Care Quality Commission

Tamaris Healthcare (England) Limited

Castleton care Home

Inspection report

Green Lane
New Wortley
Leeds
West Yorkshire
LS12 1JZ
Tel: 0113 231 1755
Website: www.fshc.co.uk

Date of inspection visit: 14 October 2014
Date of publication: 21/01/2015

Ratings

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

Overall summary

This was an unannounced inspection carried out on the 14 October 2014.

At the last inspection in June 2014 we identified that the provider had breached three regulations associated with the Health and Social Care Act 2008. We found people did not experience care, treatment and support that met their needs and ensured their safety and welfare, people were not supported to eat and drink sufficient amounts to meet their needs and people were not protected from the risk of infection because appropriate guidance had not been followed. We told the provider they needed to take action and we received a report on the 1 August 2014 setting out the action they would take to meet the regulations. At this inspection we found improvements had been made with regard to these areas. However, we found additional areas of concern.

Summary of findings

Castleton Care Home is a detached purpose built property located in the Wortley area of Leeds. The home provides care and support for up to 60 older people, some of whom have dementia or related mental health problems.

A registered manager was in place. 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.

People were not always protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines. This is a breach of Regulation 13 (Management of medicine); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found people were not always cared for, or supported by, enough skilled and experienced staff to meet their needs. Staff did not complete an induction on joining the home and opportunity was not available for staff to attend regular supervision meetings. This is a breach of Regulation 23 (Supporting workers); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and a breach of Regulation 22 (Staffing); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We observed interactions between staff and people living in the home and in the main staff were respectful to people when they were supporting them. However, at times interactions and communication between people living in the home and members of staff was poor. Some staff did not follow people's care plans putting people at risk of unsafe care and support. This is a breach of Regulation 9 (Care and welfare of people who use services); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There were not always effective systems in place to manage, monitor and improve the quality of the service provided. Staff were supported to raise concerns and make suggestions when they felt there could be improvements but it was not always clear who they should approach to do this. This is a breach of Regulation 10 (Assessing and monitoring the quality of service provision); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Activities were provided both in the home and in the community. However, these were not always meaningful and simulating. Staff told us people were encouraged to maintain contact with friends and family.

We saw from the records we looked at and speaking with relatives that complaints were not always documented or responded to appropriately.

Staff were aware of the values of the service and knew how to respect people's privacy and dignity.

People's physical health was monitored. This included the monitoring of people's health conditions and symptoms so appropriate referrals to health professionals were made.

People's health, care and support needs were assessed and individual choices and preferences were discussed with people who used the service and/or a relative. The care plans included risk assessments. Staff had good relationships with the people living at the home and the atmosphere was relaxed.

People's nutritional needs were being met. People were supported to eat and drink enough to maintain their health.

People lived in a clean, comfortable and well maintained environment and were protected against the risk of infection.

People told us they felt safe in the home and we saw there were systems and processes in place to protect people from the risk of harm.

The home had policies and procedures in place in relation to the Mental Capacity Act 2005. The regional manager told us the further work was needed to establish if people's liberty was being restricted.

We saw staff had completed mandatory training and future training had been arranged.

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

People did not always receive their medicines at the times they needed them or in a safe way. Records showed where changes had been made to people's medicines; these had not always been put into place quickly and accurately.

There were not always enough qualified, skilled and experienced staff to meet people's needs.

Staff knew how to recognise and respond to abuse correctly. They had a clear understanding of the procedures in place to safeguard vulnerable people from abuse.

Individual risks had been assessed and identified as part of the support and care planning process. There were effective systems in place to reduce the risk and spread of infection.

Is the service effective?

Requires Improvement

The service was not always effective in meeting people's needs.

Staff did not complete a comprehensive induction when they started work. Staff did not attend regular supervision meetings this meant the provider could not be sure they understood how to deliver care safely and to an appropriate standard.

Staff told us they had completed Mental Capacity Act 2005 training and ensured the rights of people who lacked the mental capacity to make decisions were respected. However, further work was needed by the management team to meet the requirements of the deprivation of liberty safeguards.

People's nutritional needs were being met. People were supported to eat and or drink enough to maintain their health. People had regular access to healthcare professionals, such as GPs and district nurses.

Is the service caring?

Inadequate

The service was not caring.

People told us they were happy with the care but did not always receive the support their needed. We found members of staff were not following people's care plans and therefore, people's care and support was not always delivered in a way that met their needs We also noted at times there was very little interaction and communication between people living in the home and members of staff.

Summary of findings

Wherever possible, people were involved in making decisions about their care and staff took account of their individual needs and preferences. However, life histories were not recorded in people's care plans.

We saw people's privacy and dignity was respected by staff and staff were able to give examples of how they achieved this.

Is the service responsive?

Requires Improvement 

The service was not always responsive to people needs.

People's health, care and support needs were assessed and individual choices and preferences were discussed with people who used the service and/or a relative. We saw people's care plans had been updated regularly and when there were any changes in their care and support needs.

There was a programme of activity for people who used the service to take part in however; these were not always stimulating and meaningful.

Complaints were not always documented or responded to appropriately.

Is the service well-led?

Inadequate 

The service was not well led.

The home did not have appropriate management arrangement in place to maintain peoples care, support and welfare needs.

There were some effective systems for monitoring quality of the service in place. However, some audits had not been carried out since July 2014. We were not able to see the management's action plan for the future of the home or whether accidents and incidents were monitored.

Castleton care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

The inspection team consisted of two inspectors, a pharmacy inspector and a specialist advisor in people living with Dementia.

Before our inspection, we reviewed all the information we held about the home. The provider had not completed a Provider Information Return (PIR) form due to the registered manager being absent.

We were aware of concerns in respect of people's care and welfare by the local authority and safeguarding teams.

Healthwatch feedback stated they had no comments or concerns regarding Castleton Care Home. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

This inspection took place on 14 October 2014 and was unannounced.

At the time of our inspection there were 45 people living with dementia in the home. During our visit we spoke with eight people living at the home, four relatives, eight members of staff, one unit manager, one support manager and the regional manager. We spent some time observing care in the lounge and dining room areas to help us understand the experience of people living in the home. We looked at all areas of the home including people's bedrooms, communal bathrooms and lounge areas. We spent some time looking at documents and records that related to people's care and the management of the home. We looked at seven people's care plans.

Inadequate

Is the service safe?

Our findings

Medicines in current use were kept securely in locked cupboards and trolleys. We could not be sure that medicines were stored at the correct temperature as members of staff were not recording the fridge and room temperatures correctly. We saw the temperature range recorded for the fridge was outside the recognised 'safe range' of 2-8C. Medication stored at the incorrect temperature may result in medication being ineffective.

It was not possible to account for all medicines, as staff members had not always accurately recorded the quantity received into the home, or how much had been brought forward from the previous month. Therefore, it is impossible to tell whether or not they had been given correctly. For example, the current medication administration record (MAR) for one person had no information about two different prescribed medicines that were present on the last month's MAR. As a result, the person was not being given all their prescribed medicines. The health of people living in the home was placed at unnecessary risk of harm when medicines records are inaccurate.

The systems in place for ordering and dealing with prescriptions were not satisfactory. Some people living in the home had not been given their medicines and creams because stock had run out or new items not obtained quickly. One person was prescribed two different painkillers to ease on-going severe pain. We saw there was no stock of one of these for eight days, and both of them for two days because stock had not been obtained. Furthermore, when new supplies were received, there was a delay of 24 hours before the person was given their medicine. Another person had been seen by an emergency doctor, but the prescription they had written had not been dealt with for over 24 hours. Neither senior management nor the nurses on duty could explain why these incidents had happened. The health and welfare of people living in the home is at serious risk of harm when adequate supplies of medicines are not maintained.

We looked at the records for two people who were given their medication covertly (hidden in food) without their knowledge or consent. There was no evidence that a mental capacity assessment had been carried out to determine whether the person had the mental capacity to understand the implications of refusing their medication.

The Mental Capacity Act 2005 and current best practice recommendations issued by National Institute for Health & Care Excellence (NICE) require that a best interests meeting is held with the person's representative and relevant professionals to determine whether it is in the person's best interests for the medication to be administered covertly and which medicines this should apply to.

Mixing medicines in food and drink may alter the way in which the medicines work and may lead to them becoming ineffective or dangerous to use. This should be discussed with a pharmacist as part of the decision making process, but there was no evidence that this had been done. There was no information in place to tell staff exactly how and in what circumstances each person should have their medicines offered covertly. It was not always possible to see from records which medicines had been given covertly and which had been given with the person's knowledge and consent. Records also showed that despite arrangements for administering medication covertly, people were still not being supported to take their medicines safely. We asked the home to refer one person to the adult safeguarding team as the way their medicines were being given was dangerous.

Many people living in the home were prescribed medicines to be taken only 'when required' e.g. painkillers and medicines for anxiety. We found little information was in place to guide staff on how to give these medicines correctly and consistently with regard to the individual needs and preferences of each person.

Medicines were not always given at the correct times due to staffing levels. On one unit, the morning medicines round had still not been completed by 11:45 a.m. This meant some people who should have been given their medicines before breakfast only got them just before lunchtime. The time of administration was not accurately recorded, making it was impossible to determine when the next dose could safely be given. This was particularly important for paracetamol containing products which must have a minimum of four hours between doses in order to avoid toxicity. Some medicines need to be taken before or after food to make them work correctly or avoid unwanted side effects. There were no arrangements in place to ensure these medicines were given correctly. The health and welfare of people living in the home was placed at significant risk of harm when medicines were not administered as prescribed.

Inadequate

Is the service safe?

Checks to determine how well medicines were handled were available, but had not been completed recently. This meant the concerns and discrepancies we found had not been highlighted by the service. It is essential to have a robust system of checks in place in order to identify concerns and make the improvements necessary to ensure medicines are handled safely within the home.

We found people living in the home were not safe because they were not protected against the risks associated with use and management of medicines. We found systems in place for ordering, administering, recording and disposing of medicines were poor and medicines checks were not effective. This meant concerns and discrepancies had not been identified or addressed. This is a breach of Regulation 13 (Management of medicine); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Through our observations and discussions with people living in the home, relatives, staff members and other visitors, we found there were not always enough regular or permanent staff to meet the needs of the people living in the home. One person said, “When I need them they normally come straight away.” However, some people thought the home could do with more staff that were permanent. They gave us an example of staff not knowing what their needs were because they were agency workers. For example, a sweet drink was brought for one person that was diabetic. We were told the member of staff apologised and said, “I’m new here.”

One relative we spoke with told us, “The staffing levels are bad especially over the weekend.”

One member of staff we spoke with told us, “Staffing levels are bad, agency nurses don’t know anything.” Another member of staff we spoke with was very helpful, their manner was polite and they appeared to know people well. However, they told us the home used a lot of agency care workers. One staff member said, “There are too many agency staff and therefore they do not get to know the residents well enough.”

Another staff member we spoke with told us normally there were two nurses on duty but there had been four occasions in the last five weeks when only one nurse was on duty due to insufficient cover being available. This showed there was inconsistency in the nurse staffing levels within the home. This meant people could not be assured of a consistent level of care at all times.

The support manager showed us the staff duty rotas and explained how staff were allocated on each shift which included weekends. They said where there was a shortfall, for example when staff were off sick or on leave, agency or bank staff were used to cover. They said they used a lot of different agency staff and the duty rotas confirmed this.

We spoke with the regional manager regarding the staffing levels. They told us, “I have grave concerns about the staffing levels.” They agreed that more permanent members of staff were needed and they were going to start looking at recruiting more staff. This is a breach of Regulation 22 (Staffing); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. There were not always enough qualified, skilled and experienced staff to meet people’s needs.

People living in the home we spoke with said they felt safe in the home and felt comfortable in the company of staff who assisted them. For example, one person told us, “I feel safe here, the staff are good people.” One relative we spoke with told us, “My mum is generally safe when I go home.”

We spoke with members of staff about their understanding of protecting vulnerable adults. They had a good understanding of safeguarding adults, could identify types of abuse and knew what to do if they witnessed any incidents. Staff we spoke with told us they would immediately raise any concerns with their manager and they were confident they would take action to address concerns raised. Staff also told us they had received training on how to recognise harm or abuse and felt they would be supported by the management team in raising any safeguarding concerns. However, two members of staff did not know about the Local Authority safeguarding team or their function. The staff training records we saw confirmed staff had received safeguarding training.

The home had policies and procedures for safeguarding vulnerable adults and we saw the safeguarding policies were available and accessible to members of staff. The staff we spoke with told us they were aware of the contact numbers for the local safeguarding authority to make referrals or to obtain advice. This helped ensure staff had the necessary knowledge and information to make sure people were protected from abuse.

We saw written evidence the registered manager had notified the local authority and Care Quality Commission of safeguarding incidents. The registered manager had taken

Inadequate

Is the service safe?

immediate action when incidents occurred in order to protect people and minimise the risk of further incidents. However, over the past four weeks incidents had not been reported appropriately due to the registered manager being absent. For example, during our inspection we alerted the regional nurse, the regional nurse was a member of staff who worked for the provider at different locations, regarding a medication safeguarding concern and they told us they would report it to the local authority safeguarding team. However, this was not forthcoming following the inspection. We contacted the regional nurse who told us one of the support managers was due to send it and would address this immediately.

Staff were aware of the whistle blowing procedures should they wish to raise any concerns about the manager or provider.

We found robust recruitment and selection procedures were in place and appropriate checks had been undertaken before staff began work. This included obtaining references from previous employers to show staff employed were safe to work with vulnerable people. The regional manager told us there were no members of staff subject to disciplinary action.

There were several environmental risk assessments carried out, for example, slips, trips and falls, burns, heatwaves and bathing. We saw the last review had taken place in 2014.

We looked at seven people's care plans and found appropriate risk management processes were in place. We saw risk assessments were in place, for moving and handling, nutrition and pressure area care. Where risks were identified, care plans were put in place which provided information to staff on how to keep people safe. This helped ensure people were supported to take responsible risks as part of their daily lifestyle with the minimum necessary restrictions. In the care plans looked at there were risk assessments in place where areas of potential risk to people's general health, safety and welfare had been identified.

We found people were cared for in a clean, pleasant and hygienic environment. There were systems in place to manage infection control and prevention, these were effective. We saw personal protective equipment, liquid hand rub and liquid soap was available to people. One of the bedrooms we inspected had an odour. We discussed this with the regional manager at the time of the inspection and were informed a number of carpets were to be replaced.

Clinical waste was bagged correctly. We witnessed a staff member putting an incontinence pad into this bag and she was wearing aprons and gloves.

Staff demonstrated good knowledge and awareness of their responsibilities for infection prevention and control and there was evidence staff had received relevant training. Members of staff we spoke with said they had completed infection control training. There were up to date infection control policies and procedures in place.

Requires Improvement

Is the service effective?

Our findings

We looked at three members of staff training records which showed staff had completed a range of training sessions. This included moving and handling, dementia and person centred care, dignity, safeguarding, Mental Capacity Act 2005. There was no training record available at the time of our inspection however; we did see future training courses had been arranged. For example, safe administration of medication was booked for 16 October 2014.

We saw from the staff files that new members of staff attended an induction training course. This included information about the company, health and safety, principles of care and human resources. However, we noted in one person's file, induction days one and two had been signed to say this had been completed on the same day. Another person's file showed they had completed induction day one and practical application on the same day. Practical application included toileting, changing people position, bed rails, social wellbeing and people's dining experience. Day two had not been completed at all.

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. One member of staff told us they had not received supervision since starting work earlier in the year. Staff told us they did have opportunities to talk to the management team if they wanted to discuss anything but this was on an informal basis. We saw from the staff records we looked at that one member of staff had received supervision in June 2012 and another member of staff had had supervision in June 2014

The provider had supervision guidance that stated, 'shall take place every eight weeks or six times per year.' There was no evidence staff appraisals had taken place during 2014.

Staff did not complete a comprehensive induction when they started work or have the opportunity to attend regular supervision meetings so the provider could not be sure they understood how to deliver care safely and to an appropriate standard. This is a breach of Regulation 23 (Supporting workers); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us they had freedom to leave the home, for example to go for a walk or out for a cigarette. We found staff understood how to help people with limited mental capacity to make decisions. For example, members of staff showed people the choices at mealtimes. We saw on occasions that people were asked for their consent before any care interventions. For example, we saw people were asked for their consent when putting aprons on people during meal times or when being assisted by staff with moving and handling.

The staff we spoke with confirmed they had attended training on the Mental Capacity Act 2005 and understood the principles of acting in people's best interests. They told us when people were not able to give verbal consent they would speak with the person's relatives or friends to get information about their preferences or observe the person body language whilst providing care. They said if people showed any signs of distress they would stop and try again later. However, on further exploration, two members of staff were unsure of what the Mental Capacity Act 2005 was and one staff member told us, "I've not heard of DoLs." Two members of staff told us they had received one days training in dementia awareness, but both staff members said they would like more in-depth training.

The care plans we looked at showed the manager had assessed people in relation to their mental capacity, whether people were able to make their own choices and decisions about their care.

However, deprivation of liberty safeguards had not been taken account where appropriate for people living at the home.

We recommend the provider considers the guidance provided by the supreme court judgement and the scope of restrictions in relation to the deprivation of liberty safeguards and people living in a care environment.

People spoke very positively about the food which they said was varied and plentiful. One person said, "The food is really good, it's cooked well and we have a choice." We found people were assessed to determine whether they were at risk of malnutrition and where risks were identified care plans were put in place to assist staff in meeting their needs. For example, in one person's care plan, we found a healthy living plan had been put in place and agreed with the person to help them maintain a healthy weight. People's weights were monitored monthly and we saw evidence of involvement of dieticians where weight loss was identified.

Requires Improvement

Is the service effective?

The catering staff said they were provided with a budget which allowed lots of fresh food, flexibility and choices. For example, three choices of meal were available at lunchtime. Information was present in the kitchen to ensure staff met people's individual needs, such as who required a diabetic diet or their food fortifying.

We observed the breakfast and lunchtime meal and saw staff provided people with appropriate assistance and no one was rushed to eat their meal. The atmosphere at both meals was pleasant, with staff engaging those they were assisting in conversation. People could also choose to eat in their bedroom. Meals came straight from the kitchen on trolley and people said the food was hot. We found drinks were available for people throughout the day and we observed staff encouraging people to drink to reduce the risk of dehydration.

People spoken with said they received appropriate healthcare support. One person told us, "The GP visits whenever they are needed." Care plans showed people were routinely referred to community health professionals such as dieticians, chiropodists and GPs. We noted one person had been assessed by a tissue viability nurse who had written a report with regard to the nursing instructions for a severe leg ulcer. People were weighed regularly and prescribed with added supplements if any had lost weight. The outcome of these visits was documented to assist care staff in meeting people's needs. Any injuries were recorded and photographed and kept in the care plans and medical assistance was sought in these incidences. For example paramedics, district nurses or GP.

Inadequate

Is the service caring?

Our findings

People living in the home we spoke with during our visit felt the care and support provided was good. People commented they felt supported and staff were approachable. We saw staff spoke with people as they moved around the home and when approaching people, staff would say 'hello' and inform people of their intentions. One person told us, "Staff are friendly and I get the care I want." Another person said, "I really like living here." However, they raised concerns that agency staff did not always have the skills and knowledge to know their needs and preferences. Some people told us this caused them frustration and were able to give us examples of how this had impacted on care. For example, one person told us they had been given inappropriate personal care because staff had not known the correct procedure to follow.

We spoke with four members of staff about people's preferences and needs. Staff were able to tell us about the people they cared for, any recent incidents involving them and what they liked and disliked. However, some staff members reported some agency staff did not always know the people they were caring for and they did not all have the required skills and experience. For example, one staff member spoken with was very concerned about the impact this had on people in the home. They said they had to start from scratch explaining people's needs and preferences every time there was a staff change.

One member of agency staff we spoke with, had difficulty in communicating with us as English was not their first language. They were unable to provide answers to some questions regarding the care requirements of people living in the home and they directed us to another member of staff.

We observed one person in the music room from 10:30am until 14:30pm; they were very sleepy and did not engage with the loud music, however, staff spoke with them in passing during this time. We were told by a member of staff this person was unable use the call bell and required 30 minute observation. However, we did not see this happen.

One care plan we looked at stated they needed to be repositioned hourly on their left side and back only as they had sustained a right sided ulcer so deep the tendons were visible. This followed an assessment by the tissue viability nurse. However, when we checked the records that were kept in the person's bedroom we found they were being positioned on their right side. In the past 48 hours this had happened 10 times. Following our inspection we spoke with the temporary manager and asked if this incident had been reported to safeguarding. They told us it had not but would report it straight away. We also spoke with the tissue viability nurse who attended Castleton Care Home on a regular basis. They told, "Pressure care management is ok but it depends on the staff on duty", "Staff follow instructions but this is not always timely. I asked for a repose mattress for one person last week and this still has not been put in place" and "Communication can be appalling. There is so much change and no consistency."

When we spoke with the member of staff they said, "I didn't know nothing about it. It is not my fault if no one tells me." When we explained it was in the person's care plan, they said, "I haven't got time to read all the care plans." One member of staff told us, "I passed this information over to the night staff on the same day she was told." We were told daily handover took place so that staff could update the next staff member on shift about people's needs and if any changes in their care had been identified. However, there was no written staff handover sheets at the beginning of each shift to enable information relating to people's care and support needs to be communicated to all staff. Staff we spoke with told us the handover at the home was a poor source of information. One relative we spoke with told us, "Communication is an issue during handover and between staff."

Members of staff were not following the care plan instructions therefore, they were not providing the appropriate care and treatment. This is a breach of Regulation 9 (Care and welfare of people who use the service); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Relatives we spoke with told us the care was ok but had concerns regarding the management of the home. One person told us, "Care is ok." Another person told us, "Care is good and I am pleased with [Name of person] care and the meals are good." One person told us, "No-one takes responsibly for decision making."

Five people we spoke with said their privacy and dignity was respected. People said when staff were providing personal care, doors were closed and curtains drawn. We observed this was routine during our observations on the day of the inspection. We saw people were asked whether

Inadequate

Is the service caring?

they wanted to wear an apron and their choices were respected. Staff were calm and patient with people and explained things well and were able to explain and give examples of how they would maintain people's dignity, privacy and independence.

Requires Improvement

Is the service responsive?

Our findings

People had their needs assessed before they moved into the home. This ensured the staff were able to meet the needs of people they were planning to admit to the home. The information was then used to complete a more detailed care plan which provided staff with the information to deliver appropriate care. We found care plans were written in a clear way and they were about the person as an individual. People and their families were involved in discussions about their care and the associated risk factors. Individual choices and decisions were documented in the care plans and people's needs were regularly assessed and reviews of their care and support were held annually or more frequently if necessary.

We reviewed the care plans of seven people living in the home. People's care plans contained several sections which we found easy to navigate around. We saw the local authority assessment for each person and found these had been accurately translated into the person's care plan by the provider.

Each care plan had sections which covered for example, skin assessments including body maps, pressure care risk assessments, mobility and dexterity and diet and weight. However, there was no information on the person's life history, likes or dislikes. We found each care plan had been regularly reviewed and where necessary changes had been made to reflect people's current needs.

People we spoke with reported the staff were responsive in providing care to meet their changing needs. For example, one person said when they had fallen in their bedroom the home ensured the GP was called they had a full check over and for a few weeks were able to use a wheelchair. However, we saw one person asked to go back to their room but they were ignored on a number of occasions by staff, we observed the person became agitated by the loud music and singing and we asked a member of staff to intervene and help the person back to their room.

Relatives told us they were involved in people's care plans. One person said, "Yes I signed the care plan." They told us they had also discussed their relative's end of life care.

We noted that call bells were not always answered promptly and on at least three occasions during the morning the call bells went to a second tone alerting staff to the fact they had not been answered immediately. We asked the support manager if they had a system for monitoring times for the call bells to be answered. They said the system that was in use did not provide monitoring information.

We saw activities included bingo, music, church service and a Halloween raffle. On the day of the inspection, there was one activity taking place in the music room which involved singing to very loud music. Only two of the four people in the room engaged with the singing. Following the end of the music activity three people were left in the music room. In the downstairs lounge there was music being played, however, there were no interactions in relation to the music.

On the day of our inspection we observed people living in the home sat either in the dining room, the lounge or in their rooms. We did not observe much interaction between staff and people other than meal time. One person we spoke with said, "We don't do nothing here, we just sit around." One relative we spoke with told us, "Not much to do, more stimulation is needed."

Although staff were friendly and polite more in-depth knowledge of dementia was required to support people through improved communication and with more stimulation through meaningful activity.

The support manager told us people were given support to make a comment or complaint where they needed assistance. Staff we spoke with knew how to respond to complaints and understood the complaints procedure. There was a clear procedure for staff to follow should a concern be raised. We saw the complaints procedures were in people's bedrooms.

All of the people we spoke with said they felt comfortable in raising any concerns with the registered manager when she was around. One person said, "I tell them if they are doing things wrong and they change it."

We spoke with three relative who told us they had spoken with the support manager on different occasions regarding their concerns but they had not had any response and were not confident anything would be done. One person said the support manager had told them, "I'll make a note and see what I can do." Another person said, "If you have niggles there is no central place to take them."

Requires Improvement

Is the service responsive?

The support manager told us there were no on-going complaints. From the records we looked at we were not able to see if complaints had been documented or responded to.

People told us the home enabled them to maintain relationships with family and friends without restrictions. Relatives spoken with confirmed they were kept up to date on their family member's progress by telephone and they were welcomed in the home when they visited.

Inadequate

Is the service well-led?

Our findings

At the time of our inspection the home had a registered manager who had been registered with the Care Quality Commission since 30 June 2014. However, the registered manager had been absent for the past four weeks and was not due to return to work for another six to 10 weeks. The provider had not informed the Care Quality Commission of the manager's absence and we were not aware of the management arrangement for the home. One the day of our inspection we were told the home was being managed by two support managers that were registered to manage homes in Halifax and Huddersfield. It was not clear on the day of our visit how often the support managers attended the home. There was also a regional manager who told us, "The situation here is quite a challenge."

On the day of our inspection we were not able to establish who was managing or taking responsibility for the home. We spoke with one member of staff who told us they must be in charge because they were the most senior person on shift but no-one had formally explained this. They told us, "It is very awful, nothing is well organised and nobody is here to direct anyone."

Three of the relatives we spoke with told us the registered manager was starting to make progress in the home for the better but things had come to a halt. One person said, "The manager has turned the place around for the better" and "They know she is going to be away sick for a long time why are they not contacting relatives to let them know the new contact details."

Staff spoke positively about the registered manager and the changes they had implemented since they took up their post. However, we were told things had changed. One member of staff told us, "You don't know who is in charge no one helps you when you need it." Another staff member said, "At one time we were positive about the way the home was heading not anymore." Another person told us, "The manager was making an impact but it is not good without her but I do not currently feel supported or valued."

At the end of our visit the regional manager informed us the regional nurse was going to be the temporary manager and they were going to inform people who lived in the home, relatives and staff immediately.

We saw from the records we looked at monthly audits were carried out which included resident admissions, pressure care, Mental Capacity Assessments and dining experience. However, these audits had not been completed since August 2014.

We were told by a member of staff that morning and afternoon 'manager walk rounds' were carried out but these had recently stopped. We saw records dated 10 September 2014 which confirmed this and these included infection control, uniform and badges. However, we were not able to locate any records after the date in September 2014.

We were not able to locate any resident, relative, staff or health professional surveys on the day of our visit.

This is a breach of Regulation 10 (Assessing and monitoring the quality of service provision); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 due to the lack of management arrangements of the home and therefore potentially putting people at risk of unsafe care and support.

We saw the staff meeting notes for August 2014 which included feedback, medication audit and care documentation. The support manager was not able to tell us how often staff meeting would be held. On the day of our inspection we saw resident meeting minutes for August 2014 which included menus, bedrooms, decorating and changes to the home. There was a sign in the entrance of the home advertising the next residents meeting for the 16 October 2014.

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 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **The registered person did not make appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified and skilled and experience staff to meet people's health and welfare needs.**

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 **The registered person did not take proper steps to ensure that each person was protected against the risks of receiving care or treatment that was inappropriate of unsafe.**

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 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **There were not always effective systems in place to manage, monitor and improve the quality of the service provided. People were put at risk from unsafe care and support due to the lack of management arrangements in the home.**

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 **The registered person did not ensure staff received appropriate training, professional development, supervision or appraisal.**

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 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **People were not always protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines.**

The enforcement action we took:
We have served a warning notice and the provider was told they must become compliant with the Regulation by 30 January 2015.