed to people living in the service. The minutes did not record which who had attended the meeting. The minutes did record the views of those in attendance regarding a need for changes to the menu and activities Some of the minutes were unclear and consisted more of making information available to people rather than asking them their wishes or views.

On our tour of the service we saw that confidential information including people's medications and information regarding discharge from hospital was readily available in a communal area. As such people's confidentiality was breached.

Although the service does undertake end of life care for people. Records showed that none of the staff have received training in this area in the last 3 years. Staff we spoke with were confident that they could support an individual appropriately with any care they needed at the end of their life. We reviewed records available within the service and this showed that there was no discussion with people around their wishes at the end of their lives or what advanced decisions they would like to make. The registered manager stated that he was confident that staff supported people appropriately at the end of their lives.

The service did not have any dignity champions and there was no policy and procedure regarding dignity.

We looked at how the service supported the dignity of people living in the service. All the people we spoke with had appropriate clothing on and looked well presented. Observations showed us that people were addressed appropriately and treated with dignity. Staff were appropriately jovial with people. Care when delivered was undertaken behind closed doors in order to preserve people's dignity and staff knocked on doors before entering.

Inadequate

Is the service responsive?

Our findings

People living in the home told us that they had limited input into deciding on the activities or meals available. One person told us, "Nobody has ever asked me what time I would like to go to bed, I go when staff are available." Another person told us that they cannot have their meals at a different time, "only if people go out (to an appointment)". We observed over lunch time everybody received their meals at the same time. We saw six people seated at the dining table for over 15 minutes before the meal was served.

The menu available in the home did show a choice of food. The registered manager confirmed that as yet people had not been asked about what they would like to see on the menu. The manager told us that surveys about food and other aspects of living in the home were to be sent to people by Rochdale Council on their behalf but they had not undertaken their own surveys for people living in the service, their relatives or staff for over a year. The registered manager was unable to explain how the service would be made aware of the results of the surveys from Rochdale Council.

There was no information available regarding activities and no activities were observed during the two days of our inspection. People we spoke with had varying views some stating that there was nothing to do and others happy with watching the television in one of the smaller lounges.

All the care plans we viewed did not have life histories and there was limited information about people's preferences. In discussion with staff they told us they had worked there for a number of years and knew a lot about the people who lived in the service. However, this relied on staff remembering information correctly and passing it on to other staff correctly rather than making sure all staff were aware of the same information about people. As our observations, showed staff were not always consistent with how to support or interact with people living in the service.

People spoken with reported that their visitors were welcomed into the service. One relative told us that they always felt welcomed and were offered a cup of tea and a meal if they visited during mealtimes.

In discussion with the staff, there were a number of set routines within the service. There have been changes to some routine including mealtimes but this was unclear as to whether this was at the request of the people living in the service. One staff member said they altered the meal times and had put the main meal at lunchtime. They told us that this had been discussed with the people living in the service however there were no records that showed this had been discussed with people or how this had been discussed with people with fluctuating capacity.

We spoke with people living in the home about how the home supported their cultural needs. Care records viewed did not highlight people's religion or if they required any support to have their cultural needs met. We spoke to people about their preferences to have their personal care needs met by staff of the same sex. None of the people we spoke with could recall being asked what their preferences were.

We looked at people's care records regarding their personal preferences, choices and wishes. We saw that there was very little or no information available in people care records that would assist staff to help people make choices. We asked for information that showed us how people less able to vocalise a choice such as food or activities were supported to take into account their personal preferences. The registered manager told us that no information was available. Staff told us that they often made choices for people living in the service as they "know them really well".

None of the four care plans or assessments we looked at had evidence that these had been discussed with the individual concerned. We spoke with four people who lived in the service they were not aware of the contents of their care plans and as such had not been able to influence the care provided. One person was admitted to the care home without an assessment completed by the service the information given to them came from social services and was out of date.

Additionally other professional organisations involved in the persons care were not contacted before they moved into the service. The person did not settle in the service and was admitted back to hospital over a week later. Staff and people living in the service reported that they had found it difficult to meet the behavioural needs of the person. When we looked at the persons care records the service had not undertaken its own assessment admission and there was

Inadequate

Is the service responsive?

no care plan in place to guide staff. Additionally the service had not monitored the person's behaviour in order to deliver care and support that met their individual needs and preferences.

The admissions policy available in the service did not refer to assessments needing to be undertaken prior or during admission. The documents shown to us were medically based and had minimal opportunities or information about the person's mental health, mental capacity, culture or social needs.

The service had arrangements in place that meant that people living in the service could only access their money if the manager or deputy manager were available. This limited people's access to their money and reduced their right to have their own money readily available.

Our observations showed that people living in the service who were independent had routines that suited their needs. As an example a member of staff took a person out for a walk as it was a sunny day and the person said they wanted a, "breath of fresh air". Another person accessed a taxi services and went to hospital and doctors' appointments independently. Those people who may find it less easy to make decisions or to be independent had choices and routines made for them by the staff.

We looked at how the service responded to people's health care needs and made sure that they received care that met their needs. We reviewed four care plans in total. None of them were person centred, with the same plans available for different people such as how to support a hygiene need. Plans were "task and medical condition" orientated and not person orientated. People's individual's needs were not recorded in plans, for example one person had behavioural concerns and these were not recorded in their care plan. There was no information available to staff that told them how to respond when the person became upset or distressed.

We spoke with health care professionals who visited the service. They told us that they thought staff did their best but needed further development to respond to people's needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014 as the provider did not have suitable arrangements in place to make sure that people received care and treatment that met their needs, reflected their preferences and was appropriate.

At this inspection, we asked to see how complaints was being progressed and what any investigations had revealed. There were no investigation records available and the registered manager explained that they had not received any complaints. On reviewing records and discussions with staff there were a number of complaints that had been made. This included people saying that there was too much soup on the menus in a residents meeting; a person who, complained about the conduct of a member of staff and staff concerns regarding medication management. There were also safeguarding concerns that had not been investigated as a complaint, or raised a safeguarding in the local authority. A complaint was received by the registered manager during the inspection. The registered manager did verbally deal with this but the relative was clearly distressed and explained that they had raised their concerns several times with staff previously.

The complaints policy was displayed in the main foyer of the service. On reviewing this policy there was no scope to allow a complaint from a person or family member to be dealt with formally until the person had reported directly to the registered manager. It advised that complaints and concerns were raised with staff and if still not resolved then speak to the registered manager. As a result, staff were not logging any complaints. The policy did not make any provision for people, their relatives or staff to raise concerns anonymously should this be appropriate. Additionally the policy did not make any provision for a potential complainant to approach the provider as no contact details were available. As such if people or their relatives had concerns regarding the registered manager they would be unable to progress these concerns.

On the first day of our inspection we explained to the registered manager that we had received Whistleblowing information and outlined that this was in relation to staff training, moving and handling and food. On our second day of inspection, a week later the complaint had not been logged nor attempts to investigate the aspects of the concerns commenced.

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

Inadequate

Is the service responsive?

Regulations 2014 as the provider did not have an effective system to ensure that they recognised, investigated and responded to complaints in a timely manner.

Inadequate

Is the service well-led?

Our findings

The culture of the service was not based on the needs of the people who lived in the home but was task orientated. This could be seen by the routines in place in the service that were not flexible to meet people's needs, the lack of choices available to people and care that did not meet people's needs as care was not appropriately planned.

A registered manager was in place on the date of the inspection. We found three notifications of suspected abuse which should have been submitted to the Care Quality Commission (CQC) had not been. The systems in place were not sufficient to ensure the delivery of high quality care. During the inspection we identified failings in a number of areas. These included medication, meeting people's choices, stimulating activities for people who lived in the service, recognising risk, care and welfare, dealing with complaints, identifying and managing safeguarding and staff training.

The provider did not have a formal system to assess and monitor the quality of care provided to people or to manage risks of unsafe or inappropriate treatment. There was some evidence of recent quality monitoring of medication and an audit had been completed by the service. This audit had not identified the gaps in practice identified at this inspection.

Care plan audits had not taken place and the registered manager acknowledged that care records were out of date and did not reflect people's needs. We asked to see a plan as to when the care plans would all be updated and what support the service, registered manager and staff would receive. There was no plan available and the manager was unable to state when all the people's needs who lived in the service would be assessed and appropriate plans put into place. We found several instances of care not meeting people's needs. These issues could have been identified through a formal system to assess and monitor the quality of care if one had been in place.

Where issues or improvements had been identified, we saw appropriate action had not always been taken to address them. For example an unexplained injury had not been investigated and complaints had not been addressed.

During this inspection, feedback from people confirmed that there was not enough to do and we observed there was limited stimulation for people. Although there was now an activities co ordinator this had little impact on activities appropriate to meet people's needs.

Policies and procedures were erratic and a disorganised array of documents, without consistency for subject, content, review and implementation. For example, many policies were repeated and some gave conflicting information. The policies in place did not reflect the practice in the service and as such did not guide staff to make sure they had a consistent approach in their job role.

Risks to people's health, safety and welfare were not appropriately reported, managed and analysed. For example, we found accidents or injuries that were recorded in people's care records and accident records. These had not been analysed or actions taken to determine the cause and prevent them from reoccurring.

People who lived in the home and staff had not had the opportunity to give their views and opinions of the care provided or any input for improvement. There had been a survey over a year ago for people living in the home. We were informed by staff that they questioned the validity of the survey as they were completed by the staff in discussion with the person. There was no results or analysis of the survey available and no plan as to what actions were needed if any from the results.

We asked to see a copy of the audits that the provider undertook in the service. We were informed by the registered manager that the provider did not undertake audits or provide the registered manager with supervision.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider did not have suitable arrangements to assess and improve the quality of the service provided.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The provider did not have suitable arrangements in place to make sure that people received care and treatment that met their needs, reflected their preferences and was appropriate.** Regulation 9 (1) (a) (b) (c) (2) (3) (a) (b) (c) (d) (e) (f) (g) (h) (I) (4) (5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The provider did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of people who lived in the home.** Regulation 11 (1) (2) (3) (4) (5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **The provider did not ensure that people's individual nutritional needs were met** Regulation 14 (1) (2) (a) (b) (3) (4) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	The provider did not have an effective system to ensure that they recognised, investigated and responded to complaints in a timely manner. Regulation 16 (1) (2) (3) (a) (b) (c)
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not have sufficient arrangements in place to ensure that staff were suitably qualified, competent and skilled in order to meet the needs of people living in the service. Regulation 18 (2) (a) (b) (c)

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 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider was failing to ensure that care and treatment was provided in a safe way.**

The enforcement action we took:
Warning Notice to be met by 5 November 2015

Regulated activity	Regulation
	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The Provider did not have an effective system in place that recognised potential abuse or took appropriate action when concerns were identified.

The enforcement action we took:
Warning Notice to be met by 5 November 2015

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 suitable arrangements to assess and improve the quality of the service provided.**

The enforcement action we took:
Warning Notice to be met by 5 November 2015