Care Quality Commission

Eldercare (Halifax) Limited

Ashleigh Care Home

Inspection report

60 Stile Common Road,
Newsome.
Huddersfield
HD4 6DE
Tel: 01484 514291
Website: www.eldercare.org.uk

Date of inspection visit: 9,10,11 & 14 September 2015
Date of publication: 02/12/2015

Ratings

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

Overall summary

The inspection took place 9,10,11 and 14 September 2015 and was unannounced.

The service was last inspected in March 2015, at this inspection the service was in breach of Regulation 12 Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was in relation to poor standards of cleanliness throughout the service which mean that there was a risk of infection control not being effective.

We found that the service had not made the necessary improvements in relation to this breach since our last inspection and we found that there were a high number of breaches of other regulations.

Ashleigh Care Home is a residential care service, who offer personal care to up to 37 people. At the time of our inspection there were 29 people living within the service.

Summary of findings

At the time of our inspection there was no permanent manager. The service was being managed by an acting manager who had been in the service for two weeks and an area manager who had been with the provider for two years.

We found that the standards of care in the service had deteriorated significantly since out last inspection. This was in relation to multiple breaches of the regulations.

Regulation 9, person centred care. We found that people's care needs had not been assessed and there were no care plans for some of the people who lived at the service.For those people who did have care plans these were out of date and the information did not reflect their current needs or the care which was being given to them.

We found that people in the service were not treated with dignity and respect. Some of the people living in the service were unable to access the toilet without assistance and were being left for long periods without being given this assistance. Staff did not recognise how people's dignity could be promoted and did not assist people when they needed help. This was a breach of Regulation 10 dignity and respect

The people living in the service were not asked for their consent for care to be carried out. The provider and the staff failed to recognise restrictive practices which were being carried out. There were no mental capacity assessments being carried out for the people living in the service to measure whether they were able to make their own decisions and which decisions they were able to make. This was a breach of Regulation 11, need for consent

The provider did not have safe processes in place to ensure that people were given the medications that were prescribed to them in the way in which they had been prescribed. We found that people who were in pain were not receiving their pain killers. There were very few risk assessments in place for people in the service and those that were in place were out of date and had not been reviewed. The equipment which was being used to assist people with poor mobility was limited. There were no assessments carried out to make sure that the equipment which was being used was safe or suitable for the needs of the person. We found widespread evidence that infection control measures were not in place and there was a poor standard of cleanliness throughout the service. This was a breach of Regulation 12 safe care and treatment

Staff did not recognise safeguarding incidents that were occurring. There were no safeguarding referrals made to protect vulnerable people living in the service until incidents were highlighted by CQC during the inspection. This was a breach of Regulation 13, safeguarding service users from abuse and improper treatment.

We found that some people were not being adequately hydrated as they were left for long periods without access to drinks. We saw that food records were inaccurate and were not filled in for long periods, which meant that staff could not monitor people's fluid intake. This was a breach of Regulation 14, meeting nutritional and hydration needs.

We found that the equipment in the service did not meet the needs of the people living there. This was a breach of Regulation 15, premises and equipment.

We found that the provider was not dealing with complaints appropriately or in a timely manner. This was a breach of Regulation 16, receiving and acting on complaints

There were no processes in place to monitor the performance of the service or to maintain accurate records of the care which was being delivered. We found that there was no effective leadership within the service. This was a breach of Regulation 17, good governance.

There were not enough staff to care for people safely and to meet their needs. We found that the staff were not well trained and were not competent in all areas of their roles. This was a breach of Regulation 18, staffing.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

You can see what action we told the provider to take at the back of the full version of the report.

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.

The service did not have sufficient staff on duty to safely care for people.

The service did not manage medicines safely and people were not receiving their medication as it had been prescribed.

Staff failed to recognise safeguarding incidents.

The service did not have measures in place to prevent and control the spread of infection.

Is the service effective?

Inadequate

The service was not effective.

Staff were not adequately trained or competent to meet people's needs.

People's mental capacity had not been assessed and there were unlawful restrictive practices in place

People were not given enough to drink, and there were no accurate records of people's food and fluid intake.

The provider had not sought consent from the people living in the service for care to be provided.

Is the service caring?

Inadequate

The service was not caring.

The service did not recognise the diversity of the people living in the service and made no provision to respond to individual needs.

People were not involved in any aspect of their daily lives, there was no consultation with people living in the service about their care and support.

Staff lacked knowledge and ability of how to support people's dignity; as a result people's dignity was not maintained

People were ignored when requesting assistance from staff

Is the service responsive?

Inadequate

The service was not responsive.

People did not have person centred care plans.

Care plans were not put in place in a timely manner and were not reviewed regularly.

There were insufficient activities to occupy people who lived in the service

We saw that there were people who did not come out of their rooms and were socially isolated.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well-led.

There was no effective leadership in the service and there had been no manager since May 2015

There was a negative culture throughout the service, with staff blaming each other for when failings were identified.

There was no evidence of quality monitoring taking place in the service and consequently failings were not being identified.

Ashleigh 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 9, 10, 11 and 14 September 2015 and was unannounced.

The inspection was carried out by three adult social care inspectors on all four days . Prior to our inspection we had received information of significant concern from a whistle blower. We also spoke to other agencies who worked with the service to gather further information; these included Environmental Health and Infection Control officers and the Local Authority Contracts team.

During our inspection we looked at the care records of 18 service users, the medication administration records for all service users, weight records, bathing records, complaints file, incident and accident files, one staff recruitment file, all staff training records, staff rotas and handover records. We asked to see auditing records which the provider was unable to produce. We spoke with all the people living at the service, some of their relatives, a dietician, an external activity provider, ten staff members and all members of the management team.

Inadequate

Is the service safe?

Our findings

One Person told us 'As I am bed bound I need staff to check on me regularly to see if there is anything I need or want'. We found this service user was physically unable to operate the call bell and summon help should they need it. We did not see staff checking on the person at regular intervals.

Another person who used the service said 'The staff work hard, but haven't time to talk to you.'

People living in the service had varied dependency needs. Some people were relatively independent and mobile, whilst others were reliant on staff to assist them with all their care needs.

People with lower levels of dependence appeared to be content and were able to voice their needs to staff which meant that their needs were met to a much higher degree than those who were not able to communicate as ably.

During our inspection we noted that a service user had been left in an unsafe position in their bed. The bed rail had been left down and was without a safety bumper. Our inspector raised these concerns with members of staff who were present with the person at that time and asked that action be taken. Our inspector re-visited the service user and found that the person was alone and had become entangled in the bed side which had been left down and unprotected. As a result of this the person's face had become pressed into the mattress which was obstructing their ability to breathe, the person was blue, sweating profusely and shaking when our inspector arrived. Our inspector took emergency action to release the person and call for help from staff in the service.

We saw an incident between two people where one person grabbed the clothing of the other and spoke to them in an aggressive manner. This incident was reported to the area manager and we asked if a safeguarding referral had been made in respect of this incident. The area manager said it had not. Staff who were present had not recognised this as a safeguarding incident when we spoke to them.

This is breach of Regulation 13 (1) safeguarding service users from abuse and improper treatment and Regulation 12 (2) (B) safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to take action to safeguard a person from preventable harm.

The service did not obtain any medical assistance to attend the person after the incident. We were told that 15 minute observations were put in place to monitor the person. However when we looked at the records these did not commence until 90 minutes after the incident, and were not an accurate record of the checks which were made. On two occasions staff had recorded being in the room with the person, however, two inspectors were present in the room and did not see staff make these checks. We also saw that in the evening there was no record of any observations being carried out from 19:30 to 20:30.

We saw that there were not enough staff on duty to safely care for and meet the needs of the people. We found that there were a number of agency staff being used to increase staffing levels and the provider was using staff from their other services. Staff who worked regularly for the service told us that this meant that they were always showing new people where things were and which service users they were talking about. On one occasion we had asked staff to assist a person to the toilet as they were calling out that they needed it urgently. We saw that the person was still in a state of distress 10 minutes later. When we checked with staff they told us that agency staff had taken the wrong person to the toilet as they didn't know the person.

There were no care plans in place for some of the people and out of date care plans for others. Staff told us that a lot of staff had left recently, which they told us meant that there were few left who knew the people and how to care for them. One member of staff told us that they spent most of there time telling agency staff what to do. There was no leadership of the staff on duty, and staff from other services and agency staff did not know how to care for the people in the service.

In cases where care plans had not been put in place for people, staff told us they 'had to guess' what their needs were and 'do what they could for them'.

We spoke to one of the cooks on the second day of our inspection. They told us "I have asked managers for care staff to help with dinners. I've been told they are short staffed. I have to cook two meals a day for 28 people. I work from 8am to 5.30pm with no breaks. I can't do it without support staff. There is no kitchen assistant and I have to wash up by hand. The steriliser isn't working properly. They have always been short of staff."

Inadequate

Is the service safe?

This is breach of Regulation 18 (1) staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to ensure that there were sufficient numbers of suitably trained and skilled staff available to meet people's needs.

We saw in people's care records that there were risk assessments in place in only one case. The ones we did see were dated 2013 and had not been updated. Risk assessments are necessary as they identify potential risks to people and document measures which need to be put in place to minimise those risks and keep people safe.

We saw in a pre-admission assessment for one person that they were at high risk of falls due to their visual impairment. We saw that the current falls risk assessment stated that they were at medium risk of falls. We noted that the risk assessment in use did not include visual impairment as a risk. This meant that the risk assessment had not included all significant risks.

This is breach of Regulation 12 (2) (a) safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to assess potential risks to people and had not taken action to mitigate those risks.

We saw that staff were not competent when using moving and handling equipment. We saw several incidents where people were assisted from chairs into wheelchairs and back again using a hoist and sling. In all cases we saw that the equipment being used had not been assessed as being suitable for the person. When we asked staff if the slings were suitable for the person they were assisting they were unable to answer. There were no moving and handling plans or risk assessments in place for any of the people we saw being assisted.

We saw that because staff were not competent or confident in the use of the equipment this increased the level of risk to the people who needed assistance. For example, we saw that a person of very small stature and was underweight was being lifted using a sling which was evidently much too big for them. This meant that they were at risk of sliding through the sling when lifted. We saw another example where a sling was badly positioned on a person. On this occasion another member of staff was concerned that the person would be injured if they used the sling in its current position. The member of staff stopped the manoeuvre and went to seek advice. The trainer used by the provider was in the service that day and came and supported the staff to safely assist the person.

This is breach of Regulation 12 (2) (e&f) safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.The provider had failed to ensure that the use of equipment within the service was safe.

We saw that staff were not reporting incidents correctly, and in some cases not at all. For example, we found that a senior member of staff had a needle stick injury whilst on duty which they failed to report. They had not followed correct protocols following an injury of this type to safeguard themselves and the service user. This was brought to the attention of the acting manager by another member of staff who was concerned. There had been a meeting to discuss the incident. There was no incident form recording the details of the incident . The acting manager could not explain why this had not been completed. The staff member involved was unable to give a reasonable account of how the incident occurred when we spoke to them. The acting manager failed to gain the details of the incident and did not taken any action. The acting manager was unable to say that the insulin pen which had been involved in the incident had not been used by the person again after this incident. This meant that there was a risk that a contaminated device could have been used to administer the next dose to the person who required it.

This is breach of Regulation 17 (2) (a) good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.The provider did not have robust systems in place to ensure that accidents and injuries were reported and investigated.

The medication administration records showed that people were not being given their prescribed medications correctly. We saw that medication was frequently recorded as being 'refused' by people. When we spoke with people they told us they were in pain and we saw that they had been asking staff for pain killers. We saw that people who had infections were not being given their anti-biotic as prescribed. We found that there was a person who had diabetes which was controlled using insulin, and that the insulin had not been given on four separate occasions within the week of our inspection. This meant there was a

risk these medicines might not work properly which could affect a person's health and wellbeing. It is important people receive their medications regularly and at the correct times to ensure they are effective. Our inspectors raised these concerns immediately to the manager and asked that measures be put in place to prevent further incidents

We saw in one person's medication administration records they had refused one of their pain relieving medications. When we checked the stock of the drug we found that it was not in stock. This meant that the provider had failed to request a prescription for this drug to be delivered in a timely manner. The person could not refuse the drug as it was not available to be offered to them. This person told us that they were unable to leave their room as pain prevented them from doing so. They said that they kept asking staff to put on their pain relieving cream but staff did not do it. We saw an entry in the daily handover sheet which reminded staff to put on gels and creams which were in the fridge saying 'they are there for a reason'. Our inspectors raised these concerns to the manager and asked that measures be put in place to ensure that there were no further instances of the person being left without pain relief and in pain.

We saw that the trolley containing medicines was kept in the hallway of the home and other medicines were kept in a locked cupboard in the hallway. Controlled drugs were kept in a locked cupboard in the care workers' office. We could not see any temperature checks of the environments in which medicines were stored. A staff member told us that these were not done. We checked the temperature in the cupboard used to store medication and in the office used to store controlled drugs. The temperature in the cupboard was recorded as 28°c and 29°c in the office. The recommended temperature for the safe storage of most medication is 26°c.

This is breach of Regulation 12 (2) (g) safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.The provider was failing to manage peoples medicines safely, and was not providing prescribed medicines in line the instructions given by the prescribing doctor. This left people in pain and unable to leave their rooms as a result.

We saw that the premises were not kept clean, for example we found a bedroom which had a very unpleasant odour. This was because the mattress was soaked in urine. We were told on three separate occasions that this bedroom had been deep cleaned, and on each occasion we found no improvement. We found another room where the bedding was stained with faeces and there was faeces smeared on the wall. Staff had made the bed and left the faeces on the wall and bedding. We saw that there was a table in one of the sitting rooms which had faeces smeared on it, we reported this and were told it had been cleaned. When we went back to look at the table we found that the faeces was still there and the table had been rotated so that the stain was no longer visible.

On the second day of our inspection we saw a person being assisted from their chair in the lounge by care staff. When the person was lifted from their chair using equipment we saw there was urine 'dripping' through their clothes. We saw that staff did not mark the wet chair as not to be used and did not arrange for it to be cleaned. We saw a short time later that another person who was living with dementia was sitting in the wet chair.

We carried out a premises check on the first day of our inspection and found that there were empty soap and hand gel dispensers throughout the home. We also saw that personal protective equipment (gloves) was stored inappropriately, for example there was an open box of gloves on the cracked and unclean toilet cistern in one toilet on the first floor.

This is breach of Regulation 12 (2) (h) safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.The provider was not taking appropriate action to prevent infections developing or to control any spread of those infections.

We found that there were three bathrooms on the first floor of the service, two of which were locked and out of service as they were to be refurbished. The area manager could not tell us why both bathrooms had been closed at the same time, how long they had been closed or when the refurbishment was to take place. On the first day of our inspection we found that the only available bathroom on the first floor had been taken over by the visiting hairdressing service which meant that there was no bathroom available to service users throughout this day.

On the third day of our inspection, one inspector sat in a chair which was in a lounge. The chair had a leg missing which caused the chair to tip when the inspector sat down..

Inadequate

Is the service safe?

The area manager was unable to explain why there was a broken chair in the lounge , how it had become broken or how long it had been unsafe. The chair was removed from the premises following this incident.

This is breach of Regulation 15 (1) (c&e) premises and equipment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.The provider had not made sure that the equipment in the home was safe for people to use.

Inadequate

Is the service effective?

Our findings

One person who used the service said, "I'm not happy with the food. For the last two Saturdays we have had Yorkshire pudding and chips. We don't get fresh fruit or salad. They haven't asked us what we want to eat in a very long time."

Staff told us that they did not feel supported by the provider. They said that they needed more training and did not receive regular supervision from their line managers. Staff told us that they felt that the provider expected too much from them and they felt unappreciated. Staff told us that they 'were blamed' when things went wrong and that when they reported their concerns these were not listened to or acting upon.

We saw no evidence that there was regular staff supervision, spot checks, competency checks or appraisals.

We looked at staff training records and we saw that staff were not well trained. There were staff who needed refresher training to carry out core duties of their roles. This had not been delivered in a timely manner and training was out of date. We saw that new staff had not been adequately trained or shadowed prior to starting work at the service.

Another person told us "I used to have an apple every morning. I have to have it peeled for my digestion. It keeps me regular. I haven't had an apple for three weeks since I arrived here. I'm fed up with being constipated. They have given me my laxative this week, but I didn't have it for the first two weeks I was here."

A visiting dietician told us that the weights of people using the service were no longer being transferred into the care plan files, which made it more difficult to see when people's weight was changing. They said that the service should have been completing MUST scores, but this had not been done for the person they were visiting. In cases where people were underweight it made it much more difficult for staff and professionals involved in their care to monitor their progress. Our inspectors raised these concerns with the manager who said they would make sure these issues were resolved.

On day two of our inspection we saw that a person who was sitting in the lounge had not been served a meal. We asked staff why this person had no meal. The cook told us that there had been no meal ordered for the person, and that they must have missed them when they did the list. The cook said "I will see what I can find for them." A member of staff brought a meal to the person and left it on the table in front of them. The person did not eat any of their meal as they were sleepy. None of the staff encouraged them to eat their meal, nor did they ask why they had not eaten it or offer an alternative. This meant that the person did not have a meal and was left without being offered anything else to eat until the next mealtime.

We saw in one person's care plan that the dietician had advised on 13/02/2015 that staff should, 'fortify all meals with extra cream, butter, puddings, snacks and nutritious drinks.' This was due to the person being underweight and at risk of poor nutrition. When we spoke with the cooks at the service they were not aware of this and were not fortifying the person's diet.

We asked the cooks if there were any people with diabetes in the service. The cooks told us there were not. We saw from looking at care records that there was a person with diabetes using the service. The cooks confirmed that the person was not receiving a diet which was suitable to their needs. We saw from the person's records that they were being given cakes and scones with jam on a daily basis as part of their meals. This meant that their diabetes was not being managed and that their blood sugar was unstable due to the sugar in their diet. This was reported immediately to the manager of the service to take action to ensure that this person's dietary needs were met.

We saw that the Speech and Language Therapist (SALT) had seen one person in May 2015 and had said that they needed to have their fluids thickened and a 'soft fork mashable diet.' We saw that none of this information had been included in their care plan or food and nutrition assessment. We saw that the care plan for food and nutrition for the person had not been updated since March 2014. We saw that this person was not served thickened fluids or a soft diet. This meant that they were not receiving a diet suitable to their needs. This was discussed with staff and the cooks to ensure that they were aware of the person's needs and that action was taken to meet their needs.

At lunchtime on the second day of inspection we saw the meal was sausages or chicken pie. We saw that five people who had chosen sausages had left them on their plates, some partially chewed. Other service users were

complaining that the meal was not warm. We asked for a small sample of each component of the meal. We found the meal to be cold and the sausage very hard and difficult to eat.

These examples demonstrate a breach of Regulation 14 (1) meeting nutritional and hydration needs of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.The provider was failing to meet the nutritional and hydration needs of the people who lived at the service.

We saw that one person who used the service and was a wheelchair user had to wait to be seated in the dining room, as there were not enough seats for all the service users. When the person was seated at the table they asked if their food could be warmed up as it was cold. Staff did not respond. Our inspector intervened and asked for the food to be re-heated.

We saw that one person who used the service cut up the sausage of another person who used the service as they were struggling to cut it. Although there were staff in the room, they did not recognise the need to assist this person.

On the first day of our inspection we heard a person calling out for a period of five minutes that they wanted to go to the toilet. We saw the cook came and said they would ask someone to assist them. The person became increasingly agitated calling out that they couldn't wait and started to cry. Staff did not come to assist them for another five minutes.

These examples demonstrate a breach of Regulation 10 (1) dignity and respect of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was failing to ensure that people were treated with dignity and respect

We saw that there was no menu displayed on any of the days we were in the service. One person who used the service said, "They come round with a list in the morning if they are not too busy."

We saw that the provider added extra tables and chairs into the dining area on day three of our inspection. We saw that the way in which the extra furniture had been added created a health and safety risk as the walk ways were no longer wide enough for people who used walking frames or trolleys to get through.

On the first day of our inspection we saw that there was a 'luncheon club' in progress. This was run by a local church and involved people from the community coming into the service to have lunch. We saw that there was a temporary table which was set up in the middle of the main lounge. This was done whilst the people who lived at the service were sitting in the lounge. This meant that some of the people struggled to leave this area as they had trolleys and walking frames and the table was obstructing the walkways.

The people who sat in the reception were causing an obstruction for others as they had walking frames which were in the walkway, which meant that some of the partially sighted service users found it impossible to access their room without the assistance of someone to guide them through the area.

These examples demonstrate a breach of Regulation 12 (2) (b) safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider failed to take action to mitigate risks to people's health and safety.

We looked at a care file for someone who lived in the home and saw a health and welfare assessment had been completed which said they had 'chronic and constant pain'. We saw a care plan dated 2013 which said they were prescribed pain relief and senior staff were to offer it to them at prescribed times. The care plan did not contain any detail about their pain relief. We saw that the care plan had been reviewed on a monthly basis without any detail being added about the detail of the pain management regime or if it was effective.

We saw that an x-ray of a person's arm had been taken in August which diagnosed a fracture. We saw from the records that a physiotherapist had visited in September and had advised the wearing of a sling and some exercises for the arm. We saw that no care plan for the care of the fractured arm had been put in place and there was no record of staff supporting them with their exercises. We could find no record of the incident which had resulted in the fracture and there was no evidence of any report being made to RIDDOR in line with regulation. RIDDOR is the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013. These Regulations require those in control of premises to report specified incidents.

We saw that the person was not wearing their sling and we asked them why, they told us they did not know. They told us they were not feeling well and their arm was very

painful. We saw that the sling for their arm was folded up on their chest of drawers. We asked the manager why the sling was not worn and they told us that the person did not like to wear it. We asked the person and they said they did not know why it was not put on for them.

We spoke to one person we found in their bedroom during the day. They told us that they stayed in their bedroom as their knees were too painful to walk and they didn't feel very well. They said they should have cream applied to their knees to help the pain and that they kept asking staff to apply the cream but they hadn't done so. We asked them if they had refused to have the cream applied. They said no because their knees were hurting. We spoke to the senior care worker about this and they told us that they would ensure that the pain relieving gel was applied.

One person told us they did not feel well and we noticed a bed pan containing a small amount of vomit. This caused a very unpleasant odour in the room. We asked staff members what was wrong with the person. Staff said they did not know the person was unwell. We spoke with the person again after lunch and we saw that the vomit had been left in the room. The staff had brought their lunch which remained uneaten on the table.

We saw in one person's records that they had been seen by a district nurse and tests had been carried out relating to their continence needs. The results of these tests had not been followed up and there was no evidence that any action had been taken to resolve the issues which had been identified. We spoke to the senior care worker on duty who rang the GP surgery later that day.

These examples demonstrate a breach of Regulation 12 (1) safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was not providing safe care which met the needs of people living at the service.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

We saw in one person's care file that they had been assessed as having capacity to make their own decisions, however we saw that there was a note which said that a consent form relating to their wishes with regard to holding a key for their bedroom door and their wishes with regard to having the bedroom door locked had been posted to their family in June 2015. This meant that the person was not being given the right to make their own decisions despite being assessed as having full capacity to do so.

This is breach of Regulation 11 (1) need for consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We noted that the call system in the home had been sounding for over 10 minutes on one occasion. We looked at the indicator panel and saw that the call bell from one room had been sounding for 11 minutes. We asked staff about this. Staff said that the call system was broken and that they had reported it to the electrician the previous week but nothing had been done. We asked the acting manager if it had been reported to the estates manager for the company. The acting manager said they did not know who that was and they had not reported the call system.

We noticed a second call system was in use which gave off a very loud piercing sound. People who were sitting in the reception area told us that they listened to the noise all day and found it very disturbing. One person said it caused pain in their ears. This meant that people living in the service were agitated and upset by the constant noise.

Inadequate

Is the service caring?

Our findings

We saw a member of staff taking some dentures to a person in the lounge area. The member of staff said loudly "Whoever got (the person) up this morning forgot to put their teeth in." This was said in the hearing of several other people and therefore did not respect the person's dignity.

We saw that a person was assisted from their chair and that their clothing was soaked with urine as was the chair they had been sitting in. Staff did not make any attempt to protect the service user's dignity by covering them up and did not take any action to clean the chair.

Whilst we saw that some of the staff knew people well, the majority of the staff in the service during our inspection were from other services or were agency workers. On person asked our inspector what was going on as there were so many people in the service that they did not recognise. People appeared unsettled and anxious as they did not know the staff who were caring for them.

We saw very little interaction between the staff and the people. The interaction we did see was task based and offered essential physical care and support only.

We saw that the people from the community came to the service and sat at the table which had been set up. We did not see any interaction between these people and the people who lived at the service. There were three people who were not assisted to the dining area on this day and they were sat around the area where the lunch club was taking place.

The people from the lunch club were served their meal at 12:30, and talked amongst themselves whilst they ate. The organiser cleared the main course and served their dessert. They had finished their meal and cleared the table by 13:05.

The three people who were in the lounge were not served their meals until 13:10, having sat and watched the members of the lunch club eat their meal.

One of the people who used the service had particular cultural needs which had been identified at our last inspection, and we had found that there had been measures put in place to meet this person's needs. We spoke with the person and they told us that this was not happening anymore. We asked staff about this and were told that this had stopped when the previous manager left as they organised the provision of special foods.

We saw no evidence that people were consulted in any aspect of their daily routines. They were not given choices of food, activities, television channels, and in some cases even where they sat.

These examples illustrate a breach of Regulation 10 (1) dignity and respect of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to ensure that people were treated with dignity and respect and that individual needs were met in relation to cultural needs.

Inadequate

Is the service responsive?

Our findings

"A long time ago they had residents meetings, but it didn't change anything. There have been no meetings with me about care." Another relative said, "My (other relative) has been to a few meetings about care."

"I like it here. If I had a problem here I would speak to the manager, go up the chain of command."

Another person said when a fitness class was in progress on the third day of our inspection, "This is the first time they have had this since I have been here." The person had been at the service for three weeks

There was no activity coordinator employed at the home. We looked at the activity records for seven people who used the service and the records stated 'chat with staff' and 'watch TV' and 'family visit' in all cases for at least the last two weeks.

A relative of one person told us "They used to like listening to the radio in the foyer, but they have moved it."

People told us that they used to get newspapers to read, but that had stopped. We asked the area manager about this and they said that they would try to get some newspapers brought in.

People who used the service told us: "I have not seen any activities." The person's relative said, "(My relative) has always been a leader of community activities. They like singing and dancing." They used to ask them about activities at the last home they were at before it closed.'

Each morning we saw that the television was put on in the lounge. The same channel was on each day and when we asked people if they liked the programmes which were on they said that they did not. People were not given the opportunity to make their own choices about the limited entertainment which was available

"There are not many activities. They had a singer in the past. I sit about all day. I am a poor sleeper now because I am unhappy."

On the first and second days of our inspection we saw that there was a group of people who sat in chairs in the reception area. We asked the area manager why this was and they told us that is where they wanted to sit. When we asked the people they told us they had to sit there because the other lounge where they used to sit had been turned into a 'junk room'. We saw that there was very little furniture in the lounge they referred to and it was being used for storage of various items.

One person told us they were unhappy as some of the items in that room belonged to them, and whilst they were happy for other people to have use of their things it was unfair that they could not access their belongings.

"They have people coming to do hair and nails. I take (my relative) to the hairdressers. There are activities, but they can't understand them. They had a stroke and have emphysema. They had Zoolab the other week. They brought some snakes in."

These examples demonstrate a breach of Regulation 9 (1) person centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service was failing to provide care which met people's needs or reflected their preferences.

One person's family told us that they had raised a complaint with the manager, in relation to a fall which had not been appropriately reported to them in July 2015, and had been mentioned by a member of staff during a visit. The manager told us that this complaint had not yet been looked into.

We identified an issue where a service user had become very ill in a short period of time, the records for this episode of ill health were not complete and there had been no investigation into how or why this had happened. This incident had taken place at the end of August 2015. When we asked the manager about this they told us that the person's relative had contacted them and raised concerns about the incident, but they were yet to meet to discuss the matter.

One member of staff we spoke with told us their complaints to managers regarding risks to people who use the service from lack of suitable equipment had not been responded to or acted on. This meant that when incident were identified and reported the manager was not taking appropriate action to resolve the issues.

This meant that complaints were not being dealt with in a timely or efficient manner.

These examples demonstrate a breach of Regulation 16 (1) receiving and acting on complaints of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Inadequate

Is the service responsive?

We looked at people's care planning documentation. We saw that in cases where people had moved to the service within the last two months or where they had come to the service for short term respite care which had then been extended (one person had been admitted in April 2015) there had not been any proper assessment of the person's needs or adequate care plan created. We saw in five cases that there was only an emergency care plan which had been created by Social Services prior to their admission to the service.

In all the care plans we reviewed we saw that whilst there were dates when the care plans had been reviewed, we could find no evidence that any changes had been made to the documentation to reflect the changed needs of the people they referred to. We did not see any evidence in any of the care plans that people had been asked if they would like family to be involved in their care planning and we saw no evidence of choice or service users preferences being included in the care planning which was in place.

Inadequate

Is the service well-led?

Our findings

The service has been without a registered manager since May 2015, there have been several other managers in place since then for short periods of time. At the time of our inspection we found that there was a 'trainee' manager who had been put in charge of the service. On the first day of our inspection we were told that the area manager was in the service three days per week supporting them. They told us that they had a three day induction.

During our inspection we found that this had not been the case the area manager had been in the service one or two days per week only. The trainee manager had been brought in from another home and had not been a manager before this post. They had been a senior care worker in their previous service and this had been 'part of their development'.

Over the four days we were in the service we saw that the trainee manager did not have the knowledge or skills required to manage the service and we voiced our concerns to the area manager and the provider. The trainee manager told us that they felt 'out of their depth.'

The area manager took over the management of the service from the third day of our inspection.

One person who used the service said, "If I'd have known the situation it's got in I would never have come. I was extremely happy when I came. It's gone downhill. We have never had a manager for long."

One relative told us "The new manager seems alright. The last manager left."

Another person who used the service said**,** "I don't exactly like it here, but you won't find many better."

On the fourth day of our inspection we saw a manager from another of the provider's services showing a person who used the service and had lived at the home for over three weeks where the kitchen and lounges were. The manager said, "I wasn't aware that you didn't know where they were." This meant that the person had not been able to access these facilities since moving to the service, as staff had not shown the person around.

The acting manager had been working at the home for around two weeks. We were told by the acting manager that the area manager was in the service every other day to provide support. The acting manager told us that they had had only three days of induction. They said, "I have found it a bit overwhelming." We asked the acting manager how many people who used the service were living with dementia. They said that there were three people showing signs of living with dementia. When we observed the people using the service we saw that at least 13 people were showing signs of living with dementia.

We saw that there was no leadership within the service during the fours days we spent there. The staff on duty did not have any structure and were unclear about their responsibilities. This meant that every task took longer than necessary due to people not working as a team. For example at lunchtimes people were served meals from 12:15 in the dining area, with most meals being served over a 20 minute period. However the people who were not able to sit in the dining area waited up to an additional 70 minutes for their meals to be served.

Handover records were in place and senior care workers were filling these in with requests for tasks to be completed. However, we saw that this system of communication was not working as the same requests were repeated for several days. For example there were requests for urine dip testing to be carried out on the same people for several days, we were unable to find any record that these tests had been completed, the results had been recorded or any follow up action taken where positive results were observed. This meant that when people were showing signs of being unwell appropriate action was not taken to access healthcare services for them.

There were no systems in place to ensure that contemporaneous care records were kept. Staff were not completing daily records of care or food and fluid intake until hours after the care had been delivered. We asked staff if they kept notes and updated the forms later from those notes. Staff said they did not. We asked staff how they knew what people had consumed, staff told us they tried to remember.

We asked to see auditing records for the service for the period since our last inspection in March 2015. The provider was unable to produce any evidence that any auditing had been carried out. We asked the provider why the failings which we had seen in the service had not been identified by the provider and their managers, they were unable to explain this.

Inadequate

Is the service well-led?

There was no registered manager in the service and the service had not had a consistent manager for a significant period. A senior care worker who had been working in the service told us that processes were not followed, for instance food and fluid charts were not completed at mealtimes, this meant that the records were not an accurate record of what had been consumed by the people living in the service as staff were completing them from memory.

We found that the provider could not locate various records. This was the case for a person who was in hospital whose care records were missing. The records were found later in the inspection. On the first day of our inspection we saw that there were care records for two people who had been admitted together in the same folder. On the second day we saw that the notes for one of the people had not been replaced in the file after being copied and staff were unable to locate them.

We saw two separate instances where care records had been filed in the wrong person's file.

We saw evidence that safety incidents were not followed up For example there had been two injuries to staff in which investigations had not been instigated or were planned.

The acting manager told us when we asked them to put in various safeguarding referrals that they did not know how to do this. We noted that the provider had not been fulfilling the requirements of their registration as they had not been informing the Commission of notifiable events.

This meant that the provider was not monitoring the service which was being delivered, there were no systems in place to make sure that accurate records were kept which reflected the care which was being given to the people living in the service

This is breach of Regulation 17 (1) good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We saw that there was a blame culture throughout the service. The area and acting managers blamed the failings we found on the care staff, referring to 'rebellion' and the provider told us they believed that the staff were sabotaging the service to discredit them.

We did not see evidence to support any sabotage or rebellion on the part of the staff. We found that the service was without process or direction. Staff told us that they were not supported and felt that the provider expected too much of them and did not appreciate their efforts. Staff were poorly trained and were not being supported. We saw no evidence of staff supervision, appraisal or observation.

Staff who did not have current training in medicines management were administering medication. None of the staff in the service had current fire safety training, despite the service having had a fire in recent months. On the final day of our inspection we found that there was no member of staff on duty who had current medication training to administer the service users medicines safely, and there was no qualified first aider on the premises.. This meant that people were at risk if there was a fire or an accident which required emergency treatment as there were no staff who were trained to manage these emergencies.

These examples demonstrate a breach of Regulation 18 (1) staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This meant that there were not enough suitably trained and skilled staff available to care for people safely

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 Care needs were not being met as there had been no assessments of people's needs and there were no up to date care plans. People were not involved in decision making about their care and there was no reflection of their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect People were not treated with dignity and respect. Staff failed to recognise when people's dignity was not being protected and promoted. .

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People were not asked for their consent in relation to the care which was being given. There were no mental capacity assessments and there were no DoLS in place

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Medication was not safely or routinely given to people as it had been prescribed. There were no risk assessments in place to mitigate risks to people. Measures were not in place to protect people from the spread of infection.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Staff did not recognise safeguarding incidents and the provider was not make safeguarding referrals to the Local Authority.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs People were not sufficiently well hydrated. Records of food and fluid intake were not accurate. Special dietary needs (i.e. diabetic) were not being identified and were not being met

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The equipment in the service was not appropriate to the needs of the people who were being assisted using the equipment. There was a broken chair in the service users lounge.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The service were not acting on or responding to complaints appropriately or in a timely manner.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Action we have told the provider to take

There were no processes in place to ensure that accurate records were kept in relation to the care which was delivered. There was no evidence that any auditing was taking place in the service.

The service had failed to identify areas of failure which were putting people at risk.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing There were not enough staff to safely meet the needs of the service users. Staff were not well trained and did not have the skills needed to fulfil their roles. Staff were not competent in some areas of their duties.