Tamcare Ltd

Layden court

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

The inspection was unannounced, and the inspection visit was carried out over two days on the 6 and 11 November 2014. We last inspected the service in June 2014 and found they were not meeting all the regulations we looked at. They were non-compliant with Regulation 9 and 12 of The Health and Social Care Act (Regulated Activities) Regulations 2010.

Layden Court is a care home providing accommodation including nursing for up to 89 older people. It is situated in the area of Maltby, approximately six miles from Rotherham town centre. It provides accommodation on both the ground and the first floor and has parking to the front of the building and accessible gardens at the rear.

The home does not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law, as does the provider. The provider had a peripatetic manager overseeing the service but we were

Summary of findings

told at the time of our inspection they were leaving in three weeks, at the time of our visit there were no alternative management arrangements. Although we were told a new peripatetic manager had accepted a position and would hopefully commence employment in four weeks' time.

People were not kept safe at the home. There were poor arrangements for the management of medicines that put people at risk of harm. We found that not all staff understood the legal requirements as required under the Mental Capacity Act (2005) Code of Practice.

The peripatetic manager had a good understanding of the Deprivation of Liberty Safeguards and had commenced assessing people to determine if under new guidance a referral was required. Although this had only commenced the week of our visit. This legislation is used to protect people who might not be able to make informed decisions on their own.

Although people's needs had been assessed and care plans developed these were not always followed so staff did not always meet people's needs effectively. People's food and fluid intake was not monitored sufficiently. We observed that privacy and dignity of people living at the home was not always maintained.

The peripatetic manager had recommenced monitoring the quality of the service, but this had not been completed fully. Therefore not effectively checking the care and welfare of people using the service.

Staff were recruited safely and all staff had completed an induction. Although we found staff did not receive formal supervision regularly, as required by the provider's policy. Clinical supervision did not take place and there were no records to confirm competency checks had taken place in areas such as medication administration.

There was not always enough staff to provide people with individual support, this was due to environmental restrictions and deployment of staff. However staff told us this had improved over the last two weeks. The provider had a system to assess staffing levels and make changes when people's needs changed. But due the staffing shortages the provider was relying on agency staff, which at short notice, on occasions they were unable to provide. This sometimes left the service with inadequate staff to meet people's needs.

The peripatetic manager told us they had received a number of formal complaints in the last twelve months. These had been dealt with and one was still being investigated. Some relatives we spoke with had raised complaints and concerns. We received mixed responses some were happy their issues had been dealt with, while others told us they had to raise issues many times and felt they were not listened to.

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 peripatetic manager was knowledgeable on safeguarding vulnerable adults procedures, and we saw that procedures had been followed. However health and social care professionals we spoke with told us that when investigating safeguarding referral they found some staff lacked knowledge.

People were not protected against the risks associated with the unsafe use and management of medicines. Appropriate arrangements were not in place for the recording, safe keeping and safe administration of medicines.

Staffing levels were being maintained using agency workers both nurses and care staff. The peripatetic manager told us, “On some occasion’s we have had to work with insufficient numbers of staff because someone has called in sick at short notice and we have been unable to get any agency cover.” We observed staff appeared at times to be rushed, therefore not able to spend the time required to complete tasks at the pace of the person who used the service.

Is the service effective?

Inadequate

The service was not effective.

Staff were recruited safely and all staff had completed an induction. Although we found staff did not receive formal supervision regularly, as required by the provider’s policy.

Although people’s needs had been assessed and care plans developed these were not always followed, so staff did not always meet people’s needs effectively.

Mental Capacity assessments and best interest meetings did not take place in line with legislation. Staff had attended training however we found this was not always effective as staff showed a lack of understanding in the way consent to care and treatment was obtained.

A well balanced diet that met people’s nutritional needs was provided. However the meal times we observed were rushed, disorganised and was not a pleasant experience for people who used the service. We observed people were not supported to receive adequate nutrition.

Is the service caring?

Requires Improvement

The service was not always caring

We found a lack of consistency in staff approach and while some individual staff were kind and caring, others lacked an understanding of how to communicate with people who had complex needs.

Summary of findings

People did not always receive care and support that was personalised. We observed staff were task orientated, rushed and at times disorganised. Care staff also told us they were not familiar with the care plans and people's detailed needs.

Some people we spoke with told us they were not happy with the care provided. There were delays in care provision, waiting to go to the toilet, waiting to get out of bed and waiting for meals to be served. At lunchtime one person told us they had been waiting to get out of bed since breakfast.

We found no evidence that people were involved in making decisions about their care. Staff did not take account of their individual needs and preferences.

We saw people's privacy and dignity was not respected by staff. People were not dressed properly to maintain their dignity and people were left in bed uncovered with their bedroom doors open.

Is the service responsive?

Inadequate

The service was not responsive

People's health, care and support needs were assessed and reviewed. However we found they were not followed by staff so people's needs were not always met. Care staff we spoke with told us they were not familiar with the care plans.

Staff did not always engage with people in a positive way, people were sat for long periods of time in their bedrooms, either in their chair or still in bed. We also saw staff were not responsive to the needs of people living with dementia. For example staff did not manage an incident effectively and caused the person to become agitated.

Satisfaction surveys were provided to obtain people's views on the service and the support they received. However these had not been sent out for over a year.

A complaints process was in place and we saw these had been dealt with appropriately since the peripatetic manager had been in post. They had also introduced a new communication book on the reception desk, which had ensured any comments made by visitors were responded to. Relatives told us this had improved things and felt they were now starting to be listened to.

Is the service well-led?

Inadequate

The service was not well-led.

There was no registered manager in post. There had been five different managers overseeing the service in the last year, relatives told us there had been no consistency in management. They also told us this had improved since the peripatetic manager had been in post. However they were leaving in three weeks.

Summary of findings

People were put at risk because systems for monitoring quality were not effective. For example audits were not sufficiently robust to monitor the safety and quality of the service.

Staff and residents meetings had not been taking place at regular intervals, however these had been reintroduced and there was a relatives meeting on the day of our inspection.

Staff were not always given guidance to support people who used the service.

Accidents and incidents were monitored by the peripatetic manager, however, we identified not all incidents and accidents had been reported appropriately.

Layden court

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 checked 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 6 and 11 November 2014 and was unannounced. The inspection team consisted of the lead inspector, two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We carried out this inspection due to concerning information we received about the service. Before we carried out our inspection we reviewed all the information we held about the service.

We spoke with the local authority, commissioners, safeguarding vulnerable adults team and Rotherham Clinical Commissioning Group. The officers from all stakeholders told us they had concerns regarding the service and were currently investigating a number of safeguarding adults concerns. The local authority had applied a suspension of new placements at the service due to the level of concerns relating to safeguarding vulnerable adults. The local authority contracts officer also visited the service at the time of our inspection. They told us the service had improved since the peripatetic manager had been in post from 29 September 2014, but were continuing to closely monitor the service and conduct weekly visits to ensure the action plan in place was being implemented.

At the time of our inspection there were 70 people living in the home. The service consisted of five units; Haigmoor and Swallowood were located on the ground level and Thurcroft, Kiviton and Becks were on the first floor. Thurcroft, Kiviton and Becks supported people living with a diagnosis of dementia.

We used the Short Observation Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We looked at all other areas of the home including some people's bedrooms, communal bathrooms and lounge areas. We spent some time looking at documents and records that related to peoples care, including care plans, risk assessments and daily records. We looked at twelve people's support plans. We spoke with 25 people living at the home and 10 relatives.

During our inspection we also spoke with 19 members of staff, which included nurses, care staff, domestics, kitchen and laundry staff, the peripatetic manager, regional manager and director of operations. We also looked at records relating to staff, medicines management and the management of the service.

Inadequate

Is the service safe?

Our findings

At our inspection in June 2014 we found breaches of regulations 9 and 12 and issued compliance actions. The provider sent us a report of what improvements they planned to make to achieve compliance with the regulations.

At this inspection we found the cleanliness of the environment had improved, however people's needs in regard to care and welfare were still not being met. The provider had failed to fully implement the planned improvements they had set out in their report to us and people were not always safe.

The peripatetic manager told us that they had a dependency tool to determine how many staffing hours should be provided. They said this was being maintained using agency workers both nurses and care staff. They told us, "On some occasion's we have had to work with insufficient numbers of staff because someone has called in sick at short notice and we have been unable to get any agency cover." We looked at staffing rotas and we saw the staff scheduled to work was in line with the services' calculated staffing levels. The correct number of staff were on duty at the time of our inspection, although agency care staff were being used to ensure staff hours met the required levels.

However from our observations and what people told us staff were not deployed effectively to meet the needs of people who used the service. For example, we observed a person had activated their call bell as they required assistance. The call bell rang for over 10 minutes while staff were providing personal care to another person who used the service and no staff were visible. A relative also told us their father had walked the full length of the corridor then fallen in the lounge and no staff had been around to provide assistance which he required when mobilising due to risk of falling. We saw one senior care worker administering medication until 12:00, whilst one person waited to be assisted out of bed. The person required two staff to support them out of bed but there was no other staff member available to assist them.

Staff told us it was sometimes difficult to meet people's needs with the numbers of staff on duty due to environmental restrictions. For example one staff member told us that they had to take people onto another unit to be bathed. This meant staff had to be released from another unit to provide cover while two staff bathed the person.

One person we spoke with was still in bed and they told us, "I'm usually up but they are busy today. I don't know why I'm in bed, I like to get up." Other people we spoke with told us, "Staff are run off their feet" and another said, "There are enough but they keep changing and it would be nice if staff knew you."

Care staff told us staffing levels had recently improved with the use of agency staff but that it was still busy. Agency staff could not always be obtained at short notice for example when staff phoned in sick.

We looked at the management of medicines, including the storage, handling and stock of medicines and medication administration records (MARs). We found staff who administered medicines did not record the amount of medicines received or the amount carried forward from the previous month. This made it difficult to account for medicines received, administered and ensure the current stock levels were correct.

We looked at PRN protocols and saw these did not provide sufficient detail for staff to be able to determine when the medication was required. The protocols just stated; give as directed or give if in pain. There was no guidance for staff to determine how people presented when they were in pain. Staff we spoke with said people told them when they were in pain; however two people we case tracked did not have the capacity to be able to verbally communicate to staff when they were in pain. This meant that some staff may not recognise the signs that someone displayed to indicate they may be in pain.

We found a number of errors with prescribed medication. For example the stock of two people's medicines did not correspond with the number dispensed and the number remaining. This meant tablets were missing and unaccounted for.

Medicines were administered by staff that had received training. However, when we asked staff if they received regular competency assessments, they said they could remember receiving one, but not sure when. One care worker we spoke with was new in post and did not have a clear understanding of medicines they were administering.

Inadequate

Is the service safe?

We were shown some competency records but they were dated 2005 and 2008, we were told some more recent ones had been carried out but they could not be found. Therefore the provider could not determine if the staff were competent to administer medication safely following their policies and procedures.

This was a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We spoke with staff about their understanding of protecting vulnerable adults and they told us they had undertaken safeguarding training and would know what to do if they witnessed poor practice. Staff had a good understanding about the whistle blowing procedures and they said they would report anything straight away. The recent safeguarding's being investigated by the local authority evidenced procedures were followed.

Before our inspection, we asked health and social care professionals for their opinion of the service. They raised concerns regarding people's needs not being met. They had received a large number of safeguarding referrals and on investigating them had found staff lacked knowledge and on occasion's there was a lack of staff on duty.

We found there was robust recruitment procedures. The manager told us that staff did not commence working with people who used the service until all information had been received and reviewed, such as references had been received and a Disclosure and Baring Service (DBS) check had been completed. This is a check to confirm if people are suitable to work in care.

We found the cleanliness of the home in general had improved. The provider had recruited additional domestic staff. The staff we spoke with said this was much better as they were able to do the job properly rather than having to prioritise and not get everything completed.

Inadequate

Is the service effective?

Our findings

We received mixed comments from the people who used the service about the food. Some said the food was very nice but others said it was cold when they got it and one said, "I am fed up with it, it is all very similar, no variety."

Staff we spoke with told us that people often complained that food was cold and they had to heat it up in the microwave. Another said, "There is not much variety."

One relative we spoke with told us they were very happy with the care received and said "I can't praise them enough". However, she said she often comes at lunch time to feed their relative and brings food in as they ate better if they had variety. The relative said the food served by the care home was often too stodgy for their relative.

We asked staff how people were encouraged to choose their meal. Staff told us that the menu was circulated the day before and staff helped people to choose. Menus were not clearly displayed and staff did not ask people if they still wanted the meal they had chosen. We asked people who were waiting for some time to have their lunch if they knew what they would be eating. They were not sure and they could not see the menu board from where they were sitting as it was at the furthest part of the room.

From our observations we found at times there was a lack of organisation, which meant it was chaotic, disorganised and people's needs were not met. For example, people waited a long time for food to be served, yet staff were standing around by the servery waiting for food to be served by one kitchen assistant, and lunch was a very slow process. We saw one person actually got up from the table and left the room, they appeared frustrated as the other two people sat at their table had been served and they had to wait. We also observed one person who we were told required finger food was given a meal with gravy and a pudding with custard. The person was finding it very difficult to eat this meal with their fingers; this person was given no assistance during our observations. On another table we saw one person had eaten all their lunch and pudding before the other person they were sat with was served with theirs. We asked the staff why they had to wait we were told that they had to send down for another mashed meal as it had not come up on the trolley.

We saw that people were not supported to be able to eat and drink sufficient amounts. On all units we saw people who used the service required support to eat their meal in the dining areas, lounge and those who were cared for in bed. We observed staff did not offer assistance to people who chose to eat outside of the dining room. For example we saw two people struggling to eat their meals. The meal had been placed on a table that was not close enough. One person had spilt the food down their trousers and the other asked us to move the table closer. When we did this they said, "That's better I can reach now" and were able to eat their meal.

We found staff were not responsive to people's nutritional needs. For example we were speaking to one person at 11:15am who told us they had not yet had breakfast. We received conflicting responses from two staff members; one told us the person had eaten and another said the person had refused their breakfast but nothing else was offered. The person was eventually given a breakfast and ate all of it. They told us, "I was hungry." We also overheard a person asking care staff for crisps and being told, "You've only just had lunch." The person was not given any crisps. The member of staff did not enquire as to whether they had eaten their lunch or enquire why they were hungry.

We observed staff offering drinks to two people in the lounge. One person was asleep and staff were unable to rouse them. They took the drink away without it being drunk. The person remained asleep throughout our observations. Lunch was served and this person remained asleep; staff told us he had recently not been very well with a chest infection. It could not be confirmed by their records that the person had received adequate hydration during the day.

We also observed one person given no assistance with their cup of tea. It was taken away not drunk; the person was not given an opportunity to drink the tea or provided with an alternative drink such as coffee or juice.

This was a breach of Regulation14 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

During our inspection we spoke with members of staff and looked at staff files to assess how staff were supported to fulfil their roles and responsibilities. We found that staff did not receive regular supervision (one to one meetings with their manager). These provide a framework to monitor performance, practice and to identify any areas for development and training to support staff. The members of staff we spoke with said they did not receive regular formal

Is the service effective?

supervision and could not recall when they last received one. The unit manager we spoke with told us that they were catching up with supervisions as they had not taken place for a while, they said, "I have only just recently received supervision after a five month gap."

We identified that staff had not received annual appraisals. The peripatetic manager told us these had taken place in the last 18 months. We also found qualified staff had not received clinical supervision. This is required by relevant professional bodies to ensure their continued fitness to practice.

Staff we spoke with told us they had received training. We looked at training records which showed staff had completed a range of training sessions. Training was mostly accessed on-line. The training matrix we saw showed staff were up to date with the mandatory training required by the provider. However staff we spoke with told us it was e-learning training and they would prefer classroom based training, to have opportunity to discuss things and ask any questions. Staff felt they learnt better in this situation. The staff said they had raised this with the management.

Staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards. This legislation is designed to protect people who are unable to make decisions for themselves. It also ensures that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) is part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken.

The staff we spoke with had varying knowledge on this legislation. For example, when we looked at the care files we saw that some people were administered medication covertly. This meant that medicines might be given to a person mixed in food or drink where the person might otherwise have refused them. We saw there was a letter from the person's general practitioner to agree to this however we did not see any evidence that a best interest meeting had been convened to agree this. A best interest meeting is a meeting of all the people who might have a contribution to make. The members of the meeting collectively make a decision in the person's best interests if someone is unable to express their consent to something because they do not have mental capacity. Staff we spoke with not aware that a best interest decisions should have been carried out. This meant the training they had received was not effective.

This was a breach of Regulation 23 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at a number of care files and found they identified the people's needs and had measures documented to show how to meet the person's needs. We also saw that they were regularly reviewed and referrals had been made to health care professionals when required.

Requires Improvement

Is the service caring?

Our findings

We received a mixed response from relatives about the care provided at Layden Court. Some people and their relatives we spoke with were positive about the staff and said they were kind and caring. Examples of comments made by the relatives were "I can't praise them enough," "The staff work hard," "She (My relative) is always clean and tidy, she can't speak but is always smiling, and she chooses her own clothes."

We saw some evidence of a warm and positive relationship between staff and people who lived at the home. For example, at lunch one person took the hand of a care worker and told us they were "A wonderful person." Another said, "I like it here (Living at the home) I don't want to move."

Also one highly dependent person who could not communicate verbally went to great lengths to ensure we knew that they thought, "Staff were great." Their relative who visited daily also commented that their family member was always well cared for, clan and tidy.

However we also received some very negative comments, One relative told us, "I am very concerned my relative has had a large number of falls, some staff are very caring but others don't seem to care". Another person told us, "Staff have their down days and not always able to give time to be able to talk."

We saw staff were task orientated and care was not delivered in a person centred way. For example, care staff we spoke with were not familiar with what was in care plans so were not aware of how to meet people's needs. The staff handover records that we were shown were predominantly about tasks. We asked a key worker to provide some personal details about one of the people they had responsibilities for and found that they did not know the level of detail that could be expected of a person with this role. On enquiring further the key worker explained her role in tasks such as; ensuing the person's laundry was put away and that people did not run out of supplies in their room.

We looked at care and support plans for people who used the service. People's needs were assessed and care and support was planned in line with their individual needs. However we saw that care and support was not always delivered in line with peoples assessed needs. For example, one person we spoke with told us they were waiting to get out of bed. The person required a hoist to get out of bed and this required two staff. The person told us they could not use the toilet as it was difficult to manoeuvre the hoist in their room, they said, "So I have to go in a pad, which I don't like." This did not preserve the person's dignity. Records we saw said the person did not know when they need to use the bathroom, yet from speaking to the person it was clear they would prefer to go on the toilet.

We spoke with staff who mostly demonstrated that they understood how to maintain privacy and dignity. For example, staff said they would always ensure that they covered the person as much as possible when undertaking personal care. However, this was not demonstrated in practice, we found a number of people were cared in bed. Two of the people we saw had removed their bed covers and were uncovered, exposing their incontinence wear to people walking past. We also observed two people in the lounge one with their skirt pulled up and another person with their top pulled up and we saw that staff present did not support people to cover up to maintain their dignity.

We asked the peripatetic manager if the service had dignity champions to ensure people were respected and had their rights and wishes considered. They told us there may be staff who have been given the role but in name only as it had not been followed through with training which covered respect and dignity. They reflected that staff did not understand the role.

We looked at individual's care files to see if they were person centred. We saw a, 'My choice, preferences' section which contained very little information to guide staff and ensure the persons wishes were considered.

During our inspection we found a large amount of people were cared for in bed. Staff told us, "They choose to stay in bed rather than get up." However two people we spoke with told us they preferred to get up and another said, "I'm waiting to get up but I need help." This meant peoples choices were not being respected.

We spoke with the activity co-ordinator about how people could access the community. She told us that there was a min bus, however relatives we spoke with told us this was never used. We saw people who were able to join in group

Requires Improvement

Is the service caring?

activities taking part in various games and activities. However we found people who lacked capacity, or were cared for in bed received very little interaction or stimulation.

We visited the laundry and found clothing was placed in boxes with people's names. When we looked closer we saw some clothes were not labelled. We were told that most of the clothes were not yet labelled with people's names making it very difficult to ensure that people received their own clothes.

We observed lots of staff movements during the day, which made it very difficult to know who was looking after whom. The changes of staff during the day would not help people living with dementia understand who was looking after them. Staff we spoke with also told us when they were moved to other units to cover they did not know people's needs and sometimes on the smaller units they were left as the only member of staff. They said it was difficult to meet their care needs because of this.

This was a breach of Regulation17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw people had chosen what they wanted to bring into the home to furnish their bedrooms. They had brought their ornaments and photographs of family and friends or other pictures for their walls. This personalised their space and supported people to orientate themselves.

We were told there were no restrictions visiting times. One relative told us they visited at different times of the day; others said they liked to visit at lunch time so they could assist their relative to eat their meal.

Inadequate

Is the service responsive?

Our findings

Care and treatment was planned in a way that ensured people's safety and welfare. Each person's care plan outlined the areas where they needed support and gave instructions of how to support the person. There were risk assessments in place for people, which identified areas of risk associated with their care. However we saw the care and support delivered did not always follow the care plan and did not meet people's needs.

For example we saw one care plan that detailed the person's moving and handling plan and what support was required to meet their needs. However this was not followed as the hoist required to be used did not manoeuvre in the person's bedroom so was not able to be used.

Another plan assessed a person at risk of losing weight the person's food intake was being monitored as they had been placed on an enriched diet. We found the documentation lacked detail and it was therefore not possible to determine if the person had received an enriched diet to meet their needs.

Staff did not always engage with people in a positive way, people were sat for long periods of time in their bedrooms, either in their chair or still in bed. We saw a person was sitting in a wheelchair at the table, they looked in an uncomfortable position as they were leant completely over one side with their hand resting on the wheel, the care worker did not acknowledge this or offer any assistance, they were not responsive to the person needs.

Another person was asleep for short periods but staff gave encouragement to drink a cup of coffee. They were singing to the person and encourage them to join in. They told us that this person should sit on a 'spenco' cushion, this is a cushion provided when people are at risk of developing pressure sores. The cushion was on another chair in the lounge. They told us that she refused to sit on it and would move to another chair if they sat her on it. The care plan said the person should always be encouraged to sit on the cushion. Staff told us that this person refused to go to bed and this had been the case for a considerable length of time. We looked at her care plan and it confirmed what staff had told us. However staff had not responded to this by considering alternatives ways to meet their needs and protect them from developing a pressure sore.

Just prior to lunch we saw a person was making their way into the lounge and two staff stood in their way and insisted that they make their way to the dining room for lunch. The person became agitated and eventually grabbed at staff and ripped off the staff's plastic apron. They sat themselves on a coffee table and refused to move. We saw staff did not deal effectively with the situation and this caused the person to become agitated. Staff were not responsive to the person needs and did not appear to be able to deal with challenging behaviour or know how to prevent this.

Staff told us they were not familiar with the care plans. For example one person's care plan clearly detailed their needs. However, when we talked with the carer about this person's personal hygiene they described how they cared for them, this did not reflect what we had seen in their care plan.

We found in practice the care staff were not always familiar with the care plans and the plans were not always followed so people's needs were not always met. For example one person was assessed as at risk of not receiving adequate nutrition. The person had been placed on a food and fluid chart and regular weight checks. We found the food and fluid charts were not completed properly there were many gaps and they were not reviewed. This person had been gradually losing weight at about 1kg a month over four months, this had not been reviewed and no referral had been made to a dietician. The documented records stated, 'weight remains stable'.

Another care plan we looked at showed that the person was at a high risk of developing pressure sores. We saw the person had a pressure sore and a record that showed the progress of wounds should have been completed weekly. This had not been updated since the 11 October 2014. This meant it had not been updated for four weeks. The nurse checked this person's pressure area and told us that the pressure sore remained. It was therefore not possible to determine if the care provided was meeting the person's needs and preventing deterioration or preventing them developing further pressure sores.

We saw no consideration had been given to the people who lived with dementia. All crockery was traditional white rather than coloured which is recommended for people living with dementia.

Inadequate

Is the service responsive?

The environment upstairs was not conducive to people living with dementia. Pastel colours were used and the doors along the corridors were also light in colour. The flooring on the corridors was a pale wood pattern and shiny. People living with dementia may interpret shiny floors as being wet and/or slippery. Memory boards were mounted at the side of the bedrooms but many were left blank.

At the time of our inspection we found there was only two assisted baths available in working order, one on each floor. We also found two toilets were out of order Staff told us this made it very difficult to meet peoples hygiene needs. Works to improved bathrooms had been required at our last inspection in June 2014, the action plan we received from the provider told us the works would be completed by the end of September 2014. This had not been completed so people's hygiene needs were still not being met effectively as adequate facilities were not available.

This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Satisfaction surveys were provided to obtain people's views on the service and the support they received. However these had not been sent out for over a year. A complaints process was in place and we saw these had been dealt with appropriately since the peripatetic manager had been in post. They had also introduced a new communication book on the reception desk, which had ensured any comments made by visitors were responded to. Relatives told us this had improved things and felt they were now starting to be listened to. One relative told us, "It has taken a while but staff are now listening but only time will tell if things are actioned."

Inadequate

Is the service well-led?

Our findings

At the time of our inspection the service did not have a registered manager who had been registered with the Care Quality. There was a peripatetic manager in post until 12 December. The provider told us they had appointed another peripatetic manager to take over from 15 December 2014 but had not yet recruited a permanent manager.

There were systems in place to monitor and improve the quality of the service provided. We saw copies of reports produced by the peripatetic manager and the company's regional manager. The reports included some actions required and these were checked to determine progress. However the systems had not identified all the issues that we identified during this inspection. For example the care plans were audited and reviewed, but there were no systems in place to determine if the care plans were effective and being followed by staff. Also the meal time was not a pleasant experience for people and this had not been monitored. For example a relative we spoke with told us they felt their relative had a good lunch usually served at 1pm but then tea was served at 4pm, which was too close so usually wasn't hungry at this time. They however felt it was then a long time to go to breakfast the following day. They said they had raised this with previous manager as they felt their relative's needs were not being met by the times of the meals but no action had been taken.

We also found medication audits had not been completed. We were shown one audit completed for one of the units however the audits had not been completed on all units. This meant not all the issues had been identified, therefore the audit was ineffective in monitoring medicines management.

Our observations identified staff were not deployed effectively to meet people's needs. For example staff were sent to units where they did not know the people and left on their own and staff taking three hours to complete a medication round. This had not been identified by the management through monitoring of the service provision. Staff told us they had raised issues with managers but were not listened to. Although they did acknowledge the peripatetic manager was holding a staff meeting where they could now raise the issues again.

We looked at recent incidents and found safeguarding referrals had been made by the peripatetic manager. We found they had reported incidents and taken appropriate action to safeguard people. We found two incidents identified by relatives that alleged neglect, we saw they had been addressed and actions implemented to prevent them occurring again. However it had not been identified prior to our inspection that these incidents had not been reported to the Commission or the local authority safeguarding. The fact that these were not reported was not picked up through the quality monitoring system.

The peripatetic manager had identified staff supervisions had not been carried out. We looked at the supervision records, these showed they had recommenced in October, but only a small number of staff had attended supervision in October and November 2014. The peripatetic manager told us she was organising other supervisions to ensure staff received the required supervision in line with the provider's policy. However nothing had been organised for clinical supervision for qualified staff or appraisals. We were told staff had not received appraisals for over 18 months. The monitoring systems had been ineffective in identifying and taking appropriate action to address this.

The staff told us it had been difficult as there had been five different managers in the last year, they said each manager had different ideas which meant things kept changing. Staff also said they did not always feel they were listened to. For example, the domestic staff told us their hours had changed with no consultation with them to determine if the changed hours could be more effective. They told us the altered hours were not always working and were having a negative impact on the service. This was raised in a team meeting on 9 October 2014. They told us they had still not been consulted for their views and felt they were not being listened to as they had proposals that they felt could improve the service delivery regarding cleanliness.

At our last inspection in June 2014 we identified a number of environmental improvements that were required; at this visit these were still outstanding. The provider had told us following our last visit these would be carried out. The director of operation who was at the service on the second day of our inspection told us these had now been approved and would be completed. The provider had assessed through monitoring that improvements were required but had not followed this through to ensure people were not at risk of unsafe care and treatment. For

Inadequate

Is the service well-led?

example the medication rooms were operating at a temperature higher than that recommended. We were told that air conditioning units would be in place by the end of September 2014; these were still not in place at this inspection.

Observations of interactions between the deputy manager and staff were inclusive and positive. Staff spoke of good leadership and support from the deputy. They felt the peripatetic manager was very busy although they told us if they needed to talk to her they said she was approachable.

Relatives we spoke with told us the changes in management had been very frustrating as they would raise concerns with one person and then they had to raise them again. Although they told us they felt the management team now appeared to be listening and seemed more committed to moving things forward.

The staff we spoke with said they did not always feel supported or listened to. They said they often worked short staffed due to high levels of sickness. They were struggling with limited bathrooms and facilities. We discussed this with the regional manager who told us the sickness policy was being reintroduced to manage absence.

This was a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The peripatetic manager had arranged a staff meeting for the day of our inspection, they told us they were trying to have regular meetings to improve communication. They had also held a relatives meeting which was well attended.

Staff we spoke with were aware of whistleblowing procedures and these had been followed in the recent safeguarding investigations

Any accidents and incidents were monitored by the peripatetic manager and the organisation to ensure any triggers or trends were identified

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **People were not involved in making decisions in their care and treatment or able to express their views. People's privacy and dignity was not maintained.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **People were not protected from the risks of receiving inadequate nutrition.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **Staff did not receive appropriate professional development, supervision or appraisal.**

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **The provider did not have an effective system to regularly assess and monitor the quality of the service provided.**

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People were not protected against the risks of receiving care or treatment that was inappropriate or unsafe.

The enforcement action we took:
We have issued a Warning Notice which we have asked the provider to comply with by 9 January 2015

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People were not protected against the risks associated with the unsafe use and management of medicines. There were not appropriate arrangements for obtaining, recording, handling, dispensing and disposal of medicines.

The enforcement action we took:
We have issued a Warning Notice which we have asked the provider to comply with by 9 January 2015