Care Homes UK Ltd

Stockingate Residential Home

Inspection report

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13 July 2016

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 11 and 13 July 2016 and was unannounced.

We previously inspected the service on 29 July 2015 and at that time we found the registered provider was not meeting the regulations relating to management of medicines. We asked the registered provider to make improvements. On this visit we checked to see if improvements had been made.

The service provides residential care for up to 25 people, some of whom are living with dementia. At the time of our inspection there were 19 people using the service, one of whom was a temporary admission.

The service is required to have a registered manager. 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.' The registered manager had left the service on 4 April 2016 and a new manager had come into post on 11 April 2016. They had applied to register with CQC but at the time of this inspection the application had not been finalised. The new manager of the service is no longer in post.

Some people who lived at Stockingate residential home told us they felt safe and three people we spoke with had concerns about safety.

Our inspection on 29 July 2015 found the registered provider was not meeting the regulations relating to the management of medicines because medicine to be returned to the pharmacy was not secured; so on this inspection we checked to see if improvements had been made.

We found medicines were not always managed in safe way for people and people were not always able to access as 'required' (PRN) medicines at night as there were no medicines trained staff on night duty. This was a breach of regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe management of medicines.

Staff had an understanding of how to safeguard adults from abuse and who to contact if they suspected any abuse, however the manager of the service had not acted on safeguarding concerns raised by people who used the service, staff and relatives. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Individual risk assessments were not always comprehensive and up to date to reflect risks to people and measures were not always in place to reduce the risks. Risk assessments were not always updated or followed to ensure people's safety when eating. This was raised at our last two inspections as a concern. This was a breach of Regulation 12 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found people were not always protected against the risks of unsafe or unsuitable premises because the necessary safety checks were not being regularly completed and emergency plans were not in place. This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Sufficient suitably trained staff were not deployed to meet the assessed needs of people who used the service. This was a breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the recruitment records of four members of staff. We found all the necessary checks had not been carried out for three of these before commencing employment with the home. This was a breach of Regulation 19 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found poor practice in the prevention and control of infections, which meant people were not protected against the spread of infection. This was a breach of Regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had not always received training to enable them to provide effective support to people who used the service, for example most staff were not up to date with or had not received training in managing behaviour that challenges or fire safety training. This was a breach of regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's capacity was not always considered when decisions needed to be made to ensure their rights were protected in line with legislation, for example when using a door sensor. This was a breach of regulation 11(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, need for consent.

People who used the service told us there was little choice of meals, and drinks were not always available. We found the risk of weight loss was not always managed well. This was a breach of regulation 14 of the Health and Social Care Act Regulated Activities Regulations 2014

A range of healthcare professionals were involved in people's care as the need arose, however one person did not receive the health care they required in line with their care plan.

We observed staff interacting with people in a caring, friendly manner. Staff were able to clearly describe the steps they would take to ensure the privacy and dignity of the people they cared for and supported, however we saw on one occasional a person's dignity was not protected with prompt personal care.
The choices of people who used the service were not always respected.

People did not always receive care that was planned to meet their assessed needs and there was a lack of meaningful activities for a number of people who lived at the home. These issues were a breach of Regulation 9 (1) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives told us they knew how to complain, however they told us the manager had not act on complaints. We saw no complaints had been recorded since the new manager had commenced employment with the service. This was a breach of regulation16 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some relatives we spoke with felt consistent management had not been in place in recent months which impacted on support for their relatives.

We found the registered provider had not notified CQC of a number of safeguarding incident in line with legislation. This was a breach of Regulation 18 (2) (e) of the Care Quality commission (Registration) Regulations 2009 (Part 4).

Staff told us they did not feel supported and the manager was not visible in the service.

Appropriate records were not always kept and shared with CQC accurately during the inspection process.

People were not always consulted in how the service was run, however occasional meetings were held with relatives and staff.

The registered provider had some audits in place, but this system was not robust enough to identify and address the multiple risks and problems we found. The above issues were a breach of Regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

People's medicines were not always managed safely.

Staff had an understanding of safeguarding adults from abuse, but the manager had failed to act on safeguarding concerns.

Risks to people were not identified or managed well.

There were insufficient suitably trained staff to meet the assessed needs of people who used the service and keep them safe.

People were not protected from unsuitable staff by safe recruitment practices.

Is the service effective?

Inadequate

The service was not effective.

Staff had not always received training to enable them to provide support to the people who used the service.

People's capacity was not always considered when decisions needed to be made in line with legislation and guidance.

People were not always supported to eat and drink enough and maintain a balanced diet.

People did not always have access to external health professionals as the need arose.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always offered choices.

Staff interactions with people were supportive, caring and enabling.

People were not always supported in a way that protected their privacy and dignity.

Staff supported people to be as independent as possible in their daily lives.

Is the service responsive?

Inadequate

The service was not responsive.

The majority of Care plans we sampled were not comprehensive, up to date or reflective of people's current needs.

People and their representatives were not involved in the development and the review of their care plans.

People were not always supported to participate in activities which were person centred.

People told us they knew how to complain but the manager had failed to record or act on complaints.

Is the service well-led?

Inadequate

The service was not well led.

The manager had failed to act to oversee safe and appropriate care to people using the service.

The registered provider had failed to notify CQC of safeguarding incidents.

The culture of the service was not positive, open and inclusive.

People who used the service, relatives and staff were not consulted regarding the quality and safety of the service.

Quality assurance systems were very poor and had not picked up and addressed the numerous risks and quality issues we found at the inspection.

Stockingate 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 11 and 13 July 2016 and was unannounced. The inspection team consisted of three adult social care inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise on this inspection was as a family carer of an older person.

Prior to our inspection we reviewed all the information we held about the service. This included information from notifications received from the registered provider and feedback from the local authority safeguarding team and commissioners. We had sent the provider a 'Provider Information Return' (PIR) form prior to the inspection. This form enables the provider to submit in advance information about their service to inform the inspection. Before this visit we had received information of concern about poor staffing levels, lack of adequate meals and lack of continence products.

We used a number of different methods to help us understand the experiences of people who used the service, including observations and speaking with people. We spoke with seven people who used the service, four relatives and three community professionals. We looked in the bedrooms of six people who used the service with their permission. We also spoke with six members of care staff, the manager and the area manager. During our visit we spent time looking at eleven people's care and support records. We also looked at four records relating to staff recruitment, training records, maintenance records, and a selection of the service's audits.

Inadequate

Is the service safe?

Our findings

Some people who used the service told us they were concerned about their safety. One person said: "sometimes other residents come into our room and they don't know where they are, we have to get staff to see to them." Another person told us, "Sometimes other residents walk into my room and I have to call staff to take them out." And another said, "There is no one in the lounge to make sure that people are OK."

A relative said, "My (relative) has told me that she is frightened." We addressed this with the manager of the service and contacted the local authority safeguarding team to ensure measures were put in place to keep the person safe.

Some people who used the service told us they felt safe. One person said, "I do feel safe because there is always someone around to care for you." Another person said, "When I ring my buzzer a carer comes and see to me, I don't have to wait if I need help."

Our inspection on 29 July 2015 found the registered provider was not meeting the regulations relating to the management of medicines because medicine to be returned to the pharmacy was not secured; so on this inspection we checked to see if improvements had been made.

We looked at people's medication administration records (MAR). A MAR is a document showing the medicines a person has been prescribed and recording when they have been administered. We saw some MAR sheets were handwritten and on some occasions the MAR sheet had not been signed by a second member of staff. This meant there was no evidence to indicate a staff member had checked to ensure the details recorded were accurate.

We found there to be no consistent approach to providing guidance to staff in the administration of PRN (as required) medicines. A PRN protocol provides guidance for staff to ensure these medicines are administered in a safe and consistent manner. The manager said they would address this.

We saw from rotas on 29 June and 6 July 2016 people were not always able to safely access as 'required' (PRN) medicines as the staff on duty did not have up to date training in medicines administration.

We found an open prescribed fortified drink in the medicines fridge with no patient label and no date of opening, which stated, "Keep refrigerated for up to 48 hours." We saw from records the drink had been given more than 48 hours previously and so was out of date. This presented a risk the medicine could be administered when it was out of date and could be ineffective or unsafe. We alerted the staff member who was administering medicines to these concerns.

Creams and ointments were dated upon opening and found to be in date; however the applications of creams were not recorded on a body map to guide staff on their use.

People's medicines were stored safely in a locked room. We saw the drug refrigerator and controlled drugs

cupboard provided appropriate storage for the amount and type of items in use, however the medicines room was cluttered and untidy and was poorly lit which could present a risk of medicines records being incorrectly read due to poor lighting.

The above issues meant medicines were not always administered in a safe way for people and evidenced a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Blister packs were used for most medicines at the home, as well as some medicines in bottles and boxes. We found all of the medicines we checked could be accurately reconciled with the amounts recorded as received and administered.

The manager told us carers at the home completed training in safe administration of medicines every year and we saw certificates to confirm this for most staff. We saw carers had also completed medicines competence assessment annually. This meant people usually received their medicines from people who had the appropriate knowledge and skills.

We saw weekly audits had been completed on medicines administration and occasional gaps in recording had been noted and addressed with staff.

Staff had an understanding of how to safeguard adults from abuse and who to contact if they suspected any abuse, however the manager of the service had not acted on safeguarding concerns raised by staff and relatives.

Staff told us they had received training in safeguarding and they were able to tell us what they would do if they had any concerns. Staff gave us a description of the different types of abuse they may come across in their work. However the staff we spoke with told us they did not have confidence in the manager to take action to keep people who used the service safe. Staff were aware they could report externally to the local authority and to the Care Quality Commission and we had received several whistle blowing concerns prior to this inspection. This showed staff were aware of how to raise concerns about harm or abuse and recognised their personal responsibilities for safeguarding people using the service.

A relative told us they were concerned about their relations safety due to another service user entering their bedroom uninvited and on one occasion having physical contact with them . Staff had been alerted to these incidents on each occasion. The relative and staff members told us they had informed the manager, however there were no records of these incidents in the safeguarding log and no referral had been made to the local authority safeguarding team. We saw no investigation had been completed or action taken by the service to reduce the risk of abuse and the manager told us they were not aware of these incidents. This meant people who used the service were at risk of abuse because the service did not effectively operate systems to prevent or investigate abuse of people using the service and the manager had not acted on safeguarding concerns.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found a number of safeguarding incidents reported to the manager or recorded in daily records had not been notified to safeguarding or CQC in line with legislation.

We saw from care records Individual risk assessments were not completed for some people to support staff with care delivery or minimise risk to people. We found one person who had displayed sexually

inappropriate behaviour during our inspection had no care plan or risk assessment in the care records relating to how to manage this behaviour or reduce risks to people using the service. The manager told us they were not aware of this behaviour; however we saw from the homes own basic pre-admission assessment and the local authority assessment in their care records that this behaviour was documented prior to admission. Staff told us they had spoken to the manager about this behaviour and we saw a record of a sexual incident towards a staff member in the person's daily records. There was no record of action taken to support the staff member or prevent recurrence or any steps taken to safeguard other people using the service. We reported these incidents to the local authority safeguarding team immediately.

Risk assessments were not always updated or followed to ensure people's safety when eating. This was raised at our last two inspections as a concern. For example we saw one person eating a chip sandwich. We saw in the persons care records they were at high risk of choking and required a 'soft diet.' The care record also stated, 'unable to eat solid food. Has her meals blended." There was no clear direction in care records regarding what constituted a soft diet and staff told us the person needed meat to be liquidised, but 'was alright to eat a chip sandwich'. The information in care records was contradictory, as chips and sausage were stated as part of the 'soft diet' and there was no speech and language therapy(SALT) assessment in the care records to inform staff how to minimise the risk of choking. Staff were unable to locate the SALT assessment during our inspection. This person had been referred to the local authority safeguarding team by inspectors at our inspection in January 2015 due to inadequate management of the risk of choking.

We found the provider had not done all that was practical to reduce risk to people from unsafe premises. We found on the upper floor of the Home two stairways with doors at the top, where the doors were not secured or locked allowing free entry up and down the stairs. This presented a risk to service users residing on the upper floor, who were living with cognitive impairments which restricted their ability to recognise risks to their own personal safety and were independently mobile. Door sensors were in place in all top floor bedrooms, however these were not always effective in alerting staff, due to poor staffing levels. No risk assessments were in place regarding this risk and the manager and registered provider were not aware this posed a risk of falls to people using the service. This meant effective measures were not in place to reduce the risk of harm to people using the service from unseen falls on unsecured stairs because the registered provider had not assessed and managed the risk. We told the registered provider to take immediate action to ensure people were safe.

We looked at the fire safety file and saw checks had not been carried out in line with the policy of the service. We saw no fire alarm tests had been completed since 29 April 2016 and there was evidence no fire drills had taken place since July 2015. We saw from the training matrix 14 staff members fire safety training was out of date and only 2 were up to date. Three new staff members employed since April 2016 had not received fire safety training. This meant the registered provider did not have effective procedures in place in the event of an emergency.

Staff told us they recorded and reported all accidents and people's individual care records were updated as necessary. Staff members were able to describe the procedure to follow and explain what action had been taken following falls and incidents. We saw some accidents and incidents were recorded and appropriate action was taken to ensure the safety of people who used the service, however some safeguarding incidents had not been recorded or acted upon.

The above issues evidenced a breach of Regulation 12 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Before this inspection we received information of concern regarding sufficient staffing levels at Stockingate

Residential Home. Relatives and people who used the service told us there were not enough staff on duty. A person who used the service said, "I have had to look after (service user) and clean him because there isn't any staff to do it." Another person told us, "When I shouted for help, no one came because there is no staff to help." And another said, "I have to shout if I need staff." One person said, "We don't think there is enough staff, it certainly is a problem. It has a terrible effect on the care you receive and it isn't fair on the other staff."

One relative we spoke with said, "I think they could do with more staff – there are 3 off sick at the moment and that leaves 3 on. If one resident fell or needed help, it takes 2 carers to look after them which only leave 1 carer to do everything else."

We asked the manager how staff were deployed within the service and they showed us the dependency tool they used. A dependency tool is a way to work out how much staff support a person requires depending on their care and support needs. We saw from this tool that risks to people relating to dependency levels had not been correctly assessed. For example one person was assessed as low dependency after they had been put on fifteen minute observations, which would take up more staff time than was allocated to a person who was rated as low dependency. The area manager accepted the dependency tool used was not effective to calculate safe staffing levels within the service.

We saw from rotas on 29 June and 06 July 2016 there were two staff on the duty rota at night and on these occasions neither of these staff were up to date with training to administer medicines, which meant that it would not be possible to safely administer any PRN (as required) medicines that may be required, such as pain relief, Asthma inhalers or PRN lorazepam which people who used the service had been prescribed. This presented a risk of harm to people who used the service from lack of access to essential prescribed medicines when required due to inadequate deployment of suitably trained staff.

We saw from rotas week beginning 4 July 2016 there were three care staff on duty during the day on 6, 7 and 9 July to support 18 people using the service, 10 of whom required two to one staffing for transfers and 11 people who had a Deprivation of liberty safeguards DoLs authorisation in place due to lack of capacity and risks to themselves or others. On 8 July one of the three care staff on duty was not trained in moving and positioning. This meant only two care staff and the deputy manager were available to support 10 people who used the service with transfers as well as all the other support required by people who used the service. On two occasions in the same week there was only one staff member trained in moving and positioning on the night duty rota so no one would be able to be safely supported to transfer or reposition at night. This presented a risk of harm to people who use the service from unsafe transfers or neglect from lack of sufficient appropriately trained staff. We told the registered provider to take immediate action to ensure extra staffing was in place and that staff on duty had appropriate training in medicines administration and moving and repositioning.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the registered provider had not ensured the premises was safe and secure for people using the service. For example; we saw a fire risk assessment dated 17 October 2015 regarding a sofa placed in front of the fire door exit in the lounge with direct access to the car park, which was used to prevent a person at risk of absconding from exiting the building. A magna lock, which opens in the event of a fire alarm being activated, had not been installed since that time as planned and the sofa was still in place. This meant people using the service were not protected from the risk of harm in the event of an emergency evacuation due to a blocked fire exit.

We found people who used the service, including those living with a diagnosis of dementia, who may lack understanding and insight regarding specific risks posed to them could access the outside laundry building, which was not locked and contained COSHH chemicals. This exposed them to the risk of harm or injury. We told the registered provider to take immediate action to keep people safe.

We found the garden areas contained a number of hazards such as a discarded food trolley, commode, rusty bin, wheelchair and black bin bags. There were no risk assessments in place regarding access to the laundry, disposing of items in the garden and unsupported access to the garden by service users in the building safety file.

This was a breach of regulation 15 of the Health and Social Care Act Regulated Activities Regulations 2014.

We saw from staff recruitment records of the three staff members employed since 27 April 2016 gaps in employment history had not been explored, two of these staff members had only one reference, and one staff member had no record of a Disclosure and Barring Service (DBS) check being received. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups. We saw these staff members working unsupervised with service users during our inspection. This presented a risk of harm to people who use the service from unsuitable or unsafe staff recruitment procedures.

This was a breach of Regulation 19 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found poor practice in the prevention and control of infections. One relatives we spoke with said, "I feel they need more staff especially when people have accidents etc. The cleanliness is not up to standard."

We saw that following soiling on the base of one chair in the lounge effective cleaning was not completed and we brought this to the attention of staff. Staff were not aware of any system at the home to ensure hygiene was maintained and ensure chairs were clean and fit for use. We found many of the chairs in communal areas were dirty, stained or wet. This presented a risk of the spread of infection.

We found a lack of Personal Protective Equipment (PPE) in an upstairs shared bathroom and a used continence pad on the floor of the shared toilet. We saw from the communication book cleaning products and PPE often ran out. We asked the manager about this and they said the problem had been resolved, however staff felt it was still a concern. We found a strong malodour in one person's bedroom, however most bedrooms were odour free and clean.

This evidenced the registered provider had failed to ensure effective systems were in place to prevent and control the spread of infections.

This was a breach of Regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

People who used the service said, "There is nothing wrong with the staff, they look after me well." and, "They all look after me very well."

Staff were not always provided with training and support to ensure they were able to meet people's needs effectively. Staff told us they completed an induction including completing an induction booklet and shadowing with more experienced staff before starting work at the service. The shadowing focused on getting to know people's individual needs and preferences. The manager told us this was followed by completion of the care certificate, however we did not see evidence of this in staff records. The aim of the Care Certificate is to provide evidence that health or social care support workers have been assessed against a specific set of standards and have demonstrated they have skills, knowledge and behaviours to ensure they provide compassionate and high quality care and support. We saw the three staff members who had started at the service since April 2016 had not completed any training at the service.

We saw evidence in staff files and training records that staff undertook some training to enhance their role and to maintain their knowledge and skills relevant to the people they supported. Staff told us, and we saw from training records some staff had completed training in areas including moving and handling, health and safety, The Mental Capacity Act, safeguarding, infection control and equality and diversity, however some essential training was not up to date. For example; 17 out of 22 staff had not completed fire safety training and some staff we spoke with were not aware of what to do in the event of a fire.

We saw the staff training matrix on the office wall and asked the manager about staff training. We saw only five out of 22 staff members on the matrix were up to date with training in managing behaviour that challenges and the three staff members who had commenced employment since April 2016 had not completed this training. We saw a number of incidents of behaviour that challenges were recorded in daily records from two people who used the service, one of whom had been sectioned under the mental health act in June 2016 following a number of incidents of physical assaults on service users and staff. This meant people who used the service and staff were not protected against the risk of harm because staff did not receive adequate training to fulfil their role.

The above issues were a breach of regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Five out of six care staff we spoke with told us they did not feel supported. One staff member said, "The manager has no time for staff. They are not hands on; anything you raise to the manager is brushed under the carpet." Another staff member said, "If you go to (name of manager) with problems nothing happens." Staff told us they had occasional supervision, as well as an annual appraisal, and supervision records confirmed this. Staff supervision records were minimal in content. However, we saw staff were given the opportunity to comment during supervision and staff discussed future professional development and training.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

Staff at the service had completed training and had a good understanding of the Mental Capacity Act (2005). One staff member said, "If they want to lock their bedroom door it's their choice if they have capacity. If they don't have capacity we consult with people in their best interests."

We saw from records 11 people using the service had DoLs authorisations in place and applications for authorisation had been made to the supervisory body for two further people, which were yet to be assessed.

We asked the manager about the MCA and DoLS and they were not able to describe to us the procedure they would follow to ensure people's rights were protected. We saw from records one person who had been admitted to the service in April 2016 had refused to return to the service on three occasions following an outing with family. We observed during our inspection this person asking to leave the service and live independently. There was conflicting information in care records regarding the person's cognitive abilities and no capacity assessments regarding the decision to live at the service were recorded. A DoLs authorisation had been applied for in July 2016, following advice from and assessment by a social worker that this person lacked capacity, although there was no record of any capacity assessment in the person's care records. This meant there was a risk the person had been previously restricted without legal authority because the service had not applied for a DoLs authorisation to ensure their rights were protected. We addressed this with the manager and spoke to the person's social worker to address these concerns.

We saw one person's care records stated the person, "Is unable to take any decisions any time." We saw the person had a door sensor in place and a sensor mat, but no decision specific Mental Capacity Assessment or best interest discussion was recorded regarding this restriction. This meant people's capacity was not always considered when decisions needed to be made in line with legislation.

All people who used the service with a bedroom on the upper floor of the home had door sensors in place and no consent to this restriction of rights was recorded in any care documents we sampled. The manager told us eight people with a bedroom on the upper floor lacked capacity to make decisions however we saw there was no record of a mental capacity assessment or best interest discussion for this decision in the records we sampled.

This meant people's rights were not always protected in line with the MCA 2005. This was breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

All the people we spoke with using the service told us the food was OK, but there was limited choice. One person said, "The food is not too bad in here." Another said, "I am not happy with the food here, I have to eat it or do without." One person told us, "I can't get a glass of orange when I want it, I have asked but they never get me one." Another person said, "You have to ask for a drink – there is no water or drinks available" One person said, "It is a big problem (food) because they only have so much money so you get what you are

given. There are not a lot of choices."

Two of the relatives we spoke with told us there relation enjoyed the food.

We found people were not always supported effectively with their meals to ensure they had sufficient nutrition to meet their needs. We saw in the lounge one staff member replaced a person's breakfast with a fresh one and encouraged and supported them to eat. However we saw another person in the lounge was prompted to eat breakfast in passing by a staff member who was busy managing continence issues at the same time.

At lunch time we saw one person had eaten a few mouthfuls of the meal and staff took the plate away without exploring the reason they hadn't eaten and no alternative was offered.

We did not see people offered snacks and drinks throughout the day, however during the afternoon on the first day of our inspection people were offered a cold drink. One person who used the service commented, "This is a first."

Staff told us they had been told by the manager not to give people using the service cooked food at supper time as they were leaving the day staff short of food. We saw in the communication book written on 10 July 2016, "can night staff please not give residents meat and onion sandwiches/chip sandwiches for supper. Please give toast, cereal, crumpets, tea cakes, malt loaf etc;" One member of staff said, "They are all losing weight. The food is shocking. We can't ask people if they want a cooked breakfast now due to lack of food."

On both days of our inspection we saw the ingredients for the meals offered on the menu for lunch were not in stock at the home in the morning. For example on 11 July 2016 the menu offered Salmon but fishcakes were served.

We found the risk of weight loss was not always managed effectively. We looked at the manager's audit records of service user's weight which stated, "No weight loss more than 2KG in June." However we found from individual weight records one person had lost 2.7kg during the period and there was no record of action taken to address this. We found there were no accurate record of food and fluid intake for people at risk of weight loss. The above issues meant people were at risk of inadequate nutrition because systems were not in place to ensure people received sufficient nutrition to meet their needs. We asked the registered provider to take immediate action to ensure risk assessments were in place and weight loss was managed appropriately.

The above issues were a breach of regulation 14 of the Health and Social Care Act Regulated Activities Regulations 2014.

The chef understood how to fortify people's diets where they were at risk of weight loss and staff were knowledgeable about people's special dietary requirements.

A relative told us, "Staff are very good at phoning for the GP or district nurse to see (person)". A community health professional told us, "The staff and the seniors have good initiative around patient care."

People did not always have access to external health professionals as the need arose. We saw several health professionals were visiting people who used the service during our inspection. Staff told us systems were in place to make sure people's healthcare needs were met. They said people attended healthcare appointments and we saw from people's care records that a range of health professionals were involved.

This had included GP's, hospital consultants, community nurses, chiropodists and dentists, however we saw in one person's care records they had not received the required chiropody appointments to manage their complex health needs in line with their care plan, which meant they were at risk of inappropriate care. We addressed this with the registered provider and they told us they would address it. This showed people who used the service did not always received additional support when required for meeting their care and treatment needs.

Requires Improvement

Is the service caring?

Our findings

People who used the service told us the staff were caring. One person who used the service said, "The staff are very kind." Another person told us, "If you have any worries about anything, you can always tell staff." And another said, "They are friendly and in general are kind."

Relatives we spoke with said, "I feel strongly that the care being given is of a good standard. Staff have a genuine, caring nature here." Another said, "Staff look after him very well". One relative told us, "Staff are excellent; they are all friendly and good humoured" and another said, "They try their best but they are busy".

Staff we spoke with told us they enjoyed supporting people who used the service. One staff member we spoke with said, "I come to work because I have such a strong bond with the residents. I see them all as my Nanna or friend." Another said, "People are brilliant. The residents light my day up."

Staff we spoke with had a good knowledge of people's individual needs, their preferences and their personalities and they used this knowledge to engage people in meaningful ways. We heard staff chatting with people about family members and special occasions.

People who used the service told us they could not choose what time to get up or go to bed, where to eat their meals, or when to have a bath, as this depended on staff availability. One person who used the service said, "It is my choice to have breakfast in my room but it depends on if there is enough staff." Another said, "It depends if there are enough staff on duty if I can have a bath. I fit in with whatever time staff wants me to get up and go to bed." This meant the choices of people who used the service were not always respected.

We observed interaction between staff and the people who used the service. We heard staff asking people what they would like to do and explaining what was happening. We saw a carer suggested a person might like to move from the dining table after lunch to a more comfortable chair and supported them to do so and one staff member engaged a person in looking at a book they were interested in.

Staff worked in a supportive way with people and we saw examples of kind and caring interaction that was respectful of people's rights and needs. For example, staff asked people's permission and provided clear explanations before and when assisting people with medicines and personal care. This showed people were usually treated with respect and were provided with the opportunity to refuse or consent to their care.

We saw staff left a person who was resistant to support with personal care saying they would try again soon, due to the person's agitation. One hour and twenty minutes later the inspector alerted staff to the fact the person had still not been supported to change their clothing. The senior staff member on duty addressed this immediately. This showed people's dignity was not always maintained.

Staff were respectful of people's privacy; they knocked on people's doors and asked permission to enter, however we found some of the shared toilet doors at the home did not lock. We addressed this with the registered provider who said they would rectify this. Some people's rooms were personalised to their taste,

with family photographs and personal items. Personalising bedrooms helps staff to get to know a person and helps to create a sense of familiarity and make a person feel more comfortable.

People were encouraged to do things for themselves in their daily life. We heard staff encouraging a person to help themselves when getting dressed for the day. We saw staff supported and encouraged a person to stand and use their walking frame to enable them to remain as independent as possible. This showed people were encouraged to maintain their independence.

Staff were aware of how to access advocacy services for people if the need arose.

Inadequate

Is the service responsive?

Our findings

One person who used the service told us, "I had a bath this morning; they choose when I have one. Staff come and get me ready for bed and they come and wake me then get me washed and dressed which is about 7am. If I want a lie in I can go back to bed once I am washed and dressed."

In the care records we sampled we saw care plans were in place covering areas such as mobility, nutrition, communication, mood, sleep and personal care. Some care plans recorded what the person could do for themselves and identified areas where the person required support.

People who used the service and relatives told us they could not recall being involved in planning their care or being invited to any reviews. This meant the choices of people who used the service were not always respected.

We found care was not always planned or delivered in an appropriate manner in line with people's needs. For example one person was assessed as being at high risk of pressure ulcers, however there was no pressure care plan in place to ensure pressure care was properly managed and recorded by staff. Another person's care file contained a nutritional risk assessment, where the total had not been calculated from the scores. Had it been calculated the score would have been medium risk and actions should include, "involve GP and family. Consider supplements. Weigh every two weeks and implement care plan to reduce risk." No care plan was in place and no actions were recorded. One person with complex health needs had no catheter care plan, COPD (chronic obstructive pulmonary disease) care plan or pressure relief care plan in place to inform staff how to ensure these needs were met. This meant people who used the service were at risk of unsafe or inappropriate care because care plans did not reflect their needs.

The home manager said people's care plans were reviewed as soon as their situation and needs changed and every one to two months. These reviews helped in monitoring whether care records were up to date and reflected people's current needs so that any necessary actions could be identified at an early stage. We saw care plans were not all complete, had not all been reviewed regularly and were not all signed or up to date.

People who used the service told us they did not receive staff support to enable them to engage in activities of their choice. One person told us, "I sometimes get taken into the garden. I would like to go to the shops sometimes as it is something I really enjoyed doing." Another said, "You have to watch whatever is on TV, I can't choose. It's enough to bore you to death." Another person said, "We do not do anything all day, I am bored stiff." And another said, "They don't have an activities co-ordinator now which means there is not a lot to do."

Occasional activities were provided but this was not a level which would meet the needs of most people using who used the service. On the first day of our inspection a singer visited the service in the afternoon and some people sung along and enjoyed the activity. No other activities were observed during our inspection.

The manager told us the post of activity coordinator was vacant and they were in the process of recruiting to

this post. As the service did not deploy adequate staff this meant people were not supported to participate in activities which were person centred to meet their social and emotional needs.

The above issues evidenced a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 9(1) because care was not delivered or planned to meet people's assessed needs and preferences.

The staff we spoke with had a good awareness of the support needs and preferences of people who used the service. Some care records included a personal history and personal details were included for example, food preferences. This helped care staff to know what was important to the people they cared for and helped them take account of this information when delivering their care.

Relatives told us they had raised issues and concerns with the manager and no action had been taken. One relative told us they had complained to the manager about a person who uses the service coming into their relative's room and they told the manager their relative was scared. We discussed this with manager who said they were unaware of these incidents and were surprised by what we had told them. Staff confirmed there had been a number of incidents were a person had entered the person's room and the manager had been made aware of this. There was no record of any complaints since the current manager came in to post and no record of any action taken regarding the incidents to safeguard the people concerned from harm. We asked the registered provider to take immediate action to address these concerns and keep the person safe and contacted the local authority safeguarding team.

Staff we spoke with said if a person wished to make a complaint they would facilitate this. We saw the complaints record showed where people had raised concerns prior to the current manager coming into post these were documented and responded to appropriately; however since that time no complaints had been recorded.

The above issues were a breach of regulation16 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

Two people who used the service said, "I know the Manager, (name of manager) and she comes to see me to ask me how I am feeling." And, "This new manager is a lot better than the other one. She is trying her best, she is OK." Other people who used the service we spoke with and some relatives we spoke with were concerned about the manager not responding to their concerns, lack of staff, lack of choice and cleanliness of the communal areas.

The registered manager had left the service on 4 April 2016 and a new manager had come into post on 11 April 2016. They had applied to register with CQC but at the time of this inspection the application had not been finalised.

The manager said they operated an 'open door policy' and people were able to speak to them about any problem any time, however staff, relatives and people who used the service told us concerns they expressed were not acted on.

The manager did not identify areas of concern with regard to safeguarding people or recognise what constituted a safeguarding concern and did not initiate the processes in place to protect people.

Under the Care Quality Commission (Registration) Regulations 2009 registered providers have a duty to submit statutory notifications to the Care Quality Commission (CQC) when certain incidents happen. We saw in the safeguarding records log completed by the manager on 13/06/2016 a person who used the service pushed another person using the service and this was reported to the local authority safeguarding team, however this incident had not been notified to CQC as required by legislation. The registered provider had not notified CQC of a number of other safeguarding incidents in line with legislation. This was a breach of Regulation 18 (2) (e) of the Care Quality commission (Registration) Regulations 2009 (Part 4).

We saw contradictory information was recorded on a fire evacuation record. Through checking the staffing rotas and speaking with staff we found the information was not accurate. This meant appropriate records were not always kept and shared with CQC accurately during the inspection process. We discussed this with the area manager who completed an investigation and took appropriate action, however the registered providers systems of recruitment, supervision and monitoring had not been effective in identifying and addressing the issues we found in respect of the effective management of the service.

We saw care staff were motivated and committed to supporting the people who lived at Stockingate, however they were not supported by the manager or the registered provider to deliver high quality care to people who used the service.

People who used the service and relatives could not recall being consulted about the quality of the service, although the registered provider had held a meeting to introduce the new manager and discuss the budget deficit faced by the service.

Staff meetings were held every few months. Topics discussed included staff training and development, health and safety, and budget issues. There was no evidence of goals set or achieved following these meetings. Staff meetings are an important part of the provider's responsibility in monitoring the service and coming to an informed view as to the standard of care for people using the service and the service was meeting this requirement.

We found a number of audits were in place within the service, however these audits had not been effective in improving the quality and safety of the service and identifying the shortfalls as described in the breaches illustrated throughout this report. This was a breach of regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance, because effective systems were not in place to assess, monitor and improve the quality and safety of the service provided to people.

The manager told us they felt supported by the registered provider and we saw the area manager had visited the service to provide support.