P S P Health Care Limited

Angela Court

Inspection report

Angela Court
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Ratings

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

Overall summary

This inspection took place on 17 and 22 December 2014 and on 05, 11 and 26 January and 1 February 2015 and was unannounced. This was our fourth inspection during 2014. The inspection continued over several weeks because of the level of on-going concerns and in order to inform regulatory decisions about next steps. We brought forward the inspection because of concerns raised with us about people's care and welfare and about staffing levels at the home. Previously, on 04 April 2014 we visited Angela Court and had no concerns. We visited again on 20 July 2014 because of concerns raised with us about staffing levels. We found a breach of regulations in staffing due to staff vacancies and high sickness absence. We issued a compliance action and the provider set out actions being taken to address our concerns. On 16 September 2014, we undertook a further inspection visit and found improvements in staffing levels had been made.

Angela Court is registered to provide accommodation for 37 older people who require nursing and personal care. Many of the people who were living at the home have

Summary of findings

advanced dementia and lack capacity, and are not able to communicate their experiences of care. Some have complex needs and require a high level of care and supervision from staff to keep them safe. A number of people display behaviours that challenge the service.

The home is required to have a registered manager as a condition of registration. Angela Court does not currently have a registered manager, the previous one last worked at the home in August 2014 and has since left and deregistered with CQC. There has been a series of interim management arrangements at the home since then. A new manager was recruited and started working at the home on 5 January 2015, and plans to register. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were not protected from abuse. This was because sufficient actions were not taken to keep people safe and prevent avoidable harm. Angela Court has been the subject of a whole home multiagency safeguarding investigation since 17 November 2014, the third such investigation during 2014. Whole service investigations are held where concerns about possible institutional abuse or neglect are being investigated. These are cases where there are indications that systemic abuse or care and safety failings may have caused or are likely to cause significant harm. On the 16 January 2015, the multiagency safeguarding meeting concluded the safeguarding concerns amounted to the neglect of people living at Angela Court.

As part of that process, a multi-disciplinary safeguarding protection plan was agreed with the provider, CQC, police and health and social care professionals to protect people's safety and well-being. This included health professionals visiting the home regularly as part of the support plan and in a protection role.

People were not protected from unsafe and unsuitable premises. In particular, we highlighted burn and scald risks related to the central heating and hot water supply at the home. Following this, the provider took immediate steps to mitigate the risks, for example, displayed warning signs and where possible, put in place measures to stop people accessing hot water supplies unsupervised. Further plumbing and maintenance work was undertaken to address these concerns.

On three days of our visit, there was a strong smell of urine in the lounge, main corridor and dining room areas of the home. This was because cleanliness and hygiene standards in communal areas of the home were not being consistently maintained and because the carpets needed replacing. On 26 January 2015 when we visited, the carpet in the lounge area had been replaced and the odour had gone.

People's health, safety and welfare were put at risk because there were not sufficient numbers of suitably qualified, skilled and experienced staff on duty at all times.

We were so concerned about some of the findings during our inspection visits that, on 13 January 2015, we wrote to the provider. We used our urgent enforcement powers to require them to provide an action plan and assurance to us by the 15 January 2015 about how they planned to ensure people living at Angela Court were being kept safe. The provider's response acknowledged the concerns raised and gave a commitment to addressing them. The letter confirmed urgent action had been taken to manage the premises and protect people from risks related to hot water, hot pipes and other environmental concerns. It also outlined further actions being taken to improve staffing and skill levels as well as day to day leadership and supervision of staff at the home.

The staff training arrangements did not ensure staff had the knowledge and skills they needed to support people's care and treatment needs. Staff needed more training to manage people with behaviours that challenged the service and to understand how to meet the needs of people living with dementia. We identified other gaps in training in relation to managing people with choking risks, the Mental Capacity Act 2005 and Deprivation of Liberty safeguards and in relation to nutrition, hydration and pressure area care.

People's care needs were not effectively communicated to staff and people did not always receive care in accordance with their individual care plans. Some people were not appropriately supported at mealtimes, which increased their risk of malnutrition and dehydration.

Summary of findings

Others were at increased risk of choking because speech and language therapist recommendations about how to support those people to eat and drink safely were not being followed.

The care provided at the home was very focused on supporting people with daily living tasks rather than in response to people's individual needs and wishes. We saw examples of staff being caring and respectful of people. However, we also saw occasions where staff did not engage with people and did not treat them with dignity and respect.

People were at significant risk because accurate records about each person were not consistently maintained. We found gaps in people's food and fluid charts, repositioning and personal care charts as well as in prescribed cream charts. We could not be assured from these records that people's care needs were being met.

The quality assurance processes in the home were inadequate; some of them had lapsed and many of the concerns found were not identified by the provider's own monitoring arrangements or had not been acted on. Many of the actions taken by the provider to protect people were in response to concerns identified by visiting professionals, and the inspection. This demonstrated the provider was reactive rather than proactive in managing risks for people. Where improvements were made, these were not being sustained and risks remained.

On 29 January 2015, the provider contacted CQC to inform us they had identified seven people who needed immediate transfer to an alternative more stable service. They confirmed they were working with the local authority and health professionals who were assisting them to facilitate those people's transfers in a safe and caring way.

On 30 January 2015, CQC received notifications from Devon County Council and the Northern, Eastern and Western Devon Clinical Commissioning Group (CCG). These showed they had decided to give notice of the termination of the individual contracts for all people at the home for whom they had funding responsibility. This was due to the considerable concerns regarding the quality of care provided at the home and because people's care and safety could not be guaranteed. They informed the provider of their intention to move people from Angela Court as soon as practicably possible. By 5 February 2015 the remaining people left Angela Court and currently, there is no one living at the home.

During the inspection, we identified a number of serious concerns about the care, safety and welfare of people who lived at Angela Court. We found 16 breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, now replaced by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People continued to be at risk of harm because the provider's actions did not sufficiently address the on-going failings. This was despite the significant amount of support provided by the multi-agency team to address those failings. There has been on-going evidence of inability of the provider to sustain full compliance since March 2011.

Notwithstanding the findings of this inspection, enforcement action was not necessary once we were satisfied that service users were no longer accommodated at this location and satisfactory action plans from the provider addressing the breaches were accepted by CQC.

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's health, safety and welfare were put at risk because there were not sufficient numbers of suitably qualified, skilled and experienced staff on duty at all times.

People were not protected from abuse and avoidable harm because the arrangements to keep people safe were not effective.

People and staff were at risk of verbal and physical aggression as staff were not skilled at managing people with behaviours that challenged the service and did not supervise people adequately.

People were not protected from unsafe and unsuitable premises. In particular, we highlighted burn and scald risks related to the central heating and hot water supply at the home and found other environmental risks.

We identified some risks for people about the unsafe use of equipment. Also, failing to identify and report faulty equipment and order recommended equipment.

People did not always receive their medicines as prescribed due to some safety concerns about medicines management.

People were at risk because recruitment checks were not always completed before staff worked at the home.

People were not always protected from risks of cross infection because appropriate standards of cleanliness and hygiene were not consistently maintained.

Is the service effective?

Inadequate

The service was not effective. Staff training did not ensure staff had the knowledge and skills they needed to support people's care and treatment needs.

People did not consistently experience care, treatment and support that met their needs and protected their rights.

Some people were at increased risk of malnutrition and dehydration. Staff did not always make sure that people were eating and drinking enough to keep them healthy.

Staff did not understand the principles of the Mental Capacity Act 2005 and Deprivation of Liberty safeguards. Mental capacity assessments undertaken were confusing and contradictory. Where people lacked capacity, relatives, staff and other health and social care professionals were not always consulted and involved in making decisions in each person's 'best interest'.

Is the service caring?

Inadequate

The service was not consistently caring. Some staff treated people with kindness and respect but others did not explain things clearly to people or give them time to respond.

Summary of findings

There was a lack of continuity of staff, which meant they were not always familiar with the needs and wishes of the people they were caring for.

People did not always receive a good standard of personal care. Some people's dignity was compromised by being in communal areas of the home without being properly dressed or groomed.

Is the service responsive?

Inadequate

The service was not responsive. People's care and treatment was task centred rather than in response to people's individual needs and preferences. People received very little social interaction from staff.

People and relatives were not involved in the development and reviews of their care plans.

Staff were responding to concerns identified by visiting health professionals rather than proactively identifying risks themselves.

Complaints about the service were managed inconsistently.

People were at significant risk because accurate records about each person were not maintained.

When some people were transferred to their new home from Angela Court, important information about their care and support needs was not shared, which put them at increased risk.

Is the service well-led?

Inadequate

The service was not well led. People were at risk because of the lack of consistent leadership at the home. This resulted in conflicting advice being given to staff, conflict and lack of discipline within the staff team.

Changes in practice meant to improve people's care were poorly communicated, understood and were not always implemented.

The quality monitoring arrangements in place were inadequate. This was because they did not highlight the serious risks for people or multiple breaches of the regulations we found during the inspection.

Accidents and incidents were not properly analysed and there was a lack or actions to reduce incidents and to respond to risk trends identified. Notifications were not reported to CQC in accordance with the regulations.

Angela Court

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 17 and 22 December 2014 and on 5, 11, 26 January and 1 February 2015 and was unannounced.

The inspection team included four inspectors. In preparation for the inspection, we reviewed previous inspection reports, information from the multiagency safeguarding process, and information we received directly and from notifications. A notification is information about important events which the service is required to send to the Care Quality Commission (CQC) by law. This enabled us to ensure we were addressing any potential areas of concern.

We met all of the people who lived at the service; most of them were living with dementia and were unable to communicate their experience of living at the home in detail. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spoke with six people using the service, and eight of their relatives and friends to obtain their feedback.

We spoke with 45 staff which included managers, nursing, care and support staff and agency workers. We looked in detail at the care provided for eleven people which included reviewing their care records. We looked at seven staff records, and at a variety of quality monitoring arrangements in the home. We obtained feedback from 15 health and social care professionals, which included commissioners, GP'S, nurses, social workers and a variety of therapists.

Inadequate

Is the service safe?

Our findings

People were at risk of receiving inappropriate and unsafe care. Their health, safety and welfare were at risk because the provider could not ensure there were sufficient numbers of suitably qualified, skilled and experienced staff on duty at all times. We identified similar concerns about staffing levels when we previously inspected the home in July 2014. When we went back to the home in September 2014 to follow up on these concerns we found improvements had been made. This inspection showed the previous improvements implemented had not been maintained.

The provider used a dependency tool to assess the staffing levels at Angela Court. From this, they calculated the staffing levels needed to meet people's needs. A senior manager confirmed they felt the recommended staffing levels of at least one nurse and eight care staff in the morning, a nurse and seven care staff in the afternoon and a nurse and three care staff at night were adequate. However, there were 11 care staff vacancies and several other support staff vacancies at the home. The manager confirmed recruitment was underway but described difficulties recruiting staff. At the time we visited staff rotas were being done two weeks in advance and were being changed frequently, which staff were unhappy about as they couldn't plan ahead.

Rotas between 21 November 2014 and 5 February 2015 showed recommended staffing numbers were regularly not achieved. Although these staffing levels were planned for, through existing staff working extra hours and the use of agency staff, they were not always achieved because of staff sickness and absence. Sometimes, there were difficulties getting agency staff at short notice. For example, when we visited the home on Sunday 11 January 2015, there had been three changes to the planned rota provided to CQC on 09 January 2015 because of staff absence.

As part of the safeguarding protection plan, it was agreed there should be two nurses on duty each day. However, this was not being maintained, and where there was only one nurse on duty, people were at increased risk. A manager explained the problems and challenges on each shift were not always related to the numbers of staff on duty but were sometimes due to a lack of skills and experience. Some nursing staff were newly recruited and were undergoing induction. There were also concerns about the skills and competencies of some staff that were undergoing capability procedures. This meant the skills and experience of staff on each shift varied considerably.

Staff confirmed staffing shortages happened on a regular basis. One staff member said, "Staffing is always an issue, especially at weekends", another said "Staff off sick causes upset because we cannot give people proper care". Staff said low staffing levels were "Very stressful", and one said, "We are doing the best we can". For example, on 05 January 2015, staff shortages meant there was only one staff member in the lounge and dining room area supervising people. This meant people were not adequately supervised, and had to wait for assistance to eat their meals. We asked staff about the impact of low staffing levels. They told us low staffing levels meant staff spent less time with each person and were more likely to offer a "Strip wash" for personal care, rather than a bath or a shower, which took longer. Staff said "It is a nightmare if we are short staffed, we can do the care but we can't do the paperwork" and we saw numerous examples of this.

Relatives gave us mixed feedback about staffing levels; most relatives said there were usually enough staff. One relative said "They have quite a high turnover of staff "and another commented, "On Sunday occasionally (the person) is a little later getting up." Relatives reported recent improvements in staffing levels since the regular use of agency staff had commenced. One said, "I see a difference, staffing levels are up, everyone is happier".

We were so concerned about staffing and skill levels at the home that we wrote to the provider on the 13 January 2015 to request information about what immediate steps were being taken to ensure safe staffing levels. In their response, they confirmed they were reviewing staffing, were interviewing applicants for vacant posts. They also outlined plans to organise the existing staff group into two teams to ensure staff with complementary skills were on duty at all times, and provide better consistency and quality of care for people.

The new team arrangements were introduced on 23 January 2015 and new agency staff were arranged to live on site. However, these arrangements created new difficulties because those staff did not know people or about their needs and some were not skilled at providing

Is the service safe?

care. Staff said they found it difficult to ensure new agency staff had the guidance they needed. This was because they were already undertaking extra tasks, as those agency staff were not familiar with the home.

Daily monitoring visits by external health professionals between 5 January and 5 February 2015 confirmed on-going difficulties with staffing and skill levels at the home. This resulted in delays in people having their personal care, and a lack of support for people who needed assistance with eating and drinking.

On 26 January 2015 when we visited, some existing nursing and care staff had left or were planning to leave in the next few weeks. This meant people's health, safety and welfare was at increased risk because of on-going uncertainty about whether there were enough suitably qualified, skilled and experienced staff on duty at all times.

This is a breach 22 of Regulation 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 this report.

We identified risks in relation to agency and newly employed staff because safe recruitment practices were not consistently followed. People were at risk because the provider's recruitment checks did not ensure information was available about their good character, qualifications and skills.

We asked managers about the arrangements in place to assure them about the skills and competencies of agency staff and about their criminal record checks. They described a folder of information about agency staff. However, when we looked at this folder, on 11 January 2015, we found information was only available about one of the seven agency staff working at the home that day. We asked the nurse in charge how they checked the identity of agency staff, they responded, "They arrive in uniform and other staff know them. They show you their timesheet and we would be expecting them." This showed people were at risk because the system in place was not robust and up to date.

On 26 January 2015 we identified new staff working unsupervised in the home. We requested to see their recruitment records but these were not available so we asked for this information to be sent to us. We followed this up on 1 February 2015, as we had not received it. The provider confirmed disclosure and barring checks had been applied for in relation to those staff, but they had not yet been received. This meant people were exposed to risk because those staff were working unsupervised at the home, but had not yet had their recruitment checks fully completed.

We looked at seven other staff recruitment files and were satisfied appropriate recruitment checks had been carried out on those staff. Where any concerns were identified these had been risk assessed and appropriate supervision plan had been made. However these recruitment files had to be obtained for us from the Bristol headquarters of the provider. Our review of records with the manager on duty demonstrated that relevant risk information about some of the staff working at the home was not known to them. The provider told us this information was available to managers at the home electronically. However, none of the three managers we met knew how to access this information electronically, and there was no administrative staff available to do so.

This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were not protected from abuse and avoidable harm because the arrangements to keep people safe were not effective. On the 17 November 2014, a multiagency safeguarding meeting was held because of safeguarding concerns about people's safety, care and welfare whilst undertaking reviews of people living at the home. The concerns raised included lack of detail in care records, failure to identify individual risks for people and staff not responding in a timely way to changes in people's care needs and in response to incidents. Also, about staff practice in dealing with decision making for people who lacked capacity. The meeting concluded there were serious concerns about the care and welfare of people at Angela Court. People and relatives were informed about this and about the safeguarding protection plan put in place. This included regular visits to Angela Court by health professionals in a monitoring and staff support role.

The provider had a safeguarding training programme in place, training evidence showed that 63% of staff were up to date with this training. Staff had some awareness of signs of abuse and knew how to report concerns. They said they felt confident any concerns reported would be investigated. Staff at the home had made several safeguarding alerts to the local authority, which

demonstrated they knew how to report concerns outside of the home. For example, in relation to verbal and physical abuse between people and by staff members. These were being investigated and followed up.

During December 2014 and January 2015, further safeguarding alerts were made to the local authority by the external health care professionals visiting the home as part of the safeguarding protection plan. For example, allegations of abuse against staff, people not receiving personal care, staff not following professional recommendations about supporting people with choking risks to eat and drink safely, people not being appropriately dressed, as well as, a number of falls, and medicines errors. Not all of these safeguarding concerns were notified to CQC , as they should have been.

On the morning of 4 January 2015, staff told us they found several people wet and cold when they came on duty in the morning. Staff said the heating was off overnight and there was no evidence people received personal care. Records relating to people's checks, repositioning and fluid and food administration records had not been completed. This increased people's risk of dehydration, skin damage and compromised their comfort and dignity. The nurse said, they were "Appalled" and phoned the manager and completed incident forms about this. When we followed this up with the provider, they told us they reported this to the agency, who would investigate further.

We received a notification that a member of staff had been suspended because of a safeguarding concern. We followed this up and the staff member had been disciplined on three previous occasions for similar matters during their employment. The senior manager confirmed they were not aware of these previous concerns.

On 11 January 2015, we raised concerns with the manager about the suspected neglect of two people. One person was at an increased risk of choking as staff were not following their care plan about food preparation and the need for close supervision with eating and drinking. The second person was at increased risk of injury from falls because staff were not responding to their call bells in a timely way and were not consistently undertaking hourly checks on the person. We raised safeguarding alerts to the local authority about the care of those two people and requested the provider take urgent action to protect them.

On 16 January 2015, a safeguarding strategy meeting was held. It concluded; "It was the view of professionals involved in the process that this amounted to the neglect of residents at Angela Court". The police safeguarding adult's investigator confirmed they had two open investigations related to the home. One was about the alleged assault of one person by a staff member and the other related to the poor management of another person's health care need.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Each person had written risk assessments and a risk management plan which identified individual risks, with information about how to reduce those risks as much as possible. These included environmental risks such as falls risks and clinical risks such as skin integrity. However, the risk management plans for each person were not always communicated to staff or consistently followed by them.

For example, some people were at high risk of falling because their care was not being managed appropriately in order to reduce their falls risks to an acceptable level. Staff told us they had introduced hourly checks of people at high risk of falls to try and reduce these by regular monitoring. However, when we looked at the hourly checks records on 11 January 2015, we found no hourly monitoring checks had been completed between 07.00 and 12.00 for seven people.

One person's falls risk assessment showed they were at high risk of falling. Their care plan instructed staff to "Maintain hourly close observation by day" and they had a sensor mat in place to alert staff when the person moved, so they could go and check on them. Their daily records showed that they were found in the corridor on two occasions and had experienced several falls. On 08 January 2015 they had a fall resulting in a deep laceration, which required them to go to accident and emergency for stitches. On 11 January 2015, when we visited, this person's bell rang regularly throughout the day. As the day went on, staff were taking longer and longer to respond to their calls, up to 10 minutes. During the afternoon, the person had walked unaided to their bedroom door before staff arrived to help them. On 26 January 2015, when we visited, the nurse call bell panel showed this person's call bell was ringing on several occasions. However, this call bell was not

audible, although staff were aware the person was ringing. This showed the person remained at high risk of falling because staff were not implementing the measures needed to reduce their risks.

People were at increased risk of injury because some staff had poor moving and handling practices. On 5 January 2015 we saw one person being assisted to move from a chair to a wheelchair in a hurried way. This resulted in the person's feet not being securely positioned on the footplate, and their foot fell off the footplate when the wheelchair was moved. On another occasion, a person was transferred in a wheelchair which did not have any footplates to support their feet, which placed them at increased risk of injury. A visiting physiotherapist raised concerns about the poor technique staff used moving a person. Reports we received from nurses visiting the home in a monitoring role, also showed they had observed poor moving and handling practice by some staff at the home.

A number of people with challenging behaviours lived at the home. These behaviours included people shouting, swearing, grabbing, pinching, punching, and kicking. People were at an increased risk because staff did not demonstrate the need to supervise people or be aware of their whereabouts. On each day of our inspection, we were concerned about the lack of supervision of people with challenging behaviour within the home. Several people walked up and down corridors and walked into other people's rooms and into the kitchen and pantry areas.

On a number of occasions, we saw two people entering the bedrooms of two other people, whose rooms were situated at the end of the rear corridor. This was particularly distressing for one of them who shouted and swore loudly at them. On each occasion, there were no staff in the vicinity, so we had to intervene and ask for actions to be taken to reduce risks for individuals. On 26 January 2015, we witnessed an altercation between two people which resulted in one of them being struck and falling. Staff didn't see the incident and were not aware the person had banged their head so we had to make them aware of this. This demonstrated staff were not alert to risks of altercations between people and didn't always intervene in a timely way to prevent behaviours escalating.

Accidents and incidents were reported in accordance with the organisation's policies and procedures. Senior managers told us these were reviewed regularly to ensure all appropriate actions to reduce risks had been taken. We confirmed this by looking at a number of accidents and incident reports. However, the level of incidents reported for people showed high ongoing risks remained and demonstrated the actions being taken were not reducing risks to an acceptable level.

We found there were no individual personal evacuation plans which took account of people's mobility and communication needs. This meant that, in the event of a fire, emergency services staff would not be aware of the safest way to move people quickly which would make it more difficult to evacuate people safely. We discussed this with the home's manager, who acknowledged they were aware of this and planned to develop these in the future.

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

People were not always protected from risks of cross infection because appropriate standards of cleanliness and hygiene were not being consistently maintained. When we visited on 17 and 22 December 2014 and on 5 and 11 January 2015, there was a strong smell of urine in the dining room, lounge area and downstairs corridor at the home. This odour made these areas a very unpleasant environment to be in. Staff told us there had only been one cleaner on duty over the previous two weekends and no laundry assistant. This had meant the staff member was not able to undertake all their cleaning duties because they had to work in the laundry for part of the day.

A senior manager said the carpet in the dining room and lounge areas needed replacement and they were awaiting authorisation to do so. We followed this up with the provider who confirmed they had arranged for some carpets to be replaced. When we visited on 26 January 2015, the carpets had been replaced and the odour had gone.

Generally, most areas of the home were clean most of the time although we identified some areas of concern which we highlighted to a senior manager. For example, faecal soiling on pipe work and thick dust under the radiator covers of several rooms, which they told us they would address. This was concerning as the home had recently undergone a deep clean following several people being ill with norovirus. Staff had undertaken infection control training. Staff hand washing facilities were adequate and

staff confirmed personal protective equipment (PPE's) were available to them. There was appropriate cleaning materials and equipment , and staff followed written cleaning procedures.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were not protected from the risks of unsafe unsuitable premises. When we visited on 22 December 2014, we identified serious risks related to the premises. We found temperatures in excess of 60°C, in 26 taps in bedrooms, communal bathrooms and shower rooms. These exceeded the Health and Safety Executive (HSE) recommended temperatures. (No hotter than 44 °C should be discharged from outlets that may be accessible to vulnerable people). This represented a serious risk of scalds for people who lived at the home. We also found four hot radiators without covers and hot pipework which represented a burn risk to vulnerable people. We immediately raised our concerns with the senior manager on duty and gave clear feedback about the need for immediate actions to reduce those risks. The senior manager told us about ongoing plumbing works by an external contractor to improve the hot water and heating systems and to fit thermostatically controlled valves to all outlets to control hot water temperatures. However, they did not know when the contractors were due to visit the home again.

In response to our safety concerns, the provider implemented further measures to protect people from these risks. These included creating and displaying hot water warning signs in all affected areas and ensuring people, who lacked capacity, did not have unsupervised access to sinks, shower or bathrooms areas. We were concerned these protective measures were only instigated in response to our concerns, although these risks had been known about since November 2014. On 09 January 2015, staff at the home reported the hot water supply to showers and bathrooms at the home had not been working for three days, whilst plumbing works continued at the home. This meant people personal care needs were not being adequately met as staff could not bathe or shower people, they could only wash them with bowls of water. These examples demonstrated the hot water and heating system was unreliable and posed risks for people. On 25 January 2015, the provider confirmed the work had been completed and that all hot water taps were within the HSE temperature range.

When we visited on 05 January 2015, staff told us that on the morning of the 04 of January, people were cold because the central heating system was not working. A heating engineer was called who identified and fixed the problem. Meanwhile, temporary electric heaters had to be used to keep people warm. These temporary heating arrangements posed risks for people as those heaters did not have any protective guards to prevent people from touching them and burning themselves.

We asked to see the environmental risk assessments for the home. The provider sent us a range of documents which they used to identify, assess, manage and review environmental risks within their nursing homes. They included record books for maintenance checks, fire safety records, and fault reporting records. Also, servicing and maintenance schedules for the heating, electric and fire safety systems. However, the information seen did not represent the 'suitable and sufficient risks assessment' required by health and safety legislation to manage and control environmental risks in the home. The measures in place did not identify all the environmental hazards to people and staff or provide assurance the provider was taking reasonable steps to prevent harm by reducing risks as much as possible.

For example, we asked about Legionella controls, (Legionella is a bacteria that can grow in hot water systems which can cause a serious pneumonia like illness). We found no evidence that a risk assessment had been undertaken or that any legionella checks were being carried out at the home. This meant no control measures were in place to prevent or reduce the risk of Legionella infection. Following our feedback the provider arranged for a specialist contractor to visit. We were sent the contractors report, dated 12 January 2015 which confirmed there was no formal legionella control scheme in place. It highlighted three water tanks were in need of cleaning and disinfection, and identified rarely used water outlets that needed weekly flushing and that shower heads needed to be cleaned, descaled and disinfected on a monthly basis. The provider confirmed the legionella controls would now be implemented.

Inadequate

Is the service safe?

We also found 14 windows on the first floor of the home with window restrictors in place had openings above the 100 millimetres maximum as recommended by the HSE. This meant vulnerable people had access to window openings large enough to fall through, and at a height that could cause them harm. We were so concerned about the environmental risks at the home that we contacted the Health and Safety Executive who have arranged to visit the home.

On 22 December 2014 when we visited, we highlighted to staff equipment blocking the fire exit next to the laundry room and the manager arranged for it to be removed. However, this fire exit was blocked again when we visited on 11 January 2015. Fire checks and emergency lighting were in place and a recent fire drill had taken place in December 2014.

This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We have since received confirmation from the provider in response to our urgent action letter, that the most urgent environmental improvements have been made. This has reduced risks for people. The provider also confirmed they have instructed a specialist firm to carry out environmental risk assessments at Angela Court.

We identified some risks in relation to the unsafe use of equipment. Some people were at increased risk of skin damage because pressure relieving equipment, such as cushions were not used consistently. On 2 December 2014, a safeguarding alert was sent to the local authority about a medication error related to the use of a syringe pump delivering analgesia for a person receiving end of life care. The investigation showed the nurse on duty was not familiar with the equipment and had switched off the alarm and pump. This meant the person did not receive the pain relief prescribed for them. The provider confirmed staff training was being arranged on the use of this equipment.

One person had a faulty wheeled walker which was highlighted to staff by visiting nurses, but was only replaced when they intervened again. On 11 January 2015, staff told us that this person had fallen and sustained a head injury which required a paramedic ambulance to attend. When we looked at this person's mobility aid, we found one of the brakes was not working. This had not been identified by staff and meant this person remained at risk of falling. We highlighted this to the nurse in charge and asked them to address this.

We looked at equipment check records and saw they included checks of wheelchairs, hoists and stand aids and call bells. However, these checks had lapsed as records showed these checks were last carried out in July 2014. Another person with choking risks had been assessed by an occupational therapist on October 31 2014 as needing a new chair to help position them safely for eating and drinking. However, no action had been taken on this recommendation and the person remained at risk.

This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff confirmed they had enough equipment to meet the needs of the people they supported. Each person who needed hoisting had their own sling with spares available for laundering. Staff had access to a range of moving and handling equipment and staff were trained to use it. Pressure relieving equipment such as specialist mattresses and cushions were available. One staff said, "If we need equipment we can get it". For example, cleaning staff confirmed they had recently been provided with two new vacuum cleaners and two steamers.

We identified some safety concerns about medicines management. Feedback received from GP's and visiting health professionals highlighted problems with medicines management in the home. These related to delays in obtaining prescribed medicines for two people and not administering a prescribed medicine to another one person, which resulted in the person becoming agitated and distressed. When we visited on 22 December 2014, there had been an audit of the medicines on the day before our visit. This identified gaps in medication which had not been signed for.

Documentation relating to prescribed creams and ointments was confusing and poorly completed. Prescribed creams did not include clear guidance about how and where they should be used on each person. We also found some creams were not being used because they had run out. Senior managers and nursing staff at the home were aware of these issues and told us about new documentation being introduced. However, these changes resulted in a variety of cream charts in use, none of which

Is the service safe?

were completed regularly. This meant we could not tell how often the creams were being used. Where the use of creams were documented, some records only referred to two of the four creams prescribed. We saw numerous similar examples of this throughout this inspection. This meant people were not having their creams applied as prescribed.

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

We found medicines were stored safely and records were available for medicines received and disposed of. Controlled drugs were locked away in accordance with the legislation and medicines which required refrigeration were stored at the recommended temperature.

Inadequate

Is the service effective?

Our findings

A nurse raised concerns with us about the ability of some nursing staff to assess, recognise and respond to changes in people's health needs. They said, "They are not trained medically to pick up signs of things like urinary tract infection, and chest infections. I feel illness progresses because it is not spotted". They also commented, "Staff training is not fit for purpose". They confirmed they had raised their concerns to the provider. A relative told us they visited one day and found the person they visited was very confused and had recently had several falls. The person was prone to urinary tract infections and the relative asked staff to test the person's urine, which showed signs of a urine infection, which was subsequently treated. They expressed surprise that nursing staff had not recognised these signs of infection and taken appropriate action earlier.

The staff training provided at the home was not adequate to meet the care needs of people who lived there, this was creating risks for people. Staff described training provided as "basic". One staff said, "I would like to see more training across the board". Staff said they needed more practically based training in some areas. For example, in understanding the needs of people living with dementia and to support people with challenging behaviours. One staff said, "Challenging behaviours is the most important training we need, unless you know a technique, it could be dangerous".

We looked at the training matrix for the home. This showed staff had completed training on fire safety, dementia, safeguarding adults, infection control, person centred care, challenging behaviour and food hygiene awareness. The training provided covered a range of topics, staff watched a DVD and then completed a questionnaire. The training matrix demonstrated poor staff compliance with this training. For example only 58% of staff were up to date with dementia training and only 68% were up to date with challenging behaviour training.

Senior managers agreed further training was needed in these areas and identified further training needs on diabetes, use of syringe drivers, managing choking risks and on the Mental Capacity Act 2005 and Deprivation of Liberty safeguards (DoLs). The provider outlined plans to move to a new training supplier, and to implement staff training on all necessary topics over the next few months. Many staff had received moving and handling training as the home had three manual handling trainers who worked there.

On 11 January 2015, when we visited, there were lots of new agency staff working at the home, whose induction paperwork had not been completed, in accordance with the PSP induction procedure. This meant people were at increased risk because those staff had not been given information about fire, health and safety and environmental risks.

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

Each person who lived at the home had an assessment of their individual health care needs when they were admitted to the home. The home used a range of evidence based tools for assessing people's needs and identifying any risks. For example, people at risk of poor nutrition and dehydration and at risk of developing pressure ulcers. From these, a range of care plans were developed completed about how to meet people's individual health needs. However, some of the care plans we looked at were confusing and contradicted one another. Care workers said they rarely had time to look at care plans and risks assessments and relied on information given at staff handover and from other care workers. This meant the information we saw in care plans was not always communicated effectively to staff.

Nursing staff did not always recognise people's health needs and did not act proactively in tackling them. Visiting professionals told us their recommendations for care and treatment were not always followed. For example, on 26 January 2015, we attended the staff handover meeting at 07.30. The night nurse reported that one person had not had their bowels open for eight days. At lunchtime, we spoke with this person who said they were feeling very unwell. Their bowel record chart showed the person had last had their bowels opened on 06 January 2015, a gap of 20 days. When we drew this to the attention of the home's manager, they said, "Now you have made me aware I will do something about it." This was despite the fact the manager had attended the same handover meeting as the inspectors, as had both nurses on duty that day. Later that

afternoon, a nurse contacted the person's GP doctor to report this concern. This showed people were put at increased risk because their healthcare needs were not responded to in a timely way.

People were at risk of receiving inappropriate care. This was because some staff did not always know what people's care needs were or how to meet them. Nurses on different shifts were giving conflicting and inconsistent information and advice to care workers about people's care. We witnessed conflict and disagreement within the nursing and care team about how best to support people's care needs. This resulted in unclear communication and instructions to the care team and nursing staff. Staff were not checking that people's health needs were being safely met. This meant people were at increased risk of receiving care that increased their health risks.

Where needed, referrals to external health professional had been made such as to the falls team, psychiatry services, and dietician and to speech and language therapy services (SALT). Some of these referrals were prompted by visiting health professionals. Feedback from GP's showed basic observations and information about people's health were often not available at the home. They commented on the lack of co-ordinated communication with the local GP practice and conflict amongst nursing staff about people's care and management. They were also concerned that staff lacked understanding of advanced dementia care.

During our inspection on 22 December 2014 and 5, 11 and 26 January 2015, we found people with swallowing difficulties were at increased risk of choking. This was because staff did not consistently follow speech and language therapy (SALT) recommendations about how to support people with swallowing difficulties to eat and drink safely. People with choking risks were not given adequate supervision and support at mealtimes and the food prepared was not at the recommended consistency. Most staff had not undertaken any training about how to support people with swallowing difficulties. Staff lacked knowledge and understanding about the types of food and drink that was safe for those people.

For example, one person whose care we looked at in detail had swallowing difficulties. They had a swallowing assessment by a speech and language therapist (SALT) on 20 October 2014. The report and recommendations recommended the person was given a pureed diet, used a teaspoon for eating, and needed to sit upright and remain in that position for 15 minutes after meals. Also, the person should be offered sips of normal fluids but not be offered full beakers of drinks. Their instructions said, "Do not offer (person) full beakers as he tends to drink it all at once".

Their care records had conflicting information about the consistency of food that was safe for this person. On the, "Resident Quick Reference Sheet", it said "Fork mashable diet – pureed meats and fish". A care plan said they required "pureed diet and normal fluids", and also needed "full supervision" when eating and drinking. Their care plan instructed staff to; "Offer the person choice to feed self as dislikes being assisted".

We spoke to eight staff in total, and asked them about this person's dietary needs, and received a variety of responses. Two staff said "pureed or fork mashable", they were not sure which. A third member of staff said the best way to support the person was to; "Give him time to eat by himself, then go back and check." This was contrary to the SALT recommendations and showed there was confusion, because staff did not understand how to meet this person's needs safely.

On 05 January 2015 we observed this person eating a bowl of jelly unsupervised in the lounge at midday. At 1300, this person was just about to be served lunch when a nurse instructed two care workers to bring this person to dining room to eat at the dining table. They explained to staff this was so they would be in an upright position and supervised. This instruction resulted in a disagreement between the two nurses and a care worker about this person's care.

On 11 January 2015, when we visited the home, we saw this person in the lounge eating their breakfast, there were no staff members nearby. We witnessed them coughing, which could indicate difficulty swallowing. We made the manager, aware and asked them to clarify to staff what supervision the person required. The manager arranged for a staff member to supervise the person with their breakfast. At lunchtime, we saw a plate of food was brought for this person to eat. An agency care worker, who had started work mid-morning, and missed staff handover started to feed the person. They offered the person their food at a pace that was inappropriately fast for someone with swallowing difficulties. When we looked at the food, we saw it included mashed vegetables, meat in a finely minced consistency and mashed potato. This was not in accordance to the SALT recommendations we saw in their

care records about them needing a pureed diet. We spoke to this agency care worker about the person, and they demonstrated they did not have the information they needed to reduce this person's risk of choking.

After a few minutes, the person had some food in their mouth and were being offered more whilst they were still chewing and swallowing. We alerted a nurse and asked them to intervene. The nurse proceeded to try and remove the food from the person's mouth. Shortly afterwards, a kitchen assistant arrived and insisted this person's food should be "fork mashable". Two other care workers joined in the discussion. We were so concerned about the safety of this person, in relation to their choking risk, that we alerted the manager and asked them to urgently intervene and provide clear guidance to staff about how to safely support this person to eat and drink. When we next visited on 26 January 2015 we identified further similar risks for other people with swallowing difficulties. Reports from visiting health professionals between 8 January 2015 and 5 February 2015 also showed they were identifying similar concerns about people's choking risks.

People were at increased risk of developing pressure ulcers because staff did not consistently follow individual recommendations about pressure area care. People were not repositioned as often as required and we found long gaps in records about repositioning. For example, one person had a Waterlow score, which showed they were at high of developing pressure ulcers and needed repositioning every 2-3 hours. (Waterlow is a risk assessment tool used to assess risk of developing pressure ulcers). On 07 January 2015, their repositioning chart showed a gap of 5.25 hours in the morning between repositioning and a gap of six hours, in the evening. We saw similar gaps for this person the next day and we saw several similar examples for other people. These long gaps between changes in position and in providing personal care, increased people's risk of skin damage.

We also found people who were supposed to be seated on pressure relieving cushions, to reduce their risk of skin damage, did not always have them. For example, on 26 January 2015, we saw one person sitting at the table in dining room for 1.5 hours without their pressure relieving cushion. We saw another person was not sitting on a pressure relieving cushion, in accordance with their care plan. When we asked about this, staff said they had stopped using the pressure relieving cushion as it was making the person slide off their chair. This decision had not been updated in the person's care plan. Reports we received from nurses visiting the home in a monitoring role highlighted numerous similar examples of concerns about people's pressure area care. These findings meant people remained at increased risk of developing skin damage.

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

Mealtimes were not always a pleasurable experience for people, as some people did not always get the support they required. There was a lack of recognition that people were not receiving enough to eat and drink and a lack of action taken in response. For example, in the dining room, some people were not supported to eat and drink and staff in the vicinity did not notice, until we drew this to their attention. On several occasions, people who needed support to eat and drink were left alone in their bedroom with their breakfast in front of them, which they struggled to eat. Their food got cold and was left uneaten.

People at risk of poor nutrition and dehydration were not always sufficiently monitored, managed or encouraged. We saw care plans in place about how to manage people identified as at risk of malnutrition. These care plans included instructions to staff about offering people at risk regular snacks and food supplements. People identified at risk of dehydration had food/ fluid charts, which included the amount of fluid each person needed to keep them healthy. However, throughout the inspection we saw gaps in these food and fluids charts. Where people did have food intake records it was not always clear how much they had eaten and drunk. Snacks and prescribed supplements were not always offered. People's weight losses were not always responded to in a timely way.

For example, one person, identified at risk of dehydration, had a nutritional care plan which recommended they drank 1700 millilitres (mls) daily to keep them healthy. Their care records showed they had received an inadequate fluid intake between the 17 December 2014 and 24 December 2014. For example, on the 17 December 2014 the person's fluid chart showed they had 450 mls of fluids and on 20 December 2014 they had drunk 650 mls. In response, on 20 December 2014, staff put in place an acute care plan regarding this increased risk, this record said, "Continue to promote fluids". However, on the 21 and 22 December 2014, there were no records of any fluid intake

Is the service effective?

for this person. On the 23 December 2014 their fluid chart showed they had 300mls, on 24 December they had 650mls. This meant that the person remained at serious risk of dehydration.

On 26 January 2014 when we visited, we were concerned to find people's monthly weights had not been completed. We made the home's manager, aware of this and asked that people were weighed as soon as possible. We were also concerned because, during this visit, we noticed a lot of people were no longer on food/fluid charts. Given the lack of support we witnessed with food/nutrition for some people, we were particularly concerned about this. On 27 January 2015, we received information from the nurse monitoring team about a person we had raised concerns about, which showed they had lost a significant amount of weight. Their weight chart showed in November 2014 they weighed 51.9kg, 50kg in December and 48.95kg in January 2015. This showed this person was at serious risk of malnutrition. Reports we received from nurses visiting the home in a monitoring role also highlighted numerous similar concerns about people at risk of malnutrition and dehydration.

This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were not always involved in day to day decisions about their care and treatment. This was because staff did not always understand what decisions people could make for themselves and how to support them to do so. For example, people were asked questions but were often not given time or encouragement to formulate a response.

Staff were not meeting the requirements of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLs) and associated Codes of practice. They demonstrated a limited understanding of the principles of MCA and DoL safeguards and codes of practice. Staff told us they had not undertaken any training in this, which was confirmed with the provider.

We looked at the Mental Capacity Act assessments for two people. The assessments completed were confusing and did not result in any clear actions to help the person be involved in decision making about them. There was no information or care plans to guide staff about how they could assist people to make some decisions for themselves. We were also aware of an incident of a sexual nature between two people. This was causing concern as there was no clarity as to whether these two people had capacity to make an informed decision about sexual relations. This meant staff were unclear about whether or not they needed to intervene. This was being followed up through the multiagency safeguarding process.

For people who lacked capacity, or had fluctuating capacity, we found relatives and other professionals had not been appropriately consulted in 'best interest' decisions. There were very few examples of best interest decisions documented. For example, about the widespread use of 'sensor mats', (a device which set off alarms when people move in their bedrooms). There was no evidence of consultation with relatives and other professionals about whether the decision to use 'sensor mats' were in each person's 'best interest'.

We looked at a MCA assessment undertaken on 7 January 2014 for one person, which showed the person had capacity, it was reviewed regularly and showed they still had capacity. On the 3 November 2014 an entry was made which showed the person was temporarily confused due to an infection. The changes made to the assessment were confusing because they showed that the person did and did not have capacity. On 3 January 2015 another mental capacity assessment was completed for this person, related to their acute confusion. The assessment showed the person lacked capacity. Following this, we found a best interest decision had been made to remove this person's telephone. This related to a request by the police to remove their telephone as the person was repeatedly dialling 999 to ask for help. Other professionals and the person's next of kin were not appropriately consulted about this decision.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff confirmed they had made applications to the local authority deprivation of liberty team for 26 people in August 2014, and were waiting for them to be assessed.

Inadequate

Is the service caring?

Our findings

One person we asked about the care they received replied, "Not so bad". Another said, "I'm not treated as well as I'd like to be treated". The person went onto say about staff, "Some are very good and some are very rude". Visitors said they were made to feel welcome and were treated with respect. Most relatives told us they were happy with the care their relatives received. One relative said, "They are doing the best they can" and another said, " Happy with the care Gran gets". Other comments included, "I am happy (the person) is cared for" and "The care is very good, no reason to complain".

One relative said, "Most staff are good but they speak really fast to her, they need to slow down, that is the only interaction she has". "They are trying so hard to turn it round, they have forgotten the residents". They went on to explain that they were worried their relative was being forgotten about as staff weren't popping into their relative regularly for a little chat anymore.

We found staff practice was inconsistent, and staff did not always support people to express their views. We saw some staff took time to explain to a person what they were doing and sought the person's co-operation. Others did not explain things clearly or give people time to respond.

We found inconsistencies in practice between staff in how they cared for and interacted with people. We saw examples of good and very poor practice. Some staff were very caring and considerate towards people, getting down to a person's level and giving them time good eye contact and positive body language. We saw staff comforting people when they were upset, encouraging and praising them for their achievements and chatting and laughing companionably with them. For example, we observed staff reassuring a person who was anxious, they offered them a cup of tea and walked arm in arm and chatted with them. However on two other occasions, the same person was left to walk around without staff interacting with them or checking on their whereabouts.

We also saw numerous examples of poor interactions between staff and people, such as staff not explaining choices to people or giving them time to respond. For example, when moving people from one place to another by hoisting or transferring them by wheelchair. People were not always given adequate explanations or time to understand what was happening, staff rushed them and did not give them opportunity to help themselves, which made them upset and angry. We saw several people being ignored for long periods.

For example, one person was sitting in the lounge supported by a care worker to have their lunch. Throughout the meal the care worker sat and stared out of the window and did not engage with the person. This resulted in the person falling asleep during the meal. Another person frequently sat alone in the dining room. They looked withdrawn and sad, on one occasion they had their head in their hands, and looked distressed and said, "I don't know what to do" but there were no staff nearby to comfort them. Another morning, two people approached this person whilst they were sitting in the dining room having their breakfast and reading their newspaper. One person tried to take their drink from them and another person sat at their table and tried to take their newspaper from them. Although it was clear the person was upset by this incident, nearby staff did not notice until we asked them to intervene.

People's care records included detailed information about each person, about their life and family circumstances before they came to live at the home and about their interests and preferences. They included information about people's communication needs such as whether people needed glasses to read or wore a hearing aid.

The high level of staff vacancies and high use of agency staff at Angela Court created a lack of continuity of staff, and many staff were not familiar with the people they were caring for. This meant people did not always receiving care and support from staff who knew and understood their likes, preferences and needs. For example, one person who lived at the home was profoundly deaf. They also had poor eyesight, refused to wear their glasses and their speech was difficult to understand. A communication book of simple sentences was available to help staff communicate with this person, which we saw in their room. In addition, a relative had provided a small whiteboard for staff to write messages for this person.

We observed staff helping this person to transfer into an armchair in the lounge. They spoke with the person in a loud voice, often without any eye contact and sought their co-operation to move them through verbal instructions. We observed staff assist this person on several occasions but only once saw a member of staff use their whiteboard to

communicate with the person. This showed that although there was good information in the care record about this persons communication needs, the information was not well known by some staff and was not followed. The person's relative and a health professional also commented they did not see staff using the person's communication aids. This meant the person was at increased risk of isolation because their communication needs were not well understood.

Staff did not consistently demonstrate they understood how to ensure people's privacy and dignity was maintained. The smell of urine in communal areas of the home, where people spent most of their day, was not very dignified for them. On some occasions, people's dignity was compromised by them being in communal areas of the home without being properly dressed or groomed. For example, some women were not wearing any bras or tights and other people were wearing clothes that were wrinkled and stained. One person was eating cornflakes but was not offered anything to protect their clothes and had spilt food on their clothing. We observed staff brushing a person's hair in the lounge using a communal hairbrush. On another occasion, a nurse carried out wound dressings on two people in the lounge area, which was not very dignified for them.

People did not always receive a good standard of personal care or receive it in a timely way. One person had long dirty finger nails and looked dishevelled and unkempt and some people had greasy hair. A visiting health professional told us a relative had reported concerns about the management of people's incontinence. This included feedback that they had to request staff to provide personal care for people who had been incontinent. On more than one occasion, they said they saw staff attempting to move people into the dining room who were obviously wet. They said staff had not attempted to provide personal care or change them. These findings did not demonstrate dignity and respect for people.

In people's rooms, we also noted several people's toothbrushes were dry, although their records showed their mouth care had been completed. In contrast, some staff took pride in making sure people they supported looked smart and well presented. One staff member tied the person's hair back and another applied the person's lipstick. One staff said "Doesn't she look gorgeous? This showed that standards of personal care given varied considerably.

Since the inspection, we have received several similar reports about poor personal care via the safeguarding team. This lack of consistency meant people did not always have their dignity maintained and were not always respected or valued.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service responsive?

Our findings

People were not always at the centre of the care they received. People's experience of care and treatment was task centred rather than focused on them, as individuals. Staff did not have a good understanding of people's needs and how to respond to them as individuals. Risks to people and the service were not always managed in a way that ensured they were protected. Staff at the home were often responding to concerns identified by visiting health professionals rather than proactively identifying risks themselves.

We attended staff handover on three occasions, during which staff were delegated to work in different areas of the home. Staff were allocated responsibility for giving people breakfast, repositioning people and for carrying out a continence care "round" before lunch and making sure people had their personal care completed. There was a predetermined list of people who needed to be bathed or showered on set days of the week. This demonstrated people's care was not based on the individual needs and preferences but on set routines at the home.

This is a breach 17 of Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Care, treatment and support plans had inconsistencies although most reflected people's needs, choices and preferences. However people's changing care needs were not identified promptly and were not regularly reviewed. All of the relatives we spoke with had people at the home who lacked capacity. Three of the relatives felt they were consulted about their relatives care but none of them had seen the person's care plans. This meant people and relatives had not been involved in the development and review of their care plans in a meaningful way. Instead, care records had been written and regularly reviewed by the nurses.

There was no effective system in place to communicate information in people's care plans to care staff. Care staff said they were too busy to access this information in people's care records. This meant staff did not always know about people's assessed care needs. For example, two people had recorded in their care plan that noise and busy environments triggered anxiety. However on several occasions we saw cleaning staff vacuuming while these people were having their meals. On 26 January 2015, a musician visited the home to play the bagpipes, as part of the Burns day celebrations. This caused those people to become distressed, a situation which was entirely avoidable. Staff and management appeared surprised by the distressed reactions of these people to the loud music.

The provider used wardrobe care plans, a quick reference care plan to communicate people's key needs/risks to care staff. These were stored inside people's wardrobe doors in their rooms. At the end of January, they were also held in individual care folders for people. At a safeguarding meeting held on December 2014, the provider reported they had updated each person's wardrobe care plan to include personalised information. When we visited on 11 and 26 January 2015, these wardrobe care plans were not always available to guide staff, as managers were reviewing and updating them. The updated versions caused the monitoring safeguarding nurses concerns, as they did not contain enough information about people's needs to guide staff.

For example, the original wardrobe care plans gave staff guidance about a person requiring long socks under their leg brace but the updated one did not. This resulted in a short sock being put on the person and the brace rubbing directly on the person's skin. Another said the person must have a call bell in reach at all times and use a heel pad to protect their heels from becoming sore. This information was not included in the updated versions which put the person at risk of not having their needs met safely. On the 1 February 2015, the original wardrobe care plans had been reinstated. However, we found staff did not always follow the guidance in the wardrobe care plans. Throughout the inspection people received support which was not in line with the guidance set out in their wardrobe care plan, which put people at risk of receiving unsafe care.

We found inconsistencies and gaps in record keeping throughout the inspection. The variability in the quality and consistency of record keeping meant we could not be confident that people were receiving the care and treatment they required. These gaps in record keeping meant people were at increased risk of malnutrition and dehydration, falls, pressure ulcers, and medication errors.

On 11 and 26 January 2015 we found staff had recorded information about people's care in advance of them delivering the care. Staff had recorded the person had been transferred to the lounge at 12.00. However, the person was still in their room at 12.30 receiving personal care. Records

Is the service responsive?

being written in advance was also brought to the attention of a senior manager by visiting safeguarding nurses. They confirmed they had investigated these concerns and found staff reported they had done so, when they were short staffed.

This is a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We asked visiting relatives about raising concerns and complaints with the provider. Four visitors said they would be happy to raise concerns with senior staff and were confident they would be dealt with. Their comments included, "I would tell the deputy manager" another said, "Sometimes (the person's) finger nails are dirty…and they are addressed".

We asked to see the complaints log, the last entry was on 8 January 2015 regarding an environmental concern, which had been responded to. Prior to that, the last recorded complaint entry was August 2014, which was appropriately dealt with. However, from speaking to one person's relative and looking at their care records, we found there had been another complaint in December 2014.The complaint raised concerns about staff ensuring the person's hygiene and dignity needs were met and about missing possessions. Each week the manager in charge at the home sent a report to the provider. On 11 December 2014 the weekly report showed another complaint had been received about the kitchen not dating food. This showed the complaint log could not be relied upon as an accurate record of all verbal and written complaints received. This meant we could not be reassured the home had effective arrangements to listen to people's concerns or had acted on all information received.

This is a breach 19 of Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

On 05 February 2015, the remaining people moved out of Angela Court to other homes. Since then we have received feedback via the local authority safeguarding team which showed important information about some people's care and treatment needs and risks was not shared with the new service. For example, information about a person who had been assessed by a speech and language therapist as at risk of choking. This meant people were at increased risk of unsafe care following transfer.

This is a breach 24 of Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

An activities co-ordinator had recently been recruited, following a previous gap in this provision. They showed us the new activities program. This included visits by a donkey, a dog and musical entertainment, arts and crafts, and jigsaw puzzles. We saw photographs of people involved in the home's Christmas party on the notice board. During our visits people were in the communal areas but there was little stimulation or activity apart from the television, music player and a few magazines on the table. We found activities were provided mostly on a group basis or to divert people when they were becoming distressed or exhibiting signs of challenging behaviour. This meant the activities provided were not based on supporting people to maintain their individual interests and hobbies. Some people, particularly people who did not use the main communal areas at the home, were at risk of social isolation and loneliness. One relative was worried about isolation as the person was spending a lot of time in their room. They said, "I don't think it's good for him, he has nothing to stimulate him".

Staff did not empower people to make day to day choices. For example, at lunchtime on 26 January 2015 people were asked if they wanted tea or coffee. The staff member did not wait for a response and gave each person the drink they felt was appropriate. Staff completed a menu sheet indicating each person's preferences. When we asked how they know people's choices, they said "We know what they like". People were not guided by a visual aid to help them choose their meal except for a small blackboard on which staff recorded the meal choices, which were difficult to read.

Inadequate

Is the service well-led?

Our findings

There was no registered manager in place during this inspection, the previous registered manager was on sick leave since August 2014 and subsequently deregistered. Since then, there have been a series of interim arrangements, with PSP senior managers and managers from other homes within the group helping. This had resulted in frequent changes of leadership at the home over the previous months. During this inspection, we met four different managers at the home. A deputy manager started their post during in December 2014 and a new manager started on 05 January 2015.

The day to day nursing leadership arrangements did not ensure the staff team were adequately led and supervised or that risks were identified, prioritised and escalated for urgent attention. We visited the home on six occasions, between 17 December 2014 and 1 February 2015. During those visits the atmosphere varied from calm and well organised to confused and chaotic. Several health and social care professionals also described day to day leadership at the home as "chaotic". One said, "There seems to be a lack of leadership, our overall impression is that of chaos". We witnessed disagreements and conflict within the nursing and care team about people's care needs which had an adverse impact on their care.

During the Christmas period, the senior manager was on leave and we found the improved systems introduced for communicating people's care needs and the improved documentation systems introduced were not maintained, which put people at increased risk. The changes in leadership during December 2014 and January 2015 with each manager introducing new systems, meant changes were often poorly communicated and understood by staff.

Most but not all staff were positive about the appointment of a deputy manager, and a new manager and about having a senior manager on site during December 2014. One staff member said, "I don't know who is here from one day to the next, it's all over the place." Another said, "No one listens, there is no point", a third said, "I want to be here but there comes a point when enough is enough, I'm feeling a bit like that at the moment". Some staff said they felt things were improving. Relatives also spoke positively about the changes, one said, "Staff are more into the residents, people are not ignored, and that's a big improvement". However, one relative said, "I still don't think it's still working well". The new manager, speaking about the previous difficulties experienced at the home said, "This has gone on too long, it's stopping".

During the inspection we witnessed disagreements between nursing and care staff in front of people. At a safeguarding meeting on 17 November 2014, the ongoing tension between two nurses was discussed with the provider's nominated individual and actions were agreed to address this and confirmed in an e mail on 24 November 2014. However, we did not see any evidence the agreements made in relation to this were followed.

The provider had a range of quality monitoring systems in the home. Some of these had lapsed since the registered manager had left in August 2014 and others were ineffective. For example, when we visited on 22 December 2014, we found that some of the environmental quality monitoring systems in the home had lapsed since July 2014. These included regular health and safety and maintenance checks and the testing of water temperatures. This meant they were not identifying and addressing the serious risks for people.

Where issues were known, these had not been dealt with in a timely way. For example, staff said they had been reporting problems with hot water since November 2014 and minutes of the residents and relatives that month confirmed this. Weekly reports to the provider through the period identified concerns about staff, environmental risks, individual risks for people such as related to falls and challenging behaviours. The lack of prompt and decisive action meant people were at risk because insufficient actions had been taken to reduce those risks.

On 19 January 2015, we asked the provider for additional information about the quality monitoring visits to the home. On the 21 January 2015, they sent us the dates of 10 visits made to the home over the previous three months by the nominated individual. The provider said these visits were undertaken to follow up and update the on-going safeguarding action plan, and to meet with contractors regarding the upgrade to the hot water and central heating systems. However, there were no written reports about these visits, which meant it was not possible to evaluate what actions were taken as a result of each visit.

At a multi-agency meeting on the 16 January 2015, a representative of the provider acknowledged the quality

assurance systems in place at the home had failed. They reported, PSP Health Care Limited would undertake a review of their quality assurance arrangements to understand how the system had failed and to ensure lessons were learnt.

Through the period of the inspection, the provider told us they were reviewing and improving the staff communication and handover systems. However, in the two week holiday period over Christmas, these systems were not reviewed and updated. On 11 January 2015, at 6.17, when inspectors visited, there were four agency staff on night duty. We spoke with the agency nurse and asked them about the information they received at handover. The document they showed us did not include the detailed information about people's needs we had previously seen in use at the home about key risks for each person. This meant the agency nurse on duty did not have up to date, detailed information about people's care needs. On 15 January 2015, as part of an improvement action plan the provider sent to CQC, they outlined new systems for communicating people's needs and risks between staff. However, when we visited on 1 February 2015, the nurse in charge did not know about this and was not able to show it to us. This meant the improved systems were not understood and being used.

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

We asked to see copies of key policies. These included PSP Healthcare Limited policies on restraint, managing challenging behaviour, disciplinary and capability. When we looked at these, we found they were very out of date, most were last reviewed in 2008/2009 and were overdue for updating. We discussed this with the quality and compliance manager who told us they had not been able to update these because of other work pressures but planned to do so. Each time we visited the home, we found the policies and procedures were not readily available to staff. This was because they were stored in an office only accessible to managers. This meant staff were not able to access or use these policies and procedures to inform their decision making.

There was an accident /incident reporting system in place at the home. The database only included a list of accidents/incidents reported until the 5 January 2015. For example, the reports completed about the night of 3 and 4 January 2015 about people being found soaked in urine, the home being cold and about food, fluid and safety checks not being completed were not on the database. This meant there were incidents reports missing from the database. We looked at the most recent three months of reports on the accident/incident database for the home. We found the monthly commentary about the analysis of trends and any actions taken was last completed in June 2014, six months previously. This demonstrated the process in place for escalating risks about accidents and incidents within PSP Healthcare Limited was ineffective and serious risks were not managed effectively.

The systems in place for assessing training needs of staff were inadequate. This was because the level of training provided was not sufficient to manage people's individual needs and risks. Also, because no action was being taken to address poor compliance of the training provided. Recent decisions about improving staff training were made in response to feedback from visiting professionals and from the CQC inspection, rather than in response to an analysis of the training needed.

The provider is required by law to notify the Care Quality Commission of significant events such as deaths, and any allegations or instances of abuse. We identified several notifiable incidents which should have been reported to us and were not, which we requested the provider to notify us of retrospectively. These have now been received but further gaps remain. This suggested the provider did not have systems in place for identifying when notifiable incidents had occurred, or for ensuring the necessary notifications were notified.

Many people at the home could not use a call bell because of cognitive difficulties due to their dementia. Some people had pressure mats, which alerted staff when the person moves in their room by triggering the call bell system. We noted call bell response times during our visits varied between two and ten minutes. One person said, "If I press that bell, if they are in a good mood, they come. If not, they don't, I might wait 20 minutes". When we asked for further information about call bell response times, and none was available. This was because the call bell system in place had no facility to monitor the response times and they were not monitored in any other way.

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 **People who use services were at risk because there were not enough qualified, skilled and experienced staff to meet people's needs. This meant people were not receiving the support and help they needed to maintain their health, safety and welfare.** **This is a breach of regulation 22**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **Appropriate checks were not always undertaken before agency and other contractor staff began work, which had the potential to put people at risk from unsuitable staff.** **This is a breach of regulation 21(b).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **People who used the service were not protected from the risk of abuse because the provider had not taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.** **This is a breach of regulation 11 (1)(a)(b).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services

This section is primarily information for the provider

Action we have told the provider to take

Treatment of disease, disorder or injury	People did not always experience care, treatment and support that met their needs and protected their rights. This was because people were not adequately supervised and supported which meant their safety and welfare was at risk. This is a breach of regulation 9 (1)(a)(b)(i)(ii)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control People who used the service were not protected by appropriate standards of cleanliness and hygiene. This is a breach of regulation 12 (2)(i)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises People who used the service and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance and operation of the premises. This is a breach of regulation 15 (1)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment People were not always protected by suitable arrangements to ensure equipment was properly maintained, suitable for its purpose and used correctly. This is a breach of Regulation 16 (1)(a)(b)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care 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 safely.** This is a breach of regulation 13.

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 **People were not consistently cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.** This is a breach of regulation 23 (1)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **People were not protected from the risks of inadequate nutrition and hydration.** This is a breach of regulation 14 (1)(a)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **People who use services and others could not be confident that important events that affected their welfare, health and safety were reported to the Care Quality Commission in a timely way, so that, where needed action could be taken.** This is a breach of regulation 18 (1)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **Where people did not have the capacity to consent, the provider had not acted in accordance with legal requirements.** This is a breach of regulation 18

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **People were not always treated with dignity and respect.** This is a breach of regulation 17 (1)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate care records were not always being maintained. This meant they could not be relied upon as an accurate record of care and showed gaps in care. These gaps in record keeping meant some people were at increased risk of malnutrition and dehydration, falls, pressure ulcers, and medication errors.** This is a breach of regulation of 20 (1)(a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints **The provider did not have an effective system in place to deal with complaints appropriately.** This is a breach of regulation 19 (1)(2)(b)(c)(d)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 24 HSCA 2008 (Regulated Activities) Regulations 2010 Cooperating with other providers **The provider did not have safe systems in place to appropriately share information to protect people's health, welfare and safety when they transferred to a new provider.** This is a breach of regulation 24 (1)(a)(b)(1)(2)
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 provision **People were at risk because the quality monitoring arrangements in place were not effective. Although the provider had a range of systems in place to assess and monitor the quality of service, these were not completed consistently. Also, because the systems used did not identify the risks, failures in care, low staffing levels, equipment and poor documentation we found during the inspection.** This is a breach of regulation 10 (1)(a)(b)(2)(b)(i)(iii)(c)(i).