Elder Homes Bingley LLP

St Ives Disabled Care Centre

Inspection report

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Ratings

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

Overall summary

This inspection took place over three days on 29 September, 7 and 15 October 2015 and was unannounced.

At the last inspection on 27 and 28 May 2015 we identified ten breaches in regulations – regulation 18 (staffing), regulation 19 (recruitment), regulation 12 (safe care and treatment), regulation 15 (premises), regulation 13 (safeguarding), regulation 11 (consent), regulation 9 (person-centred care), regulation 10 (dignity and respect), regulation 16 (complaints) and regulation 17 (good governance). Following this inspection we took enforcement action.

We carried out this inspection in response to concerns we had received since the inspection in May 2015. These related to staffing levels in the home and the impact that had on the care delivered to people using the service. The local authority safeguarding team had also been informed of these concerns and prior to our inspection the commissioners had suspended placements at the home.

St Ives Disabled Care Centre provides nursing and personal care for up to 60 people with physical disabilities; the majority of people using the service are under pensionable age. On the first day of the inspection the manager told us there were 37 people using the service, which included 18 residential clients and 19 nursing.The home is a converted listed building and is located on the St Ives Estate close to Bingley.

Summary of findings

Accommodation is provided on four floors, there are single and shared rooms and many have en-suite facilities. There are three communal areas on the ground floor and there is also a lounge on the first floor.

The home did not have a registered manager. A manager who had started in post on 22 April 2015 was present on the first day of the inspection but resigned with immediate effect the following day. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they did not feel safe in the home due to insufficient staffing levels, particularly at night. The home had no permanent nursing staff and relied on agency nurses to cover all the shifts. Although the provider tried to ensure continuity by requesting the same agency staff, people told us staff did not know their needs. This was confirmed in our observations over the three days of our inspection. People also raised concerns about the reliability of the call bell system. Although the provider put daily checks in place to ensure call bells were working, there were still problems with the system when we visited on the third day. Safeguarding incidents were not always recognised or reported by staff.

Staff recruitment processes had improved although we found one staff member had only one reference. New staff told us they had not completed a full induction. The training matrix showed many staff had not received up-to-date training in mandatory subjects such as moving and handling and safeguarding. Staff were not clear about emergency procedures, such as the action to take in the event of a fire, and emergency equipment had not been checked to make sure it was safe and available for use.

We found improvements had been made to the environment as it was cleaner and many areas had been refurbished and redecorated. However, we found carpets in some people's rooms needed replacing. Maintenance works were not identified or addressed promptly until we brought them to the provider's attention. For example, a broken washing machine had been out of action for several months.

We found systems in place to manage medicines were not always safe which meant people were at risk of not receiving their medicines when they needed them. Care records were not accurate or up-to-date which meant people were at risk of receiving unsafe or inappropriate care.

Requests for Deprivation of Liberty Safeguards (DoLS) authorisations had been made for some people following recommendations made by reviewing officers.

People's nutritional needs and weight were not monitored or reviewed to make sure they were receiving sufficient to eat and drink. People had access to healthcare services but advice and information provided by healthcare professionals was not always communicated between staff or acted upon.

We observed some kind, caring and sensitive interactions between staff and people who used the service. However, we found examples which showed people's privacy and dignity was not always respected and people's cultural needs and preferences were ignored. Activities were provided which we saw some people enjoyed, in contrast other people had little engagement or stimulation.

There was a lack of consistent and visible leadership which coupled with poor communication systems led to disjointed and chaotic service provision. Quality assurance systems failed to identify or address risks to people's health, safety and wellbeing or secure improvements in the service.

Following each day of our inspection we contacted the provider to inform them of our concerns and requested action plans to show how these would be addressed. The action plans were provided however we continued to identify concerns at each subsequent visit. We liaised with commissioners from the Local Authority and Clinical Commissioning Group, as well as the safeguarding team. Following the third day of our inspection the local authority reviewed its position regarding its commissioning arrangements with the home and worked with the provider to put resources in place to ensure the safety of people using the service.

The overall rating for this service is 'Inadequate' and the service remains in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to

Summary of findings

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

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not kept safe as there were not enough staff with the right skill mix who knew how to meet people's individual needs. Safeguarding incidents were not always recognised or reported.

Systems in place to manage emergency situations and risks to people were ineffective which meant people were not protected.

Medicines management was not always safe and effective.

Although there were improvements to the environment and the home was clean and had been redecorated and refurbished, systems in place to identify and address maintenance works were ineffective.

Is the service effective?

Inadequate

The service was not effective.

People gave mixed feedback about the food. People's weight and nutritional and hydration needs were not monitored effectively, which placed people at risk of not receiving sufficient quantities of food and drink to maintain their health.

People told us staff lacked knowledge in how to meet their needs. Mandatory training was overdue for many staff and induction for new staff was not thorough.

Applications were made for Deprivation of Liberty Safeguards (DoLS) authorisations for some people following recommendations made by reviewing officers.

People had access to healthcare services, however a lack of communication between staff which meant advice and information was not always passed on.

Is the service caring?

Inadequate

The service was not caring.

People's opinions of the staff varied with some rating them highly and others describing them as 'okay'. We saw some caring and kind interactions between people and staff.

However, there was a lack of respect for people's privacy and dignity.

People's cultural needs and preferences were not recognised or respected. People's views were not sought or acted upon.

Is the service responsive?

Inadequate

The service was not responsive.

Care was not planned or delivered to meet people's individual needs.

A range of activities were provided however these benefitted only some of the people and others had little or no social engagement.

Summary of findings

One relative told us they had no faith in the complaints system

Is the service well-led?

Inadequate

The service was not well led.

There was no registered manager. We found a lack of leadership, poor communication and ineffective quality assurance systems meant people did not receive the care and support they required.

St Ives Disabled Care Centre

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 over three days on 29 September, 7 and 15 October 2015 and was unannounced. On the first day the inspection team consisted of four inspectors and an expert by experience with experience in physical disabilities. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. An inspection manager joined the inspection team partway through the inspection and was present when feedback was given to the manager and area compliance manager at the end of the visit. On the second day two inspectors, an inspection manager and the head of inspection visited. On the third day there were five inspectors and an inspection manager.

Before the inspection we reviewed the information we held about the home. This included looking at information we had received about the service and statutory notifications we had received from the home. We also contacted the local authority commissioners and the safeguarding team.

We usually send the provider a Provider Information Return (PIR) before the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We did not send a PIR to the provider before this inspection as the inspection was planned at short notice.

We spoke with 19 people who were living in the home, four relatives, 17 care staff, six nurses, three domestics, two cooks, a kitchen assistant, two activity staff, the maintenance person, the manager, the area compliance manager and the area manager. We also spoke with six health and social care professionals who were visiting the home during our inspection.

We looked at 20 people's care records in detail and others to follow up on specific information, four staff files, medicine records and the training matrix as well as records relating to the management of the service. We looked round the building and saw people's bedrooms, bathrooms and communal areas.

Inadequate

Is the service safe?

Our findings

At our previous inspections in November 2014 and May 2015 we found a regulatory breach relating to staffing as there were not enough staff to meet people's needs. At this inspection we found improvements had not been made.

Everyone one we spoke with during the inspection, people who used the service, staff, relatives and visiting professionals, expressed concerns about the staffing levels in the home. People who used the service were particularly concerned about the staffing levels at night. One person told us the staffing levels at night were very poor, another said, "There's not enough staff all the time but it's worse on nights."

People told us they did not feel safe in the home. When we asked one person if they felt safe they said, "No not recently, I feel unsafe, very much so." This person told us their call bell was not working and at night when the door was closed they were worried that if they needed help and shouted out staff would not hear them. Another person said, "It's a really bad service particularly at night. I feel safe but only because I've got my own mobile." We asked a further person if they felt safe and they replied, "Do I hell. I don't feel safe on a night. If I can help it I don't buzz on a night." A further person told us, "I don't feel unsafe but if I was more dependent on care staff then I would."

On the first day of our inspection we arrived at 7.30am and found five staff on duty – two nurses and three care assistants, all were agency staff apart from one of the care staff. The night staff told us when they had arrived on duty the night before there had only been three night staff. They said they had phoned the manager who arranged for additional agency staff to be brought in. One of the agency staff who arrived later told us they had not received any handover and this was their first night shift in the home. The night nurse did not know who was coming on to take over from them that morning and said there was no consistency in terms of who staffed the home and it was often agency staff handing over to agency staff. This meant there was often nobody with knowledge of the people who used the service involved in handover discussions about people's care.

All the staff we spoke with raised concerns about the staffing levels and the high use of agency staff. One new staff member who had no previous care experience told us they were left on their fifth shift as the only permanent member of staff working with a group of agency staff.

One visiting professional told us, "The main problem here is the staffing, there's just not enough." Other professionals we spoke with raised concerns about the staffing levels including the high use of agency staff, particularly nurses, and the pressures put on these nurses with the amount of work they had to do.

On the first day of our inspection the manager told us the staffing levels had recently been reduced by senior managers so there was only one nurse working during the day instead of two. They said they had raised concerns about this reduction but had been over-ruled. A visiting healthcare professional we spoke with told us they were very concerned about the reduction in nursing staffing levels and the impact this would have on the health and wellbeing of people living in the home. We saw that the one nurse on day duty was still giving out the morning medicines at 11.45am, as was the senior care assistant who was administering medicines to residential clients. On the second and third days of our inspection the nursing staffing levels had been increased so that there were two nurses working during the day and the number of agency care staff had been reduced as care staff from one of the provider's other homes had been brought in to provide some consistency. However, people who used the service, relatives, staff and visiting professionals continued to raise concerns with us about the consistency of staff and their knowledge, competencies and skills in meeting people's needs. This was a breach of the Regulation 18 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found staff recruitment processes had improved. The staff files we reviewed contained application forms, interview records, proof of identity and evidence of references and disclosure and barring service (DBS) checks. Although we noted one staff member had only one reference.

We found the risks to people were compounded by the lack of a reliable call bell system. People told us the call bells worked intermittently. One person told us they had had repeated problems with their call bell and said it seemed to depend on how the call bell was positioned as to whether it

worked or not. They said a couple of months previously they had reported their call bell was broken but the maintenance person had gone on holiday and they were left without a working call bell for a week. Another person told us their call bell had been broken for a couple of days and still was not working. They said the maintenance person knew about it. They described how they had to shout if they wanted help as they were unable to mobilise. Another person told us it was 'hit and miss' as to whether their call bell was working and it was not working when we visited. The manager confirmed the maintenance person knew about these broken call bells and was dealing with it. They described the call bell system as being 'on and off' and said they did not know what the problem was. We received a similar response from the maintenance person. When we raised these concerns with the provider they instigated daily checks of the call bell system to ensure all call bells were working correctly. However, on the third day of our inspection there were still problems as one person reported their call bell was not working and night staff told us they had been unable to turn off two call bells which had been ringing intermittently throughout the night. This demonstrated unsafe care as people could not consistently summon help should they need it. This was a breach of the Regulation 12 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found risks to people were not managed safely or appropriately. For example, we saw personal emergency evacuation plans (PEEP) in people's care plans described how four staff would be needed to move each individual out of bed in the event of a fire. This would not be achievable with the current staffing levels. One person described to us how the fire alarms had sounded a couple of weeks ago and the door to their bedroom had closed. They said they assumed it was a test and no staff had come to tell them what was happening. They said the following day when a visiting professional was with them the fire alarms sounded again and the bedroom door closed. They said they waited but no staff came and their visitor went to find out what was happening and found the fire brigade had been called. The person said again no staff came to explain what was happening. This person said they were concerned about their safety as when they had asked staff how they would be evacuated in the event of a fire they had been told that four staff would come, put them on a duvet and take a corner each and lift them. They said they knew this couldn't happen as there wouldn't be enough staff to help everybody in this way. The permanent staff told us they had received fire and evacuation training, but none had received any evacuation practice. We found many staff we spoke with were not clear about the fire procedures, assembly points or number of people in the home. One agency staff member told us they had received no fire instruction but had learnt what to do by following other staff when the fire alarm went off.

We found there were no systems in place to check emergency equipment was in place and safe to use. The chef told us the contents of first-aid and burns boxes were checked regularly, however there was no contents list or evidence of checks having been completed on this equipment. Similarly when we checked the resuscitation boxes we found equipment on the contents list was missing and some items, such as dressings were out of date. The suction machine was stored in a locked room which meant it was not readily available to staff and there were no systems in place to check the machine was working or properly equipped. This meant in an emergency situation people could not be confident that staff had access to appropriate equipment that was safe to use. This was a breach of the Regulation 12 (2) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked to see the accident and incident reports and analysis since May 2015. The records showed two accident/incidents had been recorded in June, two in July, none in August and one in September. The manager showed us four incident reports which had been left on their desk which were not included in the analysis. One was dated December 2014, another July 2015 and the other two September 2015. The manager was not able to provide us with any evidence to show that these incidents had been investigated or that action had been taken to prevent a re-occurrence. For example, the action required in one of the reports was that a person needed assessing for a new hoist sling. There was no evidence in the person's care records to show this had happened and when we asked the manager they said they did not know about the incident. Although by the second day of our inspection the person had been assessed and provided with a new sling, the delay in addressing this issue had placed the person at unnecessary risk for a period of over four weeks. This was a breach of the Regulation 12 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service safe?

We looked round the building and found improvements had been made since we last visited in May 2015. The home was clean and many areas of the home had been redecorated and refurbished. We saw 'show rooms' had been created which were well decorated and comfortably furnished. Corridors and communal areas were brighter with stencils and pictures on the walls and items of interest displayed. However, some people's rooms still required attention. On the first day of our inspection we identified two bedrooms where the carpets needed replacing as they were heavily stained and ruched. New carpets were fitted by the third day, although on this visit we found a further bedroom carpet in an equally poor condition which needed replacing. This showed us the systems and processes in place for identifying and addressing environmental issues were not robust.

We found maintenance works were not carried out in a timely way. On the first day of our inspection there were two washing machines in the laundry but only one was working. Staff told us the broken machine had been out of action for a month and required a new part. Staff said they had come in at 4.15am as this was the only way they could manage to get all the washing done with just one working machine. Staff told us one of the boilers was not working and had been out of action since February 2015. We spoke with one person and their relative who told us the person had been unable to use their ensuite shower room for the last six months due to ongoing problems with the boiler which serviced their room. Staff told us one of the deep fat fryers in the kitchen was broken and had not worked for four weeks. By the second day of the inspection the washing machine and deep fat fryer had been replaced, however we were told problems remained with the boiler. This was a breach of the Regulation 15 (1) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection in May 2015 we had identified a regulatory breach in relation to medicines. At this inspection we found the breach remained. The manager told us the medicines systems had been changed recently so the nurse administered medicines to nursing clients and the senior care staff administered them to the residential clients. We found systems and processes in place to manage medicines were not always safe or effective. For example, we found medicine care plans and protocols for 'as required' medicines were generic and not up to date. We saw prescribed creams had not be signed as given on the medicine administration record (MAR). Although there were body maps for some people these were not clear. For example, one body map had circled numerous areas of the body but it was not clear if all or one of these areas were where the topical medicine should be applied. There was a long list of medicines which had been identified for disposal but no signature to show that these had been collected. When we asked the staff they did not know where the medicines were and they could not be located during our inspection. We saw medicines received into the home were not countersigned by a second staff member. One person had run out of their epilepsy medicine. This was not mentioned in the handover from the night staff to the day staff. The inspector informed the manager who was not aware but arranged for a prescription to be obtained from the GP. The daily records showed this person had run out of their epilepsy medicine three weeks previously. This showed the systems in place for ensuring adequate supplies of medicines were not effective. This was a breach of the Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection in May 2015 we identified a regulatory breach in relation to safeguarding. We found staff had not received up-to-date safeguarding training and safeguarding incidents had not been identified or acted upon. We found the same issues at this inspection.

The training matrix showed only 23.81% of staff had received safeguarding training. We made three safeguarding referrals following the first day of our inspection which related to missing money, an incident where a person had slipped out of a hoist sling and concerns about service users' weight loss. None of these incidents had been identified by the manager or reported to safeguarding. This was a breach of the Regulation 13 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

People we spoke with expressed concerns about the care they received and said the changes in the staff team and high use of agency staff meant some staff did not have the knowledge and skills to meet their needs. People told us staff did not 'understand' them and they had to keep repeating their care needs to a constant 'stream of carers'. One person told us the care staff had not known they needed turning at night and staff said they had not been told this in handover. Another person told us, "Previously new staff would work with seniors and get to know my needs. Now the onus is put on me to tell staff what to do." Another person said, "A lot of the staff don't know what they're doing."

We spoke with staff who had been recruited since May 2015 and asked about their induction. One staff member told us they had received moving and handling training and fire safety training and had been given a password to start their e-learning but had not completed this. This staff member had no previous care experience and told us they had been left on their own with agency staff on their fifth shift as the permanent staff member they were working with had to leave the shift. Another staff member told us they had received moving and handling training at the provider's other home and had induction from the night staff. They had no uniform and said they had never been given one. A further staff member told us their supervisor had started the induction with them but this had not been completed and said, "I think it's been overlooked."

The training matrix showed many staff had not received training or annual refresher updates. For example, only 38% of staff had received moving and handling practical training and 23.81% had received safeguarding training. Training percentages for all other staff training were below 75% with some areas showing very low numbers such as dignity and respect scoring 0% and nutrition awareness 2.38%. This was a breach of the Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People gave mixed feedback about the food. For example, one person describing it as 'excellent', another felt it was 'adequate' and a further person said they did not like the food. Two people told us the quality of the meals varied according to which chef was on, describing it as 'up and down'. We observed lunch on the first day of our inspection in the dining room and one of the lounges. In the dining room we saw there was a lack of staff to assist people who were unable to feed themselves, although when assistance was given this was done sensitively. There were no adapted aids used such as specialist cutlery or crockery and we saw some people struggling to eat independently. The meal was chicken goujons, potato croquettes and tinned spaghetti and did not look appetising. People sitting on tables together were not served their meals at the same time and in some cases people waited up to 25 minutes for their meal to arrive.

In the lounge there was no menu on display in contrast to the menu displayed in the dining room. People who received their nutritional intake via a percutaneous endoscopic gastrostomy (PEG) tube were positioned around the periphery of the lounge. This meant that they could not only smell the cooked food but watched as other people ate their food at a table positioned in the centre of the room. We asked one person how they felt about watching other people eat their lunch when they could not; they told us they had, "Got used to it now". We observed the room became very crowded as more people arrived in their wheelchairs and the small table in the middle of the room was not able to accommodate everyone who wanted to use the table. Unlike the tables in the dining room, there was no tablecloth or condiments provided. The meal was served in relays as there were not enough staff helping. The food did not look appetising, healthy or nourishing and we observed it was neither a pleasant or sociable occasion.

We had concerns about some food storage arrangements. For example, some opened packets had no opening dates on them and there were no thermometers to monitor the temperatures in some of the fridges or freezers. We raised our concerns with food hygiene inspectors from the local authority who visited the home.

At our inspections in November 2014 and May 2015 we had identified a regulatory breach in relation to nutrition particularly in relation to systems in place to ensure people received sufficient food and drink. At this inspection we found similar concerns.

We found people's weight and nutritional needs were not monitored effectively. Weight charts we reviewed over the three days of our inspection showed significant losses and gains in weight, yet it was unclear what action had been taken in response to this information. For example, the weight chart showed one person had lost 14kgs between

Inadequate

Is the service effective?

May and September 2015. Due to this risk we made a safeguarding referral. On the second day of our inspection when we checked the food monitoring documentation we found this person had refused all meals for two days and only accepted one glass of milk during this time period. The care records showed no record of any referral to a health practitioner regarding this person's refusal to eat and their diabetes care plan, which was undated, had last been reviewed in May 2015 and the nutrition care plan in March 2015. Although action was taken to refer this person to their GP and a dietician following the second day of our inspection, we remained concerned that these issues had not been identified or addressed by managers until we brought them to their attention.

We found people's nutritional and fluid intake and output was not monitored effectively. Staff were unclear whose responsibility this was which meant although records were maintained, no one responded to the information recorded. For example, one person received all their fluid and nutrition via a PEG tube. The dietician's instructions clearly specified the total daily intake this person required, yet charts reviewed over a three day period showed this target was not met. Records of output also raised concerns with wide fluctuations recorded between the amount of urine passed each day. This person's nutritional care plan was dated November 2012 and stated 'appears to have lost interest in eating and drinking', although the plan had been reviewed on 1 October 2015 it made no reference to the monitoring of food and fluid charts. We looked at the nutritional care plan for another person whose weight records indicated they had lost 3kg in one week. The care plan showed the person received most of their nutrition through their PEG but stated they could also have an oral diet of 'custard consistency' foods and thickened fluids. We looked at this person's intake and output charts for a period of seven days and saw no record of any oral intake. When we met this person we saw their mouth was very dry.

When we discussed our concerns regarding people's weight and monitoring of nutritional needs with the area manager they acknowledged the shortfalls and said they were taking action to address these. However, we remained concerned as we had previously identified similar concerns at our inspection in May 2015. This was a breach of the Regulation 14 (1) (4) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission (CQC) monitors the operation of the Mental Capacity Act 2005 (MCA) and specifically the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom. On the first day of our inspection the manager told us no one had a DoLS authorisation and no applications had been made. Following visits made by reviewing officers from the Local Authority to people who used the service, DoLS applications were submitted for some people who were deemed to be deprived of their liberty. We were concerned that the need for DoLS applications had not been identified by managers of the service.

Records showed people had access to healthcare services such as GPs, district nurses, opticians, tissue viability nurses and dieticians. However, feedback we received from visiting health and social care professionals raised concerns about communication between staff which indicated information about people's care needs was not always passed on. For example, the GP had made a safeguarding referral as the weekly weights they had requested for one person were not being done. Another health care professional told us they often found it difficult to get an update on people's needs as the agency nurses did not know. We also saw reference to chiropody in people's care plans which stated this service was provided every six to eight weeks, yet we could find no evidence of any chiropody visits. When we asked the area manager about this they said they did not know what arrangements were in place for people to receive chiropody. This was a breach of the Regulation 12 (2) (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service caring?

Our findings

People expressed mixed feelings about the staff although everyone commented on the high turnover of staff and how this had affected their care. One person told us they were happy with everything and described the staff as, "A1." Another person told us they liked living in the home and said staff were, "All right" but didn't like the squabbling between staff. A further person said staff were, "Generally okay" but said, "A lot of good staff have left." This was echoed by other people who talked about how staff had changed from those 'in the old days' who knew them well. One person said, "It's okay but it's not the same as it used to be." Two relatives we spoke with told us the staff were good but expressed concerns about the lack of consistency of staff and permanent nurses.

We observed many of the staff were kind, caring and friendly in their interactions with people. When people needed assistance such as with meals staff provided this sensitively and patiently. We saw staff laughing with people and sharing a joke. We observed staff knocking before they entered people's rooms.

However, some people told us staff did not always respect or act upon their choices. One person said, "You don't know where you are with agency staff. Last night I had to go to bed at 8.30pm, I didn't want to go but felt I had to, to help them out." Two other people told us night staff had not listened to them when they said they had not wanted to go to bed. One person told us that they, "Sometimes felt like asking for a glass of wine". We asked what would happen if they did ask. They said they had asked and were told "can't give you one now."

We found some staff showed a lack of respect for people's privacy and dignity and a lack of awareness of professional boundaries. One person told us that staff used their bedroom to charge their mobile phones and that staff brought in their hair straighteners which they used in this person's room. We saw a staff member using another person's bedroom to give people beauty treatments. Some people told us they did not like swearing and said this language was used by other people who used the service and staff. We did not hear any swearing from staff during our inspection.

We found a lack of awareness and consideration of equality and diversity issues. One person's relative told us no one in the home acknowledged the religious festival. This was despite the relative making sure their family member's care plan specifically stated their religious and cultural practices were very important to them. The relative told us that they knew how upset their family member would be by this omission. They said it had upset other relatives who visited when they realised that there was "not even a card" or any acknowledgement at all. Another person told us of their preference for female care staff, yet they said on the night shift they were often attended to by male staff. We looked at this person's care records which clearly showed their preference for female staff, yet they had been allocated male staff as their keyworkers.

People told us there were few opportunities for them to express their views about the service. One person said, "There's no forum for me to express my views and no one comes in to ask me what I think." Another person said, "No managers come to talk to me or ask me how things are." The area manager told us they were going to introduce weekly meetings for people who use the service. This was a breach of the Regulation 10 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

People's care was not planned and delivered to meet their individual needs. Care records we reviewed were disorganised, many of the care plans were dated 2012 or 2013 and contained information that was no longer relevant or accurate. We found the care plans were insufficiently detailed to enable staff to deliver person centred care. For example, one person had been identified as being at risk of developing pressure sores. The plan stated 'to monitor the skin', prevent tissue breakdown and keep the skin intact, yet there was no specific instructions for how this plan should be implemented by staff. In another instance, a plan to relieve constipation simply involved the giving of laxatives and the management plan for urinary incontinence stated 'be aware, assist and observe'.

One person's care plan which had not been reviewed for a year showed they were at risk of constipation and directed staff to monitor and record bowel movements, give aperients as prescribed and offer an enema if their abdomen became distended. When we asked the area manager and staff where bowel movements were recorded they all gave different answers and no records could be located. We looked at this person's MAR and found they were not prescribed any aperients or enemas. When we asked the nurse about this they said they did not think the person needed aperients as they had no problems with their bowels. The night nurse told us this person had not had their bowels open and they were concerned as the person's abdomen was distended and they had been sick. The day nurse told us the person had had their bowels open before the night staff came on duty yet this was not recorded anywhere. The day nurse told us the person had been seen by the GP and was all right, yet the lack of accurate care documentation and poor communication between staff placed this person at risk of inappropriate and unsafe care.

Another person's continence and moving and handling assessments showed they needed the support of two staff and the hoist to assist them to use the toilet. The care plan also said the person was prone to constipation. We asked two staff if this person was supported to use the toilet. Both said they were not and just had their pads changed whilst lying on their bed. This meant the person would always be incontinent as they were never offered the opportunity to use the toilet.

Another person's care plan made no reference to the fact that they were catheterised and this was only identified when we read through the person's daily records. A further person's care plan made reference to their new dentures yet this was written in 2013 so was no longer relevant. The care records for a further person showed they were not properly assessed prior to admission to ensure the home was able to meet their needs. The pre-admission assessment recorded their care and support needs as 'all personal cares'. Apart from a moving and handling assessment there were no care plans in place for this person and we found on five days there were no daily reports to show the care and support provided. This was a breach of the Regulation 9 (1) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed some people taking part in activities during all three days of our inspection. On the first day in the morning there was an exercise to music session which involved 20 people and was a lively event. In the afternoon a singer entertained people in the reception area which we saw some people enjoyed very much and were singing along. On the second day the acting manager told us one person had gone on holiday and five people had gone on a day trip to Morecambe. We spoke with one person who had been on the trip and they told us they had had a good time. We spoke with another person who had attended day care and a further person who had arranged their own transport so they could attend a local interest group meeting.

However, people told us the activities were focussed on some people and not others. We observed there were people who had little or no social interaction or stimulation. For example, we saw two people in the reception area facing the television. Both were in wheelchairs and unable to move themselves independently. The television was on and the remote control was on the table out of reach. Both people had been sat there when we arrived at 1pm and we spoke with them at 3pm. We asked one of the people if they were watching the television. They said, "No, I'm bored silly by it." We asked how long they'd been in front of the television and they said, "Hours." We asked if they were asked if they

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Is the service responsive?

wanted to sit there and they said. “No I was just brought here after lunch.” We asked if they had been asked what they wanted to watch on TV and they said ‘no’ and we asked if they wanted to see what was on the other channels and they said yes please. Although staff walked past frequently and said hello, no one checked if they were okay or wanted to move elsewhere.

Another person told us they had not been out of their room since they had been admitted two months earlier as they could not manoeuvre themselves in their wheelchair due to a slight slope outside their room. Their care plan gave no information about their social and recreational interests and just stated ‘likes to go out’. This was a breach of the Regulation 9 (3) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did not review complaints at this inspection. However, one relative told us they had, “Given up complaining” as they felt, “Staff do not care.”

Inadequate

Is the service well-led?

Our findings

At our previous inspections in November 2014 and May 2015 we identified breaches in relation to good governance and found the quality assurance systems in place were not effective in identifying shortfalls in the service provision and risks to people's health, safety and welfare. At this inspection we found there was a continued breach.

The home had no registered manager. The registered manager left the organisation in March 2015. A new manager was appointed in April 2015 and was present on the first day of our inspection. They resigned the day after our inspection with immediate effect. The area compliance manager took over the management of the home and was present on the second day of our inspection. They told us the provider was in the process of recruiting a new manager for the home. On the third day of the inspection the area manager was in charge of the home as the area compliance manager was on leave.

We found the lack of strong and consistent leadership underpinned many of the failings we have identified in this report. Although there were managers present on each day of our inspection, we saw most of their time was spent in the office rather than out on the floor overseeing the care provision and leading the staff team. There were no permanent nursing staff employed which meant the home was reliant on agency nurses to cover all the shifts, although the provider had tried to ensure some continuity by requesting the same nurses. Our observations showed it was the senior care staff who provided guidance and direction to the staff team with the nursing staff focussing mainly on medicines and people's healthcare needs.

Poor communication systems and the lack of co-ordinated team work meant managers and those in charge of the home were not always aware of what was happening. For example, staff were not clear about how many people were using the service. On the first day the nurse in charge on the night shift told us there were 34 people, when there were actually 37. On the second day the area compliance manager told us there were 37 people until we questioned this figure and then acknowledged there were only 36. On the third day the nurse in charge of the night shift told us there were 'approximately 44' people when there were in fact 36.

When we asked for information and documents often these were not provided as no one had oversight or overall control. For example, we asked the area manager where the food and fluid charts were for one person and they replied, "No idea, care staff would know" and went to enquire. Later we asked one of the senior care staff who said, "All depends where the nurse has archived them" and said they would look for them. These records were not provided. When we asked where people's bowel movements were recorded the area manager told us they were recorded in the daily records, the care staff said they used to be recorded on charts but they didn't know where it was recorded now and the nurses said they didn't know. Care records did not provide staff with accurate and up-to-date information and guidance about people's current care and treatment needs. Staff told us they relied on the verbal handovers given at each shift change and did not look at the care records. We looked at the handover records and found these contained very little information comprising of a list of people's names and comments such as, 'OK', 'PEG completed', 'Supplies ok' and 'Comfortable'.

An example of the chaotic way in which the service was run was when one person told us they had been locked out of their room overnight. A staff member had used the person's key, with their permission, to check the room but had not returned the key before going home. The night staff had not been able to find another key to the room so the person slept in a vacant room overnight. The person told us about this when we arrived at the home. The area manager was at the home but was not aware of what had happened until we informed them. No spare key could be found for the room. When the room was eventually accessed it was found to be dirty with very strong malodours and full of boxes and bags of belongings which made access to the en suite impossible. When we showed the room to the area manager they were shocked and unaware of the state of the room. Yet charts we saw showed staff had been checking this person in their room. Action was taken immediately to address this, yet this was only as a result of our intervention.

There were no systems in place to ensure people who used the service and staff were provided with the equipment and supplies they needed. Staff told us they often ran out of clinical wipes to deliver personal care. When we asked them what they used instead they became visibly distressed and told us "tissues". They said that a previous senior manager used to ensure these supplies, but since

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Is the service well-led?

they had left that had not been the case. We found another person had not been provided with the incontinence pads they needed overnight which meant they had been left in a wet bed. The area manager told us the pads had been available in an external store but no one had brought supplies in for this person.

This was a breach of the Regulation 17 (1) (2) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements 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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not protected from abuse and improper treatment as systems and processes were not established and operated effectively to investigate any allegation or evidence of abuse. Regulation 13 (2) & (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Service users were not provided with care and treatment in a safe way. Regulation 12 (1) (2) (a) (b) (e) (g) (I)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed and had not received appropriate support, training, professional development to enable them to carry out the duties they were employed to perform. Regulation 18 (1) (2) (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment All premises used by the service provider were not properly maintained. Regulation 15 (1) (e).

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Service users were not treated with dignity and respect and their privacy was not ensured. Regulation 10 (1) (2) (a) (b)

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 (RA) Regulations 2014 Person-centred care The care and treatment of service users was not appropriate and did not meet their needs or reflect their preferences. Regulation 18 (1) (a) (b) (c) (3) (a) (b).

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 Service users' nutritional and hydration needs, including parental nutrition, were not being assessed and reviewed to ensure they were being met. Regulation 14 (1) (4) (a) (b)

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 (RA) Regulations 2014 Good governance Systems and processes were not established or operated effectively to assess, monitor and improve the quality of the services provided or to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. Accurate, complete and contemporaneous records were not maintained in respect of each service user, including a record of the care and treatment provided to the service user and decisions taken in relation to the care and treatment provided. Regulation 17 (1) (2) (a) (b) (c).