HC-One Limited

Carr Gate

Inspection report

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Ratings

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

Overall summary

The inspection of Carr Gate Nursing Home took place on 23 and 27 July 2015 and was unannounced. There was a manager who was new in post and had applied for registration, but this was not yet complete.

The service was last inspected in January 2014 and found to be compliant with regulations.

Carr Gate Nursing Home is in a quiet residential area on the outskirts of Wakefield. The home provides accommodation and nursing for up to 65 people, some of whom are living with dementia. The home is on two floors and there are three units; Cherry (nursing care), Cliff (residential care) and Holly (dementia care).

Staff had a good knowledge of how to ensure people were safeguarded from abuse and understood safeguarding and whistleblowing procedures.

Staff recruitment systems were thorough and all vetting was in place to ensure staff were suitable to work in the home.

Staff understood their roles and responsibilities although reported they did not feel supported or valued.

There were insufficient numbers of care and ancillary staff to meet the needs of people and ensure the safe running of the home.

Summary of findings

Many staff had undertaken regular mandatory training, but lacked knowledge of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS).

Medications were not effectively managed to ensure people received their medicine on time.

People did not enjoy their meals and the quality and presentation of the food was poor.

Staff were caring in their approach and they were well meaning in their intentions. However, people's dignity was not always respected.

There were few activities for people to be engaged with in a meaningful way.

Audits and quality assurance systems within the home lacked rigour to ensure the quality of the provision and the safe care of the people living in the home.

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

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

There were not enough staff deployed to keep people safe and people were not assisted in accordance with their needs or in a timely manner.

There were aspects of the home that were not sufficiently clean and there were not enough cleaning staff deployed to ensure the risk of infection was minimised.

Systems for managing medications did not always ensure people received their medications when they needed them.

Inadequate

Is the service effective?
The service was not effective.

People were not always asked their consent prior to any care intervention and staff lacked knowledge and understanding of the requirements of the mental Capacity Act 2005 Deprivation of Liberty Safeguards.

The quality of food and drink was very poor; people did not enjoy their meals and the presentation of meals was not always acceptable.

Inadequate

Is the service caring?
The service was not always caring.

Staff were caring and kind in their interaction with people. Staff were patient when supporting people and assisted them at a pace that met their individual needs.

Staff were not always respectful of people's dignity.

Requires improvement

Is the service responsive?
The service was not always responsive.

We saw that people were not engaged in positive activity for much of the day. Care and support was not in keeping with people's preferences and needs.

Complaints were recorded and responded to appropriately. People said they did not have cause to complain but would be confident to speak with staff if they needed to.

Requires improvement

Is the service well-led?
The service was not well led.

The manager was new in post and had not had chance to sufficiently impact upon the quality of the service at the time of our inspection.

Staff did not feel sufficiently supported or valued in their roles.

Inadequate

Summary of findings

Although some quality assurance systems were in place, these were not sufficient or rigorous enough within the home to ensure all aspects of people's care was being well met.

Carr Gate

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 two days on 23 and 27 July 2015 and was unannounced.

The inspection team consisted of four adult social care inspectors, and one Expert by Experience whose experience was in older people's services. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

There were 49 people living in the home at the time of our inspection. We spoke with 18 people who lived at the home and four relatives. We spoke with 10 staff, the manager and the assistant operations director.

We looked at eight care records. We also saw other documentation showing how the home assessed the quality of care including accidents and incidents, maintenance logs and audits done within the home and by the organisation.

Inadequate

Is the service safe?

Our findings

People and their relatives we spoke with on all three units told us they felt safe at Carr Gate Nursing Home. One relative on the Holly unit told us "I am really happy [my relative] is here it is safe and calm [they are] a different person since [they] came here".

The staff we spoke with were able to identify different types of abuse and were aware of the safeguarding policy and the whistleblowing policy. Staff said they were confident to report any concerns about poor practice and if they felt a person was at risk of harm they would pass this information to managers and other relevant authorities if they felt this was necessary.

There was useful signage for people to navigate round the home, such as pictorial notices showing where the lounge, dining area and toilets were. Large calendars stating the day and date were available at people's eye level.

Accidents and incidents were recorded and we saw there were a number of unwitnessed falls. Staff we spoke with told us people were having falls when the units were understaffed. We saw on two accident records poor staffing levels were noted as a contributing factor.

We found staff knew the individual risks to people they cared for. For example, staff told us who was at high risk of falls and who was at risk of malnutrition and dehydration. Whilst the manager was walking around the home, we observed that they came across a person, who would normally use a stick when walking, moving around without their stick. The manager guided the person to a chair before offering to bringing their stick to them.

Although staff knew the individual risks to people, these were not always documented thoroughly in their individual risk assessments. For example, for one person who we saw had a mashed diet and thickened fluids the risk assessment for choking did not reflect this.

People's personal emergency evacuation plans (PEEPs) were not always dated or reflective of current needs.

We saw moving and handling techniques were not always carried out properly to ensure people were safely supported. For example, we saw a person with an injury to their leg and the person told us the hoist had caused this.

People were not always comfortably positioned. For example, one person's legs were not supported and they were dangling above the floor. We asked staff to locate a footrest for this person.

People's safety was not always considered in the daily routine. For example, on the Holly unit some people were given hot drinks with nowhere to place the cup down. We saw a visiting relative offered to move some tables so people could use one to put their cups on.

In the garden area we noticed an unstable table which may have caused an injury to someone. In one bathroom we saw a shower chair which was cracked in the middle and had sharp edges protruding which would cause an injury to anyone using this. We asked staff to remove this and they did so.

We looked at the first aid kits on each unit and found these to be inadequately stocked. The few items that we found in the boxes were out of date and unwrapped. One kit contained only four small plasters, some empty dressing packets and a triangle bandage. This meant people would not have access to appropriate first aid treatment if they needed it. Staff we spoke with said they would use their common sense if people needed first aid and seek emergency help where necessary. We asked the manager to address this matter immediately. However, when we returned four days later the manager told us there had been an order placed, but the first aid kits were not yet stocked.

This meant the provider was in breach of in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 12(2)(c)(b) as they were not doing all that was reasonably practicable to mitigate risks to the health and safety of service users.

We looked at records which showed staff had been recruited safely and all checks had been made to make sure staff were suitable prior to starting work in the home. We were told the home was actively recruiting for staff.

Staff told us that there were not enough of them to make sure people's needs were met in a timely fashion. On several occasions we had to try to find staff because people who lived at the home had told us they needed assistance to go to the toilet. On one occasion we told staff that a person was calling out for the toilet but staff said they were "doing the feeds." We noted the person waited a further fifteen minutes until staff were available to support them.

Inadequate

Is the service safe?

On another occasion we saw a person's visitors looking for staff. We asked why this was and they told us their relative was desperate for the toilet. The visitor said "It's always like this."

Another person visiting their relative told us that people in the lounge did not have access to call bells. They said there was one on the wall but as people were not able to mobilise, they were unable to access this. The person said they had raised this with staff but they had been told there were always staff available in the lounge. They told us there were very rarely staff in the lounge and we saw this to be the case during our inspection.

Another relative told us there were "not enough staff – never is. If two are doing something there's no-one left".

On the Cliff unit we noted there were only two staff available to support people who appeared to require differing levels of care. For example some people required a lot of support when getting from a chair to a wheelchair. If both members of staff were engaged in this task there was no one around to answer call bells or respond to other people's needs. Staff we spoke with on this unit told us this was a concern and at times people had to wait to be supported.

Some people told us that call bells were answered in a timely manner. One person told us "I need help to get to the toilet, I just press my buzzer and they come. I don't usually have to wait long". This person explained that they always sat in the same chair and would press the call bell on behalf of other people to alert staff that they needed help in the lounge. They told us: "I feel safe but other residents get a bit confused at times so I would press my buzzer if I needed to".

We found there were not enough staff to make sure people's needs were met and we saw this had a significant impact on people's care and welfare. For example, on one unit we saw people had fallen and records highlighted this was because there were too few staff on duty to adequately support those at high risk of falling. We raised concerns about staffing levels with the assistant operations manager and the manager on day one of our visit, yet on day two we were told by staff about two incidents that had occurred since our first visit in which people suffered injuries as a result of falls on a unit that was understaffed. Staff told us they were asked to carry out washing up duties for their own unit which left their unit short staffed because it took them away from caring duties.

We saw staff were rushed and did not have sufficient time to give people the attention they required to support their needs. For example, on day two of our visit in the Holly unit we saw one member of staff was working alone in the lounge area and there were 11 people in the lounge. It was apparent many of these people needed attention and two were expressing distress. The member of staff told us there were three people on duty in that unit, but one was in the office and the other was on a break. The member of staff was unable to give any quality attention to meet people's needs until another member of staff returned.

We saw and discussed with staff that many people had high dependency needs requiring two staff to assist them with their personal care. Staff told us and the staffing rotas verified, that sometimes there were only two staff on duty on a unit, which meant if both staff were attending to one person, there were no other staff available should people need support. Staff gave us examples of where people had to wait up to thirty minutes for support with their care. Staff expressed concern that there were too few of them to meet people's needs safely. Staff told us in the event of a fire they did not feel there were enough staff on duty to assist people safely, particularly at night.

Furthermore, on both days of our inspection staff were diverted from their care responsibilities in order to wash up after the teatime meal. We were told, and staffing rotas verified, that this was because there was no kitchen assistant available. This meant whilst staff were washing up, the units were not staffed to safe levels.

People we spoke with on the Cherry unit also felt there were not enough staff. All but one person said that buzzers were not always answered directly. Staff we spoke with gave us examples of how people's care needs were not met. Two members of staff told us people's continence needs were not adequately met and some people in the lounge areas 'sat in the same pads all day' without being assisted to the toilet. Staff said: "We can only manage to change people if they are soiled, but otherwise, we just can't do it, there are not enough staff" and "It's just not right that these people have to wait".

Inadequate

Is the service safe?

We noticed one person had a strong odour of urine and we pointed this out to a member of staff. We also saw one bath seat on the Cliff unit was marked 'Do not use *unsafe*' and when we asked about this we were told it was awaiting replacement parts. Staff and the manager were not able to tell us when this would be repaired. Staff told us people could use other bath facilities in the home but they usually used the shower. Staff reported to us it would not be easy for them to support people to use the bath on another unit due to poor staffing levels. Staff we spoke with told us they tried to assist people with baths but this was not always possible if they did not have enough staff available.

One person said "sometimes it can take a long time for a member of staff to come. Particularly at night, meal times or bed time, 5.30 to 6 pm is the worst time to wait. I have had two accidents because I have had to wait. Makes me feel like an unwanted child". Another person told that they "wait ages for someone to come and sometimes I end up having an accident".

One relative told us they felt the staff were always rushing about. They said "if I had one complaint it would be there isn't enough staff".

We looked at the staffing rota and saw the staffing levels for each unit were not matched against the dependency needs of the people. We asked the assistant director of operations if there was a summary of people's dependencies to show how the staffing was worked out. They said there was no summary, but that people's dependency was recorded in their individual care records.

Staff told us and we saw from the rota that on night duty staffing levels were significantly reduced. We discussed this with the new manager and staff on each unit, who all confirmed these levels of staffing were not safe for people's dependency needs. Staff told us if there was an emergency they called for assistance from another unit and staff came promptly, but this meant the other unit was left understaffed.

There was no clear system in place for on-call staff during the night shift. The new manager was not clear what arrangements were in place. Although we were told the new manager or the deputy were designated on-call staff at weekends and night times, staff told us this system had not worked effectively over the previous weekend when staff requested on-call help and there was a considerable delay in receiving this.

All of the above examples illustrate the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 18(1) as sufficient numbers of staff were not deployed to meet people's needs. We referred our concerns to the local authority safeguarding teams as we saw the lack of staffing impacted upon people's care and safety.

We looked at the systems in place for the receipt, storage and administration of medicines in the home in all three units of the home.

We saw that medicines in use and those in stock were stored safely and that temperatures of storage were recorded daily. However on one unit we saw a large box containing boxes and bottles of medicines on the floor in the clinical room. We asked the nurse what these were. The nurse said they were waiting to be sorted out to be returned to pharmacy but staff had not had time to do this.

We saw that, included with the Medication Administration Record (MAR) sheets, there was, for people who needed it, a protocol for medicines taken on a PRN (as required) or variable dose basis. The protocol included information about the medicine, what it was taken for and what the dosage and frequency for taking the medicine was. The protocol also included information about whether the person would be able to say if they needed the medicine or what symptoms they might exhibit which would indicate the medicine was needed even if the person was unable to say.

When checking the medicines on the Cliff unit, we saw that one person was prescribed paracetamol tablets on a PRN basis for pain. We could not find any paracetamol for this person. When we asked staff they said they thought it had probably been discontinued. We could not find any information to support this. This meant the person may not have had their own prescribed pain relief when they needed it.

On another person's MAR we saw that staff were administering two homeopathic medicines. The MAR included the handwritten instruction "Residents Choice". We asked the staff what these medicines were for but they were not able to tell us. We asked if there was anything in the person's care plan about these medicines. Staff confirmed there was not. This meant that staff were

administering medicines which they had no information about and therefore had no knowledge of any side effects or any possible risks to the person if these medicines reacted with those prescribed by the doctor.

We saw from another person's MAR that their pain relieving patch should have been changed on the morning of our inspection as the prescription was for 9am. There was no signature of administration to say this had been done. The senior care assistant responsible for medicines told us they had been trying to get another member of staff to come and check this medicine with them but all staff were too busy to do that.

We saw another person was prescribed medicine to be given on a PRN basis for panic attacks. We checked with staff who found there was none of this medicine available.

We saw that the dates on one person's MAR were incorrect. This meant that medicines administered on the day of our inspection, 26 July, were being signed as administered on 28 June.

On the nursing unit (Cherry) we found there had been errors with the ordering of medicines the weekend prior to our inspection. The nurse in charge told us they had been left a message on the Saturday to say the medicines were 'in a mess.' The nurse told us that due to this, some of the people who lived on that unit were without their prescribed medicines for the weekend. The nurse told us they had resolved this for some people on the Saturday by obtaining emergency supplies from the supplying pharmacy. However on the Sunday the nurse found that another person did not have any of their prescribed medicines available in the home. The nurse told us they had to call 111 to obtain emergency prescriptions for this person and had needed to send the cook out to a local supermarket pharmacy to obtain the medicine. The nurse said this meant the person did not have their medicines prescribed to be taken in the morning until later in the afternoon.

The nurse told us they had tried to contact the manager, who was on call, to ask for help with this matter but the manager had not answered their phone. Therefore kitchen staff had been sent out to collect the prescription.This meant that people were put at risk because systems for managing medicines were not safe.

The above examples illustrate the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 12(2)(f) because systems for managing medicines were not safe.

The home was not sufficiently clean because there were too few cleaning staff on duty and as a result, there were malodours on some units. We accompanied the manager, who was completing some quality checks on the first day of our inspection. The manager told us they completed these checks twice a day. The manager opened and closed a bathroom door, stating that it needed to be cleaned. We entered the bathroom and found there was faeces on the bath seat. The manager acknowledged this and requested that it be cleaned. We saw this was done when we checked later in the day.

We saw staff did not always follow hygienic practices with regard to people's care. For example, we saw one member of staff assisted a person to eat, but when food slipped from the person's spoon into their chair, the member of staff scooped it back up and gave it to the person to eat.

We saw on the cliff unit, the refrigerator was dirty inside and some people's bedding was not clean. On day two of our visit we were told there had been no cleaning staff on duty over the weekend. In one person's bedroom there had been an incident at the weekend and there had been faeces on the carpet and in the bathroom area. Staff told us although they had cleaned this as best as they could but they were not confident this was sufficient to prevent the spread of infection. Staff said because of shortages of staff this had been left for the cleaner on Monday. We spoke with the cleaner who told us there was 'faeces everywhere' and said they 'had only been able to give it 10 minutes (of cleaning time) when it should have had an hour'. The cleaning staff confirmed there had been no cleaning staff over the weekend and they had six hours to clean the home singlehandedly, which they said was not enough.

We noted that the lounge chairs in the Cherry unit smelled strongly of urine. After sitting in one of the chairs for a while the smell had transferred onto our clothing. We brought this to the attention of the assistant operations manager who agreed the smell was unacceptable. Staff told us that it was the job of night staff to clean the chairs. However, from reading care notes it was clear that night staff would be very busy with care duties and have little time for cleaning.

Inadequate

Is the service safe?

The above examples illustrate the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 12(2)(h) because there were no effective risk management procedures in place for preventing, detecting and controlling the spread of infections. The provider was also in breach of regulation 15(1)(a) as premises and equipment were not visibly clean and free from offensive odours. We referred our concerns to the infection control team following our visit.

Cleaning staff were aware of the need to use personal protective equipment (PPE) and knew what their different coloured cloths and cleaning solutions were for.

Staff were able to say when they should use PPE and they knew where it was stored. Staff said there were always sufficient supplies of PPE. We saw that signs were displayed, showing correct hand-washing procedures in the bathroom.

Inadequate

Is the service effective?

Our findings

On the Holly unit one relative we spoke with felt staff were well trained to support their family member. They told us "staff give me up dates regularly for example [their] medication has been reduced and [they are] much more responsive than [they were] at the last place. [My relative] has been wandering at night but is now sleeping better. I get lots of information".

Staff told us they had training in the form of e-learning. Staff said this was not always effective in helping them to understand how to meet people's care needs. We saw the training matrix highlighted staff training and indicated where staff needed to undertake updates.

Staff told us they had been given the opportunity to shadow more experienced colleagues before being expected to carry out their role. They told us their training had mostly consisted of online training.

Staff told us they received no regular supervision. One member of staff said they recalled having a supervision meeting but this was in relation to improving performance, rather than a supportive discussion. One member of staff told us that they had had formal supervision only three times in the last three years. Staff we spoke with told us they did not feel supported by managers in their role.

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

We spoke with the manager about whether people were being deprived of their liberty and whether any applications for DoLS had been made. She showed us a 'DoLS log' which was a list of 35 people's names, all of whom it was intended to submit DoLS applications to the local authority for. However, it was unclear and the manager was unable to tell us, whether these people lacked capacity and whether applications for DoLS would be appropriate.

We asked staff about their understanding of mental capacity and Deprivation of Liberty Safeguards. One member of staff said they had done some training which they said was covered in a dementia awareness course. Another member of staff said they thought they had covered this through e-learning, but said they were not sure. We found staff had limited understanding of mental capacity and how decisions might be made in someone's best interest if they lacked capacity. Staff did not understand Deprivation of Liberty Safeguards. Staff told us they would actively prevent people from leaving the home if they wished to as staff did not think it was safe for people to leave unaccompanied.

We saw there were locked doors and staff told us people did not know the security codes to unlock the doors. This meant people were being unlawfully deprived of their liberty. We also saw doors to communal areas, such as a café area on the residential unit, were locked and inaccessible to people.

We noted from one person's daily records that staff had removed the person's buzzer because they continued to press this. It was also recorded that the person was not allowed to watch television after midnight.

These restrictions meant that people's rights were not being upheld.

All of the above examples illustrate the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 13(5) as the provider was not acting in accordance with Mental Capacity Act 2005 and people were not looked after in a way that did not inappropriately restrict their freedom.

We had concerns about the about the quality of the food. We asked people about the food and got a mixed response although some people felt the food was "alright".

One person told us that the food was not always good. They said the menus displayed on the tables were rarely followed and that it was always soup and sandwiches for tea. The person said they could not tell what the soup was and when they asked staff, they didn't know.

One person told us: "We are told not asked what sandwiches there are at tea time, there is usually a choice of two fillings and you get a yogurt. I am not sure I could get something different".

Inadequate

Is the service effective?

One person told us that if they did not want either choice the staff would make a sandwich. They explained that sometimes they were not hungry at lunch time: "We have breakfast 9 / 9.30 then coffee and biscuits as I don't do much I am often still full".

No one was able to tell us they knew what was on the menu for the day. One person said "I never know what there is apart from Friday when we always have fish and chips. The cook knows I don't like pork so when that is on the menu I will get an omelette. They don't usually offer me anything else but the chef knows I don't like pork. I am diabetic so I can't eat the puddings. They usually offer me fruit salad or sometimes a yogurt. I don't remember being offered a diabetic pudding".

This person told us that they got plenty to drink pointing out the drinks dispenser which they said was always kept topped up and explained staff would pass drinks out to those who could use the unit. However, in one unit we saw there were no available cups or glasses for people to use with the dispenser. People told us lollipops and ice creams had been given out during the very hot spell recently. We saw on one unit people were offered extra drinks if they wanted these. However, staff on another unit said they often did not have chance to make people drinks outside of set times.

Staff told us about a person who ate a very restricted diet and they were trying to encourage them to eat a more varied diet. We saw staff ask this person if they would like an omelette. When the person said they would, staff immediately contacted the kitchen to ask for one to be provided.

One relative told us they had been there at meal times. They said "[my family member] seems well cared for but [they don't] eat much they [the staff] have trouble getting [my family member] interested". The relative said their family member had lost quite a lot of weight recently. We were unable to validate this information against the person's care records.

We saw that people were served with drinks at set times of the day. When one person asked for a cup of tea they were told that the trolley would be around soon. We did not see people offered snacks between meals.

We observed lunch on day one of our inspection and found this was not a pleasant experience for people. For example, people were assisted to the dining room half an hour before the meal, therefore some people were waiting quite a long time on their own before the meal was served. Tables were laid with condiments but there were no napkins or menus available. The meal came in a hot cabinet trolley and was served individually from large containers. Staff gave people the choice of meal by asking them whilst standing at the trolley, although this meant they shouted across the room at times.

We saw the food detailed on the menu for lunch on the first day of our visit was pork with cream and mustard or Lasagne. When lunch arrived it was diced chicken in a very pink sauce or shepherd's pie. The food when it was served on day one appeared hot but the shepherd's pie was very runny and the potato mixed in with the meat. There were two people requiring a soft diet and although each pureed item was separated on their plate, they were given no choice as to what to have.

There were some fried sliced potatoes which were very soft and greasy and some vegetables. We asked people if they were enjoying it and they said not. We asked for a sample of each component of the meal to taste. We found the chicken and sliced potatoes very unpleasant and the shepherd's pie and vegetables to be completely lacking in taste. When we asked, the manager and operations manager agreed to taste these and they agreed with our findings.

The dessert was treacle sponge which people said they enjoyed. However, when one person asked if they could have cream on theirs instead of custard they were told there was no cream.

We saw one person was very sleepy during the meal time and did not have much food despite the verbal encouragement from staff. One member of staff did try to help by loading the person's fork although the member of staff was standing up which had little effect on encouraging the person to eat. The member of staff did eventually get a chair and sit with this person once they had given out desserts and cleared away. However, by this time the person's meal was cold and the member of staff was not engaged in the process of supporting the person to eat their meal.

We saw aspects of daily recording had not been fully completed, such as people's food and fluid intake. For example, one person's food intake record only had two

Inadequate

Is the service effective?

entries for food and another person's fluid intake only had one entry. Where these lacked detail or where records showed people had refused food it was not clear what action had been taken to support the person's health.

Staff told us that people did not always receive food suitable for their needs. For example, they told us of an occasion when a person with swallowing difficulties had been sent ice-cream. This was not suitable as the person needed thickened food. The member of staff told us that as there was nothing else available, and they did not have access to the kitchen, they had resorted to mashing cake up with milk in order to provide the person with a dessert.

When we brought these issues to the attention of the manager and assistant operations director, they said they would take immediate action.

When we returned four days later we observed the tea-time meal being served on the Cliff unit. We saw people were being served their meal on small paper plates. Staff told us this was because they did not have time to wash up. We saw the meal, for people who required a soft diet, consisted of what staff identified to us as fish cake liquidised together with baked beans and some mashed potato. We asked staff if they would eat that. They said they would not. We asked for a sample of these and found both to be very unpleasant. Again the manager and operations manager agreed to taste these and agreed with our findings. They also agreed that it was unacceptable for the meal to be served on paper plates.

The above examples illustrate the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 14(4)(a) because people did not receive suitable nutritious food and hydration.

We saw from care records, other professionals were appropriately consulted in support of people's care. People told us they were supported to see other professionals such as the doctor or optician.

One person's relative arranged for their family member to attend a hospital appointment. They told us they would liaise with the home and were sure a member of staff would take their family member to the appointment.

Requires improvement

Is the service caring?

Our findings

One person told us that some staff were much more caring than others. They told us about how staff had assisted them with their personal care that day and that they had experienced great discomfort because of the way staff were assisting them. They said that when they tried to stop the action by taking hold of the staff member's hand, they were "told off."

Some people told us they felt staff cared for them. One relative on the Cliff unit told us: "The staff try to put like-minded people together so they can talk; I think the staff are kind".

One person on the Cherry unit told us: "The staff are really nice. I like to walk around the corridor or garden if the weather is ok and they supply a young lady to help me".

However one person on the unit explained that sometimes staff would rush and catch their legs. They said "Sometimes when they push me under the table I get stuck as they've pushed me too far. It can be sore". We noted this person had a dressing on their leg.

We spoke with one family member who commented that, "Walking into Carr Gate was just like walking into someone's home". This person commented on how welcoming the reception area was and how one particular member of staff was "brilliant".

We observed the manager and care staff demonstrated positive relationships with people and they were kind and caring in their approach. We saw staff knocked on people's doors and asked them if it was alright to enter. We also heard staff asked people before carrying out a task, for example helping them into a wheelchair.

We observed that some staff demonstrated kindness and compassion towards people. They made good eye contact and used caring forms of touch, such as holding someone's hand. Staff we spoke with told us how much they felt passionately about the people in the home and this was what motivated them to do their work.

We saw one member of staff was very kind and caring. This member of staff asked a person if they could place an apron around them prior to assisting the person to eat lunch. Additionally this member of staff talked to the person, reminded the person what they were having for lunch, before they were assisted to eat it, and engaged the person appropriately throughout. However, we observed members of staff place aprons around people who were about to eat, without speaking to the people to tell them what they were doing. One member of staff turned on the television without speaking with anyone and without asking anyone what they wanted to watch.

We saw that some staff did not always consider people's privacy and dignity needs. For example we saw staff remove a used commode from a person's room and take it down a corridor without any cover. When we asked staff how they would feel if it was them who had used the commode, one person said "I would be mortified."

The staff we spoke with said they maintained people's privacy and dignity by ensuring that doors and shower curtains are closed. We saw some staff were discreet when offering assistance with personal care and when helping people to move using the hoist we saw staff covered people's legs with a blanket to ensure their dignity. However, on one occasion we saw staff assist a person to use the hoist in the lounge. Staff did not speak to the person and did not notice that their skirt and underwear had pulled down exposing the person to all of the other people in the vicinity.

A visitor told us that staff spoke to each other when delivering care rather than speaking with the person they were supporting. We observed this to be the case on several occasions, particularly during moving and handling procedures. We heard staff refer to people as "feeds" to indicate they were people who needed assistance with their meals. We also heard staff speak with one another about people in their presence, rather than with the people.

Whilst we were sitting in the lounge speaking with people, the home's handyman came into the lounge with two workmen who looked at radiators. Although the three men walked directly in front of people, they did not acknowledge them or give any explanation or apology as to why they were in their lounge and no member of care staff offered this explanation.

We observed staff to be well meaning and caring in their approach. However when we asked them about aspects of their practice that would compromise people's dignity, they

Requires improvement

Is the service caring?

told us they had not considered the implications of their practice and had never been made aware of the impact these practices would have on people who lived at the home.

The above examples illustrate the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 10 (1)(2)(a) because people were not always treated with dignity and respect.

We observed staff spoke kindly and with patience and they did not appear to rush people, although staff had little opportunity to interact on a more social level with people. Staff we spoke with told us they knew how important it was to spend time speaking with people but they were concerned they did not always have the time to do so.

Some relatives we spoke with told us they could come and go as they wanted and felt informed of their family member's condition and well-being. Other relatives we spoke with felt they were encouraged to get involved with their family member's care. Two people told us they did their family member's laundry as they preferred this to the home doing it.

Requires improvement

Is the service responsive?

Our findings

People gave us a varied response when we asked them about activities available in the home. One person on the Cliff unit told us they sometimes got to play cards, bingo or quizzes. One person said "There are activities in the afternoon but the lady does all three floors so it depends on how busy she is as to whether we get daily activities. Most people join in, sometimes we have a singer". This person who had lived in the home for a year told us: "I have been out twice. We went to a garden centre for lunch. Unfortunately the man who drives us has been ill although he is back now".

Other people told us there was not much to do other than sit and watch television either in their room or one of the lounges. One person on the Cherry unit said "After breakfast I get wheeled in here (the dayroom) and I'm stuck. The telly is always on I would prefer quiet sometimes although I don't like being left in my room".

We found that although there was some social activity, on the whole people were not stimulated and had little to do. We observed on one occasion some staff spent time with people, fondly reminiscing, looking through books of photographs from years gone by. They received a positive response from people. On another occasion staff knew what music a person liked and put this on for them to dance. However, this quality of interaction was limited and for the majority of our inspection we found people had little to do except sit in chairs around the walls of the communal lounges.

In the Cherry unit we did not see people engaged in any meaningful activity. People were seated in front of a television which was quite high up on the wall. We did not see people asked what programme they might like to watch. We did not see staff spend any time interacting with people on a social level.

We saw one person was constantly trying to stand up from their chair. Staff continually told the person to stay seated. We observed no attempt by staff to keep the person engaged in anything.

In the Cliff unit we saw people were seated in the lounge area or in their own rooms and there was little for people to do. There were two staff who were occupied with physical care tasks and this meant they had no time available to support people with any social activities or meaningful conversation.

In the Holly unit we saw there were some activities on a table, such as draughts and a jigsaw, although we did not see anyone use these. One person was colouring.

A member of staff asked one person if they wanted to play dominoes and they produced an oversized dominoes pack. The person said "not with those ones I don't". The staff member did not suggest an alternative or try to engage the person in something else. Therefore the game did not go ahead and the staff member went across to another person in the lounge and engaged them in conversation.

A member of staff was able to explain how they had responded to a person who was becoming anxious. The staff member was able to explore the person's life history and, using items that related to the person's previous interests, was able to use approaches that calmed the person when anxieties arose.

We saw staff responded appropriately when one person living with dementia wanted a cuddly toy that they thought was lost. This person's care records showed their attachment to cuddly toys and it was evident from staff interaction they knew how important this was to the person.

In the Holly unit, there were display boxes on the wall outside people's rooms. These boxes displayed photos and personal items outside the person's room and were used to assist with people's orientation to their room. We saw in the Cliff unit there was a seated area with a chest of drawers containing items of interest for people to look through and books in a cabinet.

We saw people had very limited choice in how they received care and support and this was not managed in a person-centred way. Some people said they could choose their routine. For example, one person said "I get into bed after tea about six and watch telly. It is my choice to get into bed I could sit up". However, others felt they had little choice in this.

People on the Cherry unit told us they got ready for bed just after tea and would either go to their rooms or sit in their

night clothes back in the day room. Staff we spoke with told us people were supported to get ready for bed just after tea and this was more to ease the workload rather than promoting choices for people.

One person told us "I come back into the lounge in my [nightwear] and my [relative] sits with me until [my relative] goes at about 7.30 then I go to bed". We asked the person what time they would have gone to bed at home and were told 10 to 10.30 pm.

We noted that one person's care plan said they liked to go to bed between 11pm and midnight. However the person told us they were always taken to bed at 7pm, as were the majority of people living on that unit. Daily records confirmed this. We saw from care records that this person had had some disturbed nights when their behaviour had been confused. There was nothing to say how staff had addressed this or looked into the possible cause. When we spoke to the nurse in charge they said they were not aware this had happened.

We noticed a number of people stayed in their rooms, either in bed or in chairs. When we asked staff about this they said some people chose to do this but sometimes they did not have time to support people to get up. One member of staff we spoke with on day two of our inspection told us they still had not assisted a person to get up for the day; this was at 14.30 and even though the person wished to get up, there were not enough staff available to assist. This meant people were not receiving care according to their needs and preferences.

When mid-morning drinks were being served we asked the staff member serving the drinks what options and choices were available for people. The member of staff told us they knew what people liked and whether they took sugar. The staff member said "it's in their care plan". However, people were not asked what they would like and staff presented them with drinks they assumed they wanted.

We saw there was a pre-determined 'bath list' showing who would be offered a bath for the following week. This illustrated people were not offered baths according to their own choices.

The above examples illustrate the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 9(1) because people who used the service did not receive person centred care and treatment that met their needs and reflected their personal preferences.

We looked at eight care records and found the quality of recording was varied. Some of the care files contained a range of detailed and informative assessments. This included a pre-admission assessment and risk assessments in relation to such as malnutrition universal screening tool (MUST), dependency, falls and moving and handling. There was also a personal emergency evacuation plan (PEEP) in place. These had been reviewed on a monthly basis.

We saw some files contained a thorough social and life history and gave information of what the person's interests were. We found in the Holly unit people's care records were mostly very detailed and contained information about personal preferences and specific information about living with dementia.

Some of the care plans were written from the person's perspective but others were not. There was little indication that the person had been involved in the care planning or review process. When we spoke with two people and one relative they told us they had not had any involvement. However, one family member who we spoke with said, "[staff name] is wonderful. They did a thorough assessment and know all about my [relative's] history. Another family member we spoke with said they were involved in reviewing the care needs of their relative and that they always felt welcome in the home.

Care records we looked at for some people did not always contain sufficient detail for staff to provide person-centred care. For example, in one person's care file we saw the moving and handling assessment and the social and psychological care plan were blank. The care plan for daily activities dated six months prior to our inspection said for the person to meet with the activities organiser. There was no indication of this having happened. We saw that this person was in their room throughout our visit. However the social care plan for this person said they liked to spend time in the lounge. We were not able to find any record of the person being supported to come out of their room or any explanation why they stayed in their room.

We saw in two files it was stated the person had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order in

Requires improvement

Is the service responsive?

place, yet there was no DNACPR form in their files. This is where a clinical judgement has been made about whether to attempt CPR based on how effective this would be in relation to the person's condition.

We asked care staff on the Holly unit how often they looked at people's care plans. They said they did not. This meant staff would not have up to date knowledge of a person's needs to be able to provide appropriate care.

No one we spoke with was able to tell us if there was a procedure for complaints, although all the relatives we spoke with said they had written information at home. Everyone said they would speak to the manager if they needed to although as the manager was new they did not know her. No one we spoke with said they had any comments or complaints to make.

One family member we spoke with said, "Staff always look you in the eye. They always try to be helpful". This person said they had raised "small things" with staff, such as their relative not wearing slippers, but this was quickly resolved and did not happen again.

We saw complaints were recorded appropriately along with the provider's response to these and the complaints procedure was available for people to see, displayed in the entrance to the home.

There was a tablet (computer) in the reception area, although this was not turned on upon our arrival for the inspection. However, the manager later showed us how this worked. This was there for people who had lived or stayed at the home, visitors, friends, relatives or staff to give feedback.

Inadequate

Is the service well-led?

Our findings

People knew who was in charge of the unit they were in. People were aware there was a new manager but no one we spoke with had met her. The manager had only been in post for three weeks prior to our inspection and was beginning to identify work that needed to be done to improve the quality of the service. The home had not had stability in registered managers and staff felt this had a negative impact on morale.

We were told by the manager that twice a day they walked around the home, in order to identify whether any action needed taking in relation to staff practice or anything relating to the premises that may need action taking. We observed one of the walk rounds and saw the manager took action when she identified areas to improve. However, areas of concern we had noticed on our inspection were not picked up during these manager checks. For example, the first aid boxes, faulty shower seat and hazards in the garden area. Staffing levels, which were clearly not supportive of people's needs were not identified or addressed as a result or manager walk rounds.

We looked at quality assurance systems and saw data was collected monthly by the organisation to look at a dashboard and trends in relation to aspects of people's care. The information included people's skins integrity, weight loss/gain, hospital admissions, infections and reporting of expected deaths. Information about the organisations auditing was filed systematically and easy to locate. There was evidence of external monitoring through quality visits carried out by the organisation's senior managers.

However, we saw the quality assurance systems within the home lacked rigour and although audits were carried out, these were not done thoroughly or regularly enough to address areas to improve or ensure safety of people living in the home. For example, the medications audit was not robustly carried out to identify errors in practice and procedures. We saw quality checks on the units were not completed regularly. For example, some checks of equipment had not been recorded since January 2015. The manager told us that cleaning audits and information about infection prevention and control was held on each unit but not yet collated for the whole home.

Care documentation was not robustly audited and we found there were gaps in people's daily notes. Where aspects of daily recording had not been completed, such as people's food and fluid intake, this had not been picked up on through audits or addressed.

We found there were gaps in the home managers daily walk rounds. For example, we saw on our visit on 27 July 2015 there were only daily walk round records for 14 dates in July. It was not always clear from these checks what action had been taken to address areas of concern.

The above examples illustrate the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 17 (2)(a) because there were significant weaknesses in the systems and processes in place to monitor and improve the quality of the services

The manager said she was aware the auditing systems within the home needed to be improved and this was something she was preparing to do. She told us she had produced an action plan for senior managers of the organisation which identified aspects of quality she aimed to address.

We found evidence of good teamwork on each unit and staff communicated frequently with one another when carrying out tasks or going for breaks. We observed the daily management meeting which we were told was held at 11am each day. Key information was shared with senior staff for each unit and then noted for care staff. We saw handover notes were detailed for each shift to be able to follow on from the previous shift.

We saw a poster displayed in the reception area, aimed at staff, called 'share your voice'. The poster encouraged staff to share their views and highlighted that 'staff opinion matters'. However, staff we spoke with said they did not feel their opinion mattered and they did not feel valued by the management. Some staff expressed optimism that the new manager would help to improve the quality of the service and they felt that in the short time she had been there, she had become actively involved.

Staff told us they had found it difficult to contribute to any staff meetings because there had been a high turnover of managers. However, some staff we spoke with said they felt that the current manager was making positive contributions to the home and they hoped that this would be sustained.

Inadequate

Is the service well-led?

We saw a notice, advertising relatives meetings and the dates were listed from February to June 2015. Our visit was in July 2015 but no dates were listed beyond June. People and relatives we spoke with said they had not been asked to give feedback about the home. The last recorded minutes were from February 2015.

On display in reception was the provider's aim, which was to "be the provider of kindest homes in the UK, with the kindest and most professional staff". Also on display were policies on safeguarding, medication, rights and finances. The complaints procedure was displayed and an equality and diversity statement.

We overheard a visitor who had been to look around the home, say to a member of staff as they were leaving, "Even if we don't take up a place, we think you've got a lovely home".

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **There were not enough meaningful activities for people. Care and support was not delivered in line with people's needs and preferences**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The provider was not acting in accordance with Mental Capacity Act 2005 and people were not looked after in a way that did not inappropriately restrict their freedom.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **People did not receive suitable nutritious food and hydration.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Premises and equipment were not visibly clean and free from offensive odours.**

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 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect People's dignity and rights were not respected

The enforcement action we took:
We issued a warning notice to the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Risks to people were not safely managed, systems for managing medicines were not safely implemented.

The enforcement action we took:
We issued a warning notice to the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Audits were not robust enough and there were poor systems for monitoring the quality of the provision in order for people to receive safe care.

The enforcement action we took:
We issued a warning notice to the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staffing levels were insufficient to meet the needs of people and provide safe care.

The enforcement action we took:
We issued a warning notice to the provider.