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Cherry Acre Residential Home

Inspection report

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Ratings

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

Overall summary

This inspection was unannounced. It took place on 4 December 2014, 12 and 13 December 2014 and 16 December 2014. At the last inspection in June 2014 the care home was compliant with the regulations we inspected.

Cherry Acre provides accommodation and personal care for up to 17 older people with a wide range of care needs. Some were living with dementia, mental health illness or displayed behaviours that might cause harm to themselves or others. Many people had mobility problems and others were fully mobile. There were 16 people living in the home when we inspected.

At the time of our inspection there had not been a registered manager employed at the service since 24 January 2011. A registered manager is a person who has registered with the Care Quality Commission to manage

Summary of findings

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. The provider had appointed a manager who had been in post but was not registered with CQC. This meant CQC had not had the opportunity to assess this person's suitability and competence to manage the service.

People's safety was being compromised in a number of areas. The arrangements that were in place to safeguard people from the risk of abuse were not adequate as incidents which should have been reported to the local authority and CQC had not been. The management of risks relating to people's health, safety and well-being were inadequate. This put people at risk of serious harm.

People who displayed behaviours which were challenging and a risk to others had not been assessed. People did not have risk assessments or care plans in place to ensure they were adequately supported. This put them, and other people in the home at risk of harm, and people had been assaulted a number of times. The provider had not taken any action to ensure people were cared for and supported properly, and had not taken any action to ensure people were not harmed.

The provider did not have a system to assess the number of staff needed and there were not enough staff at all times to meet people's needs. The provider did not ensure that staff hours were replaced when staff were absent. For example by using agency staff. This often left even fewer staff in the home to provide care to people. The deployment of staff in the home was not based on what individual people needed. This meant that staff time was not directed towards the people at the times they needed care. For example, staff were not there to ensure people who may fall when they walked were safe or available to intervene before people who might harm themselves or others hit out.

Not all staff had received necessary training and some training was out of date. There were no systems in place identify if staff had the right skills to carry out their roles or to check they had learnt from the training they had received. The provider relied heavily on staff doing their best for people, rather than providing them with the training they needed. The training staff received was poor. They were expected to learn from watching a short film on the internet and complete basic questions. However, the training did not reflect the level of skills the staff needed to care for people well. Staff had not received practical training in subjects like moving and handling people. This put people at risk of accident or injury and pulled down the quality of the care staff provided.

Care plans lacked Information about people's health and care needs. They were not sufficient to enable staff to plan people's care, manage risk and respond to people's needs. When people's needs changed, for example if their dementia became progressively worse, their care was not reviewed to ensure staff could meet their current needs. Referrals were made to outside community services, like mental health nursing teams, but they were not followed up with any urgency.

Restrictions imposed on people did not consider their ability to make individual decisions for themselves as required under the Mental Capacity Act (2005) Code of Practice. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The manager and provider did not understand when an application should be made and they were not aware of a recent Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty. Unlawful restraint had been used within the home to control people's behaviours.

Staff we observed during the inspection had a caring approach, but they lacked the skills and knowledge to recognise the culture in the home had become uncaring. There were people in the home who were frightened to leave their bedrooms, they had become isolated but staff failed to recognise this.

Staff had a knowledge of people's likes and dislikes and people spoke positively about the staff. One person said, "They (staff) will do anything for you, you just have to ask". However, a lot of staff time was taken up because they were reacting to incidents in the home which meant they did not have time to respond to people's needs.

We found that medicines were not being administered in a timely way. There was a procedure in place for the administration of medicines. Staff followed this, ensuring that medicines were ordered, administered stored and deposed of safely.

Summary of findings

The provider did not carry out audits to check the quality of care people received. The manager carried out some audits, but these were not used to drive improvement. There was no structure in place to ensure the provider looked at practice and improve standards of care being received by people. Opportunities to discuss issues relating to the home and identify areas of improvement or development were not available for people or staff.

People felt they got enough to eat and drink, they had access to fruit and snacks. When we observed lunch, people were encouraged to eat and drink and staff assisted those who needed support. People could help themselves to drinks and snacks in the kitchen if they wanted to. For people who were at risk of malnutrition and dehydration there were no systems in place to ensure these risks were addressed.

Managers in the home followed robust staff recruitment practices, checking that people applying to work at the home were suitable.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we have taken at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People in the home had not been protected from physical and emotional harm. Risks were not properly assessed and managed to keep people safe. People were not protected from recurring injury or accidents as no lessons had been learnt.

The provider had not reported abuse when it occurred. Staff told us they knew how to recognise abuse, but we observed that they had not recognised abuse when it happened.

The provider did not have adequate systems to assess the staffing levels required to meet people's needs safely. There were not enough staff available to meet people's assessed needs and manage the risks to people to protect them from harm. Medicines were not always administered at the correct times as there was a lack of staff.

Is the service effective?

Inadequate

The service was not effective.

Care plans lacked detail about how people's needs should be met. Staff were not consistently following people's care plans especially when they used equipment. Restraint was being used within the home unlawfully.

The training available for staff was not well planned and did not equip staff with the skills they needed to provide care for people. Staff did not have sufficient know how to respond appropriately to people when they became aggressive or violent.

People's capacity to make their own decisions had not been assessed. People were subject to restrictions and decisions had been made without staff implementing the best interest decision process nor had a Deprivation of Liberty Safeguard application been made.

Is the service caring?

Inadequate

The service was not caring.

Although staff were friendly and relaxed with people they did not have time to spend with people. When abuse occurred between people, staff did not spend any time listening and reassuring people who had been harmed.

Privacy and dignity was not upheld by the provider as people in the home could not stop others from entering their bedrooms. Their personal belongings were often damaged by other people as they could not keep them secure.

Staff in the home did not understand how to care for people living with dementia. People or their relatives were not always involved in decisions about their care and treatment.

Is the service responsive?

Inadequate

The service was not responsive.

Summary of findings

People's needs were not re-assessed by staff to ensure they received care that was up to date. When people's needs changed or following an incident, care plans did not clearly show how staff had responded by making adjustments to the way they delivered people's care.

When people needed support from other professionals such as mental health nurses, staff did not respond with any urgency so people's behaviours became progressively worse.

Complaints were recorded and had been responded to in writing. However, there was a lack of willingness by the provider to resolve complaints in a timely manner to prevent the situation getting worse.

Is the service well-led?

Inadequate

The service was not well led.

The provider did not have systems in place to monitor risks to people or to monitor the quality of care people received.

The provider actively encouraged staff not to report issues of poor practise outside of the home and staff had become dependent on this culture.

People and their visitors were not regularly asked for their views about their experiences of the home.

Cherry Acre Residential Home

Detailed findings

Background to this inspection

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

This inspection took place on 4 December 2014 and was unannounced. Furthers visits took place on 12, 13 and 16 December 2014. The inspection team consisted of two inspectors and an inspection manager.

This inspection was carried out in response to concerns raised; therefore before the inspection the provider had not completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Prior to the inspection we looked at previous inspection reports and any notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law. We also exchanged information with the local safeguarding team and commissioners. Following the inspection we looked at information the provider sent to us, such as the provider's policies on employing staff.

On the day we visited we spoke with five people who lived at the home, two night staff, the head of care, six care staff and two relatives. We looked at five people's care plan files and five files that related to staff recruitment, training and supervision. We talked with people, their relatives and staff. We talked with the home manager and the owner (provider) of the home.

We observed daily life within the home including the care being delivered. We spent time looking at records, we looked for the systems that were in place to monitor the safety and quality of the care provided. We also looked around the home, including three bedrooms, two bathrooms, the kitchen and communal areas and the outside spaces available to people.

We looked at the provider's policies and procedures, complaints records and quality auditing systems. We inspected the health and safety systems within the home and we observed staffs health and safety practice. For example how staff carried out moving and handling safely. We checked records such as for clinical waste disposal, fire procedures and legionella risk management. We also looked at what information the provider gave to people about the home in the statement of purpose.

Inadequate

Is the service safe?

Our findings

People told us they did not feel safe. Two people told us about incidents when they had woken at night and found other people in their bedroom. They told us they felt frightened by this. Another person said they preferred not to come out of their bedroom because other people shouted, swore and were frightening.

A person visiting the home told us that they were worried about what effect it was having on people when there were people in the home who might harm themselves or others. They said, "Some of the people can be frightening". People in the home were not sure how to protect themselves, some had taken to their bedrooms, but they were still at risk as they could not secure their bedroom doors. The provider had not sought to ask people about how they felt after experiencing harm nor had they supported people to understand how to avoid harm as they did not feel safe. There were no records of people being supported after they had been assaulted by other people.

People relied on staff and on the provider to keep them safe from harm; this had not happened. People had not been protected from abuse. There were serious failures to respond to allegations of abuse or to take steps to prevent abuse from occurring. Between 17 September 2014 and 1 December 2014 there had been sixteen recorded incidents of abuse in which people were harmed by other people living at the home. This included people being hit or punched in the face and arms or being kicked. Hot tea had been thrown over people and there were instances where people had been harmed when they had been held tightly by the head or hands. Despite all of these incidents the manager had not re looked at the risk assessments in the home or learnt from what had happened to prevent further occurrences. This practice had placed people at risk of continuing harm and injury.

There had been a systemic failure by the provider and the manager of the home to ensure that incidents involving acts of abuse or neglect were reported to the local authority or to us so that they could be investigated and steps taken to prevent abuse. It was concerning to us that the provider did not recognise that abuse and neglect had been occurring. They told us that they had chosen not to report abuse because they did not feel it was that important. The provider had a policy for staff to follow if they had concerns about people's safety and welfare but this had not been followed by staff. Staff described what action they would take if they suspected abuse was occurring. However, staff did not recognise it was taking place in the home. They did not understand that they could have taken action to prevent the abuse by speaking to the local authority or to us. The omission to report these incidents for investigation had exposed people to prolonged harm and suffering.

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

The manager and staff told us that at times there were not enough staff to meet people's needs. Staff told us that they had raised their concerns about this to the managers in the home continually since August 2014. The manager confirmed to us that low staffing levels often meant that people did not receive care when they needed it in areas such as helping people to wash and dress and keeping people safe when they wanted to walk. No assessment tool was in place or used to calculate how many staff were needed on each shift. Some people had dependency assessments which gave an indication of the levels of care and support they would need. However, these assessments were not accurate or up to date. For example, information about how much staff time was required for people who were challenging to others had not been recorded on their assessments. We checked the rota to see if additional staff had been identified to support people at higher risk of hitting out at other people, but this had not happened. Therefore people's needs were not linked to the amount of staff in the home, this prevented staff from keeping people safe and meeting their needs.

Some people needed a lot of staff time because they were cared for in bed. However, although their assessments indicated which people needed more staff time, it did not bring about any changes in the numbers of staff available to care for people. Other people were receiving end of life care. The staff rota took no account of the levels of care people needed, such as two to one staffing to support people to move around the home and keep them free from harm.

At key times in the early evenings there were only two staff available. This meant that staff could not be available when they were needed. For example, staff were not available to intervene before people were harmed by others or to observe people who were at risks of falls. We noted that incidents of aggression and violence had occurred between

Is the service safe?

6 pm and 8 pm when there were only two staff available. We asked the manager why the staffing numbers had not been maintained. The manager told us that the provider would not agree to cover staff absences sick days and annual leave.

Five people required two staff to support them with personal care due to their physical disability. They needed help to eat and drink, take medicines and with washing and dressing. Staff told us that it took two of them a minimum of fifteen minutes to carry out tasks such as helping someone to wash and dress. When there were only two staff people would be left to wait until staff had finished what they were doing. For example in a four week period there were seven occasions where only two care workers were on shift. Even with the normal number of staff available they could only react to incidents after they occurred rather than preventing them from happening. On the day of our inspection we observed a person who required staff to be with them because of their behaviours was not supported and was in the lounge with other people. This meant that people were at risk of being harmed.

Managers in the home acknowledged that the staff rota was not always planned to meet people's needs. When asked why there were times when there were only two staff on shift the managers said, "It would be difficult for the provider to agree to pay for extra staff". Not providing staff based on peoples assed levels of need resulted in some people not receiving the care they needed, or being at risk of harm. The skills mix of staff available to people was not constant with their needs. Three staff from a team of 16 had been trained to respond when people became aggressive to others. Without the appropriate staff available, people were not safe.

This is a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There had not been any learning from incidents and accidents. Staff had used forms to record what happened before and after incidents but they had not identified any significant trends or patterns. For example, an incident had occurred on 5 November 2014. The record of this stated that a person had been upsetting other people in the lounge by taking their personal possessions. It went on to say that for no apparent reason the same person had hit another person who was sleeping in a chair. The same thing happened on 17 November 2014. The same person had been involved in eight similar incidents in which they had caused distress to other people. Staff had recorded this and the manager, deputy manager or head of care had looked at what had happened. No action had been taken to prevent the incidents from continuing. The lack of understanding about the impact this would have on others demonstrated risks were not reviewed.

In one case the manager had made a referral to the local mental health team, but they had not thought to take some action to reduce the risk of incidents reoccurring whilst they waited for an assessment by a mental health nurse. Urgent action would have helped reduce incidents, protect people from harm and so reduce their fear and anxiety.

Throughout the home there were small corridors leading to peoples bedrooms and the communal spaces were cramped by furniture. This created situations where people could not avoid risks as they had nowhere to retreat to. The manager had not considered the risks posed to people by the environment they were living in. Had they done this, changes could have been made to the layout of the communal areas to reduce the number of incidents happening to people.

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

When people moved into the home the manager carried out an assessment of their needs which included considering any risks there may be from providing care, such as if they may be prone to falls. However, we found that these risks assessments were not based on a person's individual needs. For example, the same information was recorded on peoples risk assessment even though it was clear that some people were at more risk of falls than others. We compared a falls risk assessment for one person against what had actually been happening. They had had seven falls between 26 September 2014 and 26 November 2014. Their risks assessment did not reflect this and as a consequence they continued to have falls and had injuries that could have been avoided.

People in the home who might harm themselves or others were left unprotected by the failures of the provider to assess the risk posed to others. Risk assessments had not taken account of people's behaviours or how these could be minimised. For example, on a document called 'General risks assessment' dated 31 May 2014 a short statement saying that a person had been using their walking stick as a

weapon had been recorded. The risks from this to other people had not been considered. Even though it had been recorded as a high risk under the heading 'severity' no action had been taken to reduce the risk. The risk assessment stated under the heading 'Action taken to reduce risk' that staff needed to document what happened after the person had used their walking stick as a weapon. No guidelines were developed for staff to follow to prevent people from harming themselves or others. People were left un protected through inadequate risk assessment.

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

There was a policy in place for the administration of medicines and staff were aware of its contents. We observed that staff followed the policy, ensuring that medicines were dispensed to one person at a time. Staff told us that they were assessed prior to being allowed to administer medicines. We saw records of these assessments in the staff files that we reviewed.

Medicine records were identified by people's picture which ensured that the correct person had received the medicine.

Notes were made on medicine administration records of any reasons for medicine changes. However, people were not always receiving their medicines in a timely manner. Staff told us that the designated members of staff administering medicines were often interrupted. They told us it was difficult when two staff were administering medicines as they were called away to deal with incidents or to provide care and support. This often caused the medicine administration to be delayed. One member of staff said, "The evening medicine round is worst as we need another member of staff". Medicines were not administered at the prescribed times, this may have affected people's health and wellbeing and reduced the effect the medicines had on people's condition or illness. A notice displayed informing people that staff should not be disturbed while administering medicines was ignored because there were not enough staff available. During our inspection we observed that the staff member who was giving out medicines was interrupted several times by people requiring care. This created a risk that errors could occur in the administration of medicines.

The risks posed by fire had been assessed by an external company specialising in risk assessments for business and care homes. If the home had to be evacuated there were procedures in place that dealt with these emergencies so that people's care could continue in other places. We found recorded evidence that evacuation drills were practiced and records of regular fire system servicing. We noted that any faults of the system were repaired promptly by an electrician. The fire system had been tested in November 2014 and the manager of the home had developed personal evacuation plans (PEEP's) for people that enabled their safe evacuation in the event of a fire. These plans considered peoples abilities to leave the home and any disabilities people may have that required them to have assistance from staff to leave.

There was a recruitment policy that had been followed by managers. Staff had completed applications for their jobs and been interviewed for roles within the home. Staff had evidenced their fitness to carry out the work through health questionnaires; there was proof of identity, written references, and confirmation of previous training and qualifications. The home manager had made checks to ensure that people were eligible to work in the UK. Staff had been checked against the Disclosure and Barring Records (DBS). This gave people reassurance that staff were suitable to work with adults at risks.

Inadequate

Is the service effective?

Our findings

Staff were not able to demonstrate that they provided effective care. Although staff told us they had received training, they also told us that they were concerned about the quality and relevance of the training they had received.

There was a lack of an effective training plan which gave staff the skills to meet people's needs and keep up to date with social care practice. The training plan provided to us by the manager did not give any indication of when staff were being booked on training and there were gaps for some staff in key training areas. For example, two members of staff had not received health and safety training. Staff who had started working at the service in February 2013 had not completed their moving and handling training until seven months after they started at the home and their health and safety training had not been undertaken until 12 months after they started working at the home.

One member of staff who started working at the home in October 2014 had training dates on the training plan from 2011. They told us that they had previously worked in services that delivered care to people living in their own homes. It was important that their training in key areas such as fire awareness, moving and handling and health and safety was updated so that it related to the people they were now working with and reflect that they were working in a different social care environment.

Staff had only received basic on line desk based training. This did not provide them with the skills they needed to provide care. For example the moving and handling on line training course content made it clear that staff should receive practical hands on training in addition to the on line awareness course. Health and Safety Executive guidance makes it clear that it is important care home staff receive practical training on any equipment used, like hoist and handling belts. This helps to prevent injury to people and staff. Staff had not received this specialist training.

The lack of practical training for staff had a negative impact on how they carried out care tasks. Staff were required to move people when they could not stand or walk unaided. In these situations staff needed to use equipment that if used incorrectly put people and staff at risk of injury. We observed two staff using a handling belt to help someone stand. One member of staff had put one of their feet onto a walking frame to steady it. This created a situation where the member of staff did not have a firm base prior to the person standing up, which could have put people at risk of falling over. Had staff been trained properly to move people safely they would have understood their actions may lead to people being hurt.

Staff had not been provided with information about best practice or guidance so that they could meet people's needs safely. People lived in the home who might harm themselves or others. However, we found that only three staff working at the home had received up to date training so that they could help people manage their behaviours. This left most of the staff team unable to deal with the behaviours they faced when providing care. Staff needed more knowledge and experience of delivering care to people who could become aggressive towards them or others in the home. Staff were not aware of the correct way to approach people or of how to respond to calm people down when they become challenging towards them or to other people in the home. This led to people in the home and staff being injured as they could not deliver care in a way that met people's needs.

We found and staff told us that they were not trained to understand the needs of people with behaviours that were challenging to others as they were living with dementia. Had staff been trained in caring for people living with dementia, this may have calmed people. However, only two staff were up to date with their training in dementia care. Therefore, staff could not support people effectively, especially when they were presented with situations when people needed to feel safe and calm. Staff did not know how to promote people's welfare. The provider did not understand that caring for people living with dementia required staff to have a specialist knowledge and awareness to meet their needs. This was reinforced by the manager who told us that the provider was telling people that the home caters for elderly people who are living with dementia. The manager said, "I keep having to tell people we are not (Staff) trained for dementia, but the provider wants the money from the beds".

Four staff from a staff team of 14 had received first aid training. More staff needed to be trained in first aid because people in the home needed staff available who would provide first aid to them in an emergency. There had been instances where people had cuts after falling. There were

periods on the rota where there were no first aid trained staff available. The risk that people would not receive effective treatment was increased at night because there were no night staff trained to administer first aid.

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

The manager of the home had been asked by the provider not to take account of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). We observed that three people living with dementia at the home needed to be assessed for their ability to make certain decisions about their lives, their health and their wellbeing. Where people lacked the ability to make certain decisions, staff should have been following the principals of the MCA so that any decisions made had been taken in people's best interest. For example, when people needed treatment in hospital.

People living at the home needed to be protected from unlawful deprivations of their liberty. The manager was not aware of how to submit DoLS applications to the local authority so that a decision could be made as to whether a restriction was required or that the least restrictive option was being used. The recording of restraint was not monitored and no attempts were made to minimise the need for it to be used. Records showed that restraint had been used by staff to control people's behaviour. This had been practiced without the person's rights being considered under the deprivation of liberty safeguards, (DoLS).

The provider and staff did not understand the difference between lawful and unlawful restraint. Staff at the home had been told by the provider that they could restrain people and this was recorded in the provider's statement of purpose. However, the provider had not given staff training about what was lawful restraint and had not sought to satisfy themselves that any restraint that took place in their home was lawful. For example, staff had used a wheelchair to restrain a person by strapping them into it and removing them from the communal area of the home. Other people had been restrained by the arms to stop them hitting out at people or to move them out of a room. There were no records to show that the use of restraint had been assessed to prevent people from being harmed by the actions of staff. Restraint practiced by untrained staff was potentially dangerous and without DoLS agreement this was unlawful.

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

People who had been identified as at risks from dehydration and poor nutrition had been weighed regularly. For one person this monitoring had indicated they had been losing weight. A nutritional assessment had been carried out and a referral had been made to a dietician. Staff had followed the recommended course of action and the person had subsequently gained weight. However, we found other instances when people were at end of life that their nutrition and hydration was not being monitored. For example, the deputy manager of the home told us that one person on end of life care was at high risk of dehydration and malnutrition and that their food and fluid intake was being monitored. However when we asked to see the monitoring charts these could not be found. We asked the provider to send us copies of the monitoring charts for this person, but these had not been completed. This left people at risk of poor care which could seriously affect their health and welfare.

People were at risk of receiving unsafe care because staff were not provided with best practice guidance to follow. For example when people had falls that resulted in a head injury or any suspected injury to limbs or bones treatment was not being sought without delay from a doctor or paramedic. In one case, the manager had identified a person at high risk of falls but they had not provided them with a falls care plan. Had this been in place staff would have understood what they needed to do after the person fell.

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

Food and drinks were available at any time of the day or night and drinks and biscuits were being served to the few people who were up when we arrived for the inspection at 06:45 am. Staff told us that some people were awake all night and that they were provided with snack foods and drinks. One person said, "You are given a choice of food before they cook it." People told us that they enjoyed the food that was offered to them. Another person said, "The food is good most of the time."

Inadequate

Is the service effective?

We observed the lunch service in the home. Some people told staff that they were not hungry when lunch was served. Staff offered to save meals for these people to eat later. We saw staff encouraging people to eat and they assisted those who needed help.

Relatives were 'more than happy' with the access people had to a doctor, both if they felt it was needed and (more often) when the staff had made a referral. They commented positively on how quickly they were informed of the outcome and of any subsequent changes. One said, "They called me straight away to say that they were giving antibiotics as a precaution". Another relative was pleased that the doctor, "Talked to me, as well as the staff." However, we found that after people had been hit by others, staff did not always seek medical advice and people were often checked over by staff in the home that were not medically trained. This left people with possible untreated injuries.

Staff told us that they received an induction when they started working at the home. We found induction checklists were completed with staff by the manager. These checklists made sure the induction was fully covered and signed off by the manager. Staff met with the manager to discuss their performance at work. We saw that these meetings were recorded in staff files and that discussions included matters such as training, the care of people who used the service, and relationships with other staff members. The staff we spoke to told us that they had met with managers often.

Staff had attended group team meetings and felt they were encouraged to discuss issues they had about their work. Meetings with staff were recorded so that people could check what was required of them. However, we found that the provider did not arrange appropriate training for staff or enable the manager to do this.

There was a communication diary used by staff to communicate information regarding people and entries seen included dates. Care records showed people received visits from a range of healthcare professionals such as GPs, district nurses, chiropodists and opticians. When staff started their shift they were provided with a handover by staff finishing their shift. Each person in the home was discussed at the handover. This gave staff coming on shift up to date information about the care people had received.

Inadequate

Is the service caring?

Our findings

One person said "There is not much to moan about"; another said "The staff are very nice". Others said "The staff are very good". Care staff made every effort to sit beside people in the lounge and chatted to people when time allowed. People who were able to remained independent. One person was making their own drink in the kitchen. They said "I am quite happy and well cared for".

Staff told us they felt confident that they understood how to care for people living with dementia. However, care being delivered to people living with dementia was not caring because staff did not recognise people's needs. For example, staff could not rely on information they read in care plans because it did not provide them with in depth explanations about each person's dementia care. Staff were reactive to behaviours rather than presenting a proactive approach to people with dementia. Staff were keen to remove people with from the area if they became upset, rather than calm them. Staff did not engage with people to prevent them from becoming unsettled which led to problems happening between people. The Department of Health and Alzheimer's society publishes guidance on supporting people living with dementia. Such as Quality Outcomes for Service users with Dementia; Building on the work of the National Dementia Strategy, published September 2010 and the associated published guidance as appropriate. However, information about people did not reflect published guidance.

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

Staff attention and time was focused on dealing with people who were hitting out at others. They did not recognise that other people who may have witnessed aggression or those who had been on the receiving end of aggressive behaviour needed reassurance, care and support. Some people we talked with told us they were happy living in the home. Others had become isolated and afraid.

For people living with dementia it's important that they can find locations in the home such as toilets because they cannot always find their way around, even if the home was familiar to them. Instances of urination in other places indicated that some people had been looking for the toilet. Better information could have been provided in the home through signage to assist people to find the facilities they were looking for or staff could have been more attentive when people moved around the home looking for a toilet.

People's privacy and dignity was not always respected. Some people who lived in the home had accessed other people's bedrooms. In some cases people had experienced others urinating on their personal clothing in bedroom drawers and wiping excrement on surfaces in their bedrooms. This would have been very distressing and emotionally disturbing for the people involved. However, the provider had not discussed these issues with relatives or the people affected. There was a lack of care shown by the provider about people's wellbeing.

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

Some care plans contained information about people's personal histories. Others were still under development. Information had been provided by family members for people who were unable to tell the manager about their needs and aspirations. We found that the manager was introducing pictorial care plans, but these had not been fully implemented. These would help people to better understand the care being provided. For one person living with dementia a facial expression pain chart was being used to assist staff to understand the person's needs. Facial expression can indicted the intensity of pain, with research about this published by the National Institute For Health And Care Excellence.

People were able to move around the home freely and at times we observed staff chatting to people. One person became annoyed with staff when they came to offer them some support. We noted that staff remained calm and continued to reassure and talk to the person calmly. This resulted in the person calming down and agreeing to the care staff were offering.

Staff felt they were doing their best. We observed that they were very friendly towards people. When they provided care they were patient with people, allowing them to walk at their own pace. Staff knew people well and showed a good understanding of their general needs. For example they described a person's likes and dislikes to us, and told us about people's medical needs including upcoming appointments and tests.

Inadequate

Is the service responsive?

Our findings

People had care plans that included initial assessments of their needs and information about who the person was, life histories and their likes and dislikes. However, the care planning processes being used were not flexible and the same information was contained in different people's care plans. This gave the impression that people were not being treated as individuals and did not recognise that people would need staff to approach their needs individually.

Staff told us that they did not know what to do when people hit out at others and that they did not know how to prevent assaults from happening. Staff told us they were unable to keep people or themselves safe from physical harm.

For people living with dementia it was important that their care plans were based on best practice guidance that would enable them to maintain a quality of life set against their individual preferences. The Department of Health publishes guidance such as Quality Outcomes for Service users with Demetria; Building on the work of the National Dementia Strategy, published September 2010 and the associated published guidance as appropriate. We found that the care planned for two people living with dementia did not follow any recognised guidance and put them at risk because their needs were not met. For example, information about one person told staff that the person liked to 'clean and tidy'. We saw that on more than one occasion this person had become involved in violent and aggressive behaviours towards others because they had been attempting to tidy up people's belongings in the lounge. The incidents happened after the person had been stopped from tidying things up and could have been prevented if staff understood how to respond to the needs of people living with dementia.

We found records that people had been punched when they went into other people's bedrooms and of instances when people had tried to get into bed with other people. These were potentially dangerous situations for people, but the provider had not taken action to respond or adjust the care people received to minimise these incidents occurring. Staff had been asked to keep people under observation, but staffing levels were not reviewed so that a member of staff could stay with people on a one to one basis.

Mangers in the home were slow to respond to changes in people's needs. In some cases, people's assessments had been reviewed but they did not inform staff what they needed to do to meet people's needs. One person had been involved in eight incidents of aggressive behaviour towards others. Their care plan had been reviewed but did not reflect the eight incidents or what actions staff needed to take to meet the person needs. There was a failure to put measures in place to assist people to manage their behaviours and keep them safe through effective care planning.

Guidelines had been put into place telling staff how equipment such as handling belts and hoist should be used. However, the guidelines were not based on proper moving and handling risks assessment. The risk assessment and guidelines had not identified why the equipment was needed and when it should be used. Also, they were not dated to show if they were still relevant. There were two sets of guidelines for the same person, one for using a hoist and one for using a handling belt. Different staff had recorded that they had either used the hoist or handling belt. It was confusing and unclear why this was. People could not be confident that their moving and handling needs would be properly assessed and carried out safely by staff.

People were at risk of not receiving care or treatment to maintain their health and wellbeing. People were identified as being at high risk of falls or had suffered physical attacks by others in the home. However, staff responded differently for example when people had fallen. Some times staff sought medical assistance, for example from paramedics, but other times no action was taken. Injuries could have been missed by staff as they did not follow a set procedure to get people checked by a qualified health professional.

When people required urgent follow-up or assessment from health care professionals outside of the service, there was a lack of urgency to ensure this happened. For example, a person had suffered repeated falls and hurt themselves. They were referred to the community falls team in September 2014. However, by the end of November 2014 staff still recorded that they were waiting for the falls team to come. Managers took no action to ensure this happened as a matter of urgency. In the meantime the person continued to suffer from falls and injuries.

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

Inadequate

Is the service responsive?

Staff knew how to respond to complaints and understood the complaints procedure. There was a complaints policy that had been followed by the manager. The manager kept a record of how complaints had been resolved. One person said, "Staff make you feel comfortable, you can share your thoughts or concerns with them. However, we found examples where the resolutions of complaints were not a priority for the provider. For example, a bedroom sink had been leaking for some time and a bowl had been put under it to collect water. The manager told us they had asked the provider to get the leak fixed. This had been causing the person who used the bedroom some distress and worry. Eventually, after a complaint from relative the manager paid for the sink to be repaired themselves. Although the problem had been resolved, the provider had not responded to the complaint well.

Complaints were not used by the provider to improve the quality of the service for people and were not fully investigated so that people were safe and felt listened to. We saw a record of a complaint made about an alleged sexual assault that had taken place in a person's bedroom. The provider had met with the victim and promised them a full investigation would take place. There were no records that an investigation had taken place and we saw that since the incident had been reported there had been further instances of people trying to get into bed with other people.

Relatives came and went during our inspection and they told us they were able to visit the home at any time. People told us that they were looking forward to a Christmas concert at the weekend. Other activities were not planned that would reduce social isolation or that reflected people's interest. There was a notice in reception indicating what activities were available to people. However, we were told that not all of these activities were provided, and there were no activities taking place on the day of our inspection. The television was on in the lounge throughout our inspection, and many people were asleep in their chairs for much of the day. A visitor told us "The TV is on all the time. They could have more to do". People spent the day either in their rooms or in the lounge area. We saw from people's care plan files that they had been asked about things they liked to do. One person told staff they would like one to one time and to sit and listen to music. Another person told staff they liked to do puzzles. We checked people's daily notes going back over ten days. No activities had been offered relating to the things people liked to do. We noted that people spent their time in the lounge asleep or watching television. In one person's daily notes it stated that the person was shouting out for staff. Staff had not taken the time to try and find out why the person wanted them. Records showed that they were left in the lounge or taken back to their bedroom. Staff were not responsive to people's individual preferences.

A care plan of a person living with dementia contained a 'This is me' section with information about the person's likes and dislikes. It had been written in conjunction with the person's relative. Staff had taken steps to involve the person's family in their care and to understand the person's needs. However, they had not used this information to develop any individualised activities for the person. The care plan also included information about others involved in the person's care, such as an optician and a chiropodist. This provided staff with some information about maintaining people's health.

We found assessments had been carried out by health care professionals in response to people's changing needs or if their health deteriorated. For example one person had been assessed by a continence nurse because they required additional support in this area of their life. Also, dieticians had assessed people in response to those at risk from poor hydration and nutrition. One person's weight had improved and they no longer needed specialist dietary supplements.

An occupational therapist had recommended that a person needed to move from the home to a home that was more appropriate for their needs. We looked at how this had been supported and found that the move had gone smoothly. The manager had helped the person and their relatives to plan the move so that it did not cause too much distress. For example they had communicated with staff at the new home regularly and kept people informed of what was happening.

Inadequate

Is the service well-led?

Our findings

The provider had sent questionnaires to people and their relatives in June 2014 asking for people's views about the service. People had made positive comments which included 'The staff are very important and caring and make you feel comfortable', and 'Staff treat you fairly and honestly'. One member of staff told us "We all get on really well". Staff and people told us the manager was very friendly and approachable. One person said "The manager is lovely".

People told us that they did not often see the provider of the home on the premises. We spoke to a visitor who told us that the staff were not supported by the home's provider. They said that care staff undertook decorating work because the provider had not arranged for this to be undertaken by professional decorators. They told us that people who used the service had to wait a long time for a replacement television to be purchased when the old set broke recently. Another visitor told us that there were leaky gutters and that they felt that the owner should invest more in the premises.

Information recorded by the manager that would assist the provider to improve people's experiences of the care they had received was not acted upon by the provider. The manager told us they had informed the provider about the number of significant incidents occurring in the home. The provider had a duty to report these to the Care Quality Commission (CQC). However, we found that this had not happened. For example, there had been nineteen serious incidents involving people between 18 April 2014 and 1 December 2014. These were not reported to the Care Quality Commission. It is a legal duty to report these incidents to the CQC. Doing so ensures that we can monitor the service and take immediate action if people are not being protected from harm. When we talked to the provider about this they said, "Sending notifications to CQC was not that important." This demonstrated a serious failure by the provider to understand their responsibilities to comply with the regulations and keep people safe.

Staff told us that they were discouraged by the provider from reporting concerns outside of the home. There was an inward looking culture to protect the provider rather than people in the home. For example, during our inspection the manager provided us with information that had not been made accessible to us at previous inspections about incidents of violence and aggression in the home. These had been locked in a filing cabinet by the provider. Staff described situations where they did not feel the provider understood the issues within the home. There had been nine incidents where staff had been injured by people when they were working to provide care to them. This included staff having their fingers dislocated and receiving cuts to their face. Staff did their best but needed the provider to train them for these situations.

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

Staff told us that the provider did not always respond to their requests for improvements to be made to the home in a timely manner. The manager had identified that the shower room was too small to enable people with physical disabilities to use safely. It was difficult for staff to help people to use the shower. The manager had asked the provider to fund the enlargement of the shower room by combining it with the next door bathroom. However, this work had not progressed, despite a number of requests being made by the manager. For other maintenance work, the manager had engaged their own maintenance person because the provider had not addressed the issues in a timely manner.

The provider had failed to monitor the quality of the risks assessments for people so that they were relevant to their needs. We looked at the dependency assessments staff had used to work out the levels of risk people were at when they moved into the home. These assessments included key area such as washing and dressing or how much assistance people needed when they walked around the home and whether people were at risk of falls. It was stated in one assessment that a person was at high risks of falls. However, no further action had been taken and there were no instructions for staff so that they could help the person reduce the risk of falls happening. When we checked we found that this person had been having a lot of falls. However the provider could not tell us how the assessments staff completed were put into practice so that the person's safety and welfare was protected. The provider did not understand how to assess and manage risks effectively.

The provider had failed to manage risk because they were not following guidance about this issued by the Health and Safety Executive (HSE).For example, the HSE guidance

Inadequate

Is the service well-led?

states that all moving and handling task involving people should only happen after staff have completed a person specific risk assessment or each task. We found that the risks assessments in the home relating to moving people were not person specific.

The manager did not have enough experience and knowledge to lead the home well. They lacked the confidence to challenge the provider about issues in the home or were ignored by the provider. They told us that they had been frustrated in their attempts to improve the quality of the training provided for staff by the provider who just stopped listening to them. This included training that would have supported staff to reduce the risk to people they were caring for and from the correct response to risk within the home evidence by the number of incidents of violence and aggression. The provider was aware of these incidents but had failed to take responsibility for the safe delivery of care or review the risk to people of receiving the care provided.

The provider was unable to demonstrate that they were capable of assessing and managing risk to the health, safety and welfare of staff who were there to provide care to people. We looked at what had been recorded about incidents of injuries to staff when they had been delivering care to people. One member of staff we spoke with had a wound on their face. Other staff had reported that their fingers had been dislocated. However, the risk assessments in the home did not reflect that these serious events had taken place. No action was taken by the provider to reassessed the risk and minimise the potential for them to occur again. When we discussed this with the provider they did not understand why the risks assessment they already had in place were not adequate.

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

The provider had consistently not complied with the conditions of their registration because they had failed to appoint a registered manager to manage the home. This was recorded on their registration certificate dated 24 January 2011. The provider had received written notification in January 2014 that they must have a registered manager in post. When we last inspected the service in June 2014 we recorded in the summary of the inspection report that there was no registered manager in post.

This is a breach of the Health and Social Care Act 2008 and Regulation 6, 28(11) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Morale was poor within the staff team. The manager of the home told us that the training received by staff was not good enough. They had presented a plan to the provider that would enable the quality of staff training to be improved. They said “I have not been able to book practical training because the provider will not pay”. Recently staff had not been paid on-time. Some staff had decided to leave because of this. Other examples staff told us about included staff paying for food so that people were given meals. This left staff feeling helpless and frustrated.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services The registered person was not making suitable arrangements to ensure that service users privacy and dignity were protected or to treat service users with consideration and respect. Regulation 17(1) (a) (2) (a) which has now been replaced by regulation 10 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered person was not taking proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe. Regulation 9(1) (a) (b) (i) (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which has now been replaced by regulation 9 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The registered person was not protecting service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of health and safety and quality monitoring systems.

This section is primarily information for the provider

Action we have told the provider to take

Regulation 10(1) (a) (b) (2) (a) (b) (i) (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which has now been replaced by regulation 17 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse The registered person was not making suitable arrangements to ensure that service users are safeguarded against the risk of abuse. Regulation 11(1) (a) (b) (2) (a) (b) (3) (a) (b) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which has now been replaced by regulation 13 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered provider had not notified the Care Quality Commission about incidents that affect the health, safety and welfare of the people who use the service. Regulation 18 (1)(2)(a)(ii)(iii)(b)(i)(e)(f) of the Health and Social Care Act 2008 (Registration) Regulations 2009, which has now been replaced by Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing

This section is primarily information for the provider

Action we have told the provider to take

The registered person was not taking appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity.

Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which has now been replaced by Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered person did not have suitable arrangements in place in order to ensure that persons employed for the purposes of carrying on the regulated activity are appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard. Regulation 23 (1) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which has now been replaced by Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 6 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to registered managers The registered person had not complied with the conditions of their registration in appointing a registered manager. Regulation 6, 28 (11) (b).