Care Quality Commission

Scaleford Care Home Limited

Scaleford Care 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?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

This unannounced inspection took place on 29 January 2015 and 02 February 2015.

Scaleford Care Home is situated in a largely residential area of the Marsh in Lancaster and overlooks the River Lune. Bedrooms are situated over two floors. A stair lift is available to assist people with poor mobility to gain access to the upper floor. There are three lounge areas and a dining room.

A registered provider was in post at the time of the inspection. A registered person is registered with the Care Quality Commission to manage the service. 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 service was last inspected in September 2014. They did not meet the requirements of the regulations during that inspection. They breached regulation 18, consent to care and treatment, and Regulation 22, staffing. The registered provider sent us an action plan explaining what they were going to do to rectify these problems. However at our inspection on 29 January 2015 we found that the registered provider had failed to complete the actions as stated. We identified there were continued

Summary of findings

breaches of Regulation 18 and Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the registered provider to take at the back of the full version of the report.

Seven of the nine people we spoke with were happy with the service being provided and had no complaints.

Feedback from relatives in relation to care provision was positive. Family members stated that their relatives were happy living at the home and that they were well cared for. However this did not reflect our findings.

We observed mixed interactions between staff and people who lived at the home. Staff didn't have time to sit with people and communicate. When staff did find time to interact with people we observed some positive interactions. We observed staff engaging in meaningful conversations with people. Staff were kind, patient, and compassionate and were caring towards people.

Staffing levels or deployment evidenced that staff were stretched and focussed on completing tasks rather than spending time with people. This meant that people who lived at the home were left for long periods of time without any stimulation. You can see what actions we have asked the provider to take at the back of the full version of the report

The registered provider did not have appropriate systems in place to manage medications. Medicines were not administered, stored and recorded for, in accordance with good practice guidelines. You can see what actions we have asked the provider to take at the back of the full version of the report.

Staffing at the home was inadequate. The registered provider had failed to meet their own action plan in order to recruit more staff. This meant that safe staffing levels (as risk assessed by the registered provider) were not always maintained. Staff employed at the home told us that they were stressed and were under pressure to work long hours. Staff also said that staffing levels impacted upon their own safety as they were not always appropriately supported in challenging situations. You can see what actions we have asked the provider to take at the back of the full version of the report.

The registered provider had failed to implement thorough recruitment practices to ensure that staff employed to work at the home were suitable for their role. You can see what actions we asked the provider to take at the back of the full version of the report.

Infection control and standards of hygiene within the home were poor. The registered provider did not have any domestic staff in post when we visited and the home was dirty. Carpets needed cleaning and replacing. Communal bathrooms and bedrooms were dirty. There was a strong smell of urine from some bedrooms. You can see what actions we have asked the provider to take at the back of the full version of the report.

Although the provider was registered to care for people living with dementia we found that the home was not suitably adapted to meet the needs of these people. There was poor signage and the decoration of the home had not considered the needs of people living with dementia. We have made a recommendation about consulting with good practice guidelines to improve the service.

The registered provider had not adequately provided training to staff to equip them with the skills required to carry out their role. Despite there being a significant number of people who lived at the home that displayed some behaviour which challenged the service, staff were not trained to deal with such situations. You can see what actions we have asked the provider to take at the back of the full version of the report

People were all expected to sit in one lounge for the majority of the day, under constant supervision from one staff member. A senior staff member said that this was in place to protect people from being assaulted by a person living at the home. The registered provider had failed to consider and implement the Mental Capacity Act code of practice in relation to depriving people of their liberty. You can see what actions we have asked the provider to take at the back of the full version of the report.

There was a lack of person centred activities on offer throughout the day and people were not encouraged to be active.

We observed the registered provider supporting a person at the end of their life. The provider ensured that the person's needs and wishes were maintained throughout the full process. This involved working closely with the

Summary of findings

hospital and other health professionals to enable the individual to be at the home at their death. Staff dealt with this situation professionally and showed compassion and dedication to the individual.

Although staff stated that they were "burnt out and exhausted", staff displayed commitment and passion to their role and spoke highly of the people they were supporting. Staff responded in a timely manner when a person requested pain relief.

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 told us that they felt safe but we found that people at the home were not protected from the risks of harm. Staffing levels did not match the organisations risk assessment for safe staffing levels.

People were not protected from unsuitable people working at the home as suitable arrangements were not in place to ensure that staff were correctly vetted before they commenced work.

Suitable arrangements were not in place to ensure medicines were safely administered. People were at risk of not receiving medication as directed by the health care professionals. Medication was not always adequately spaced and staff failed to record times on which medication was administered. Medication was not always stored appropriately.

People were not safe as the home had poor systems in place for carrying out and monitoring infection control. We found the home dirty and poorly maintained.

Is the service effective?

Inadequate

The service was not effective.

Staff were not appropriately trained to manage behaviours which challenged the service. This meant that staff did not have the skills and knowledge to support people effectively.

Good health care was not always promoted and maintained. Although care plans were in place, they were not updated and audited regularly. This meant that information in files was not reviewed and information was missing.

The registered provider had little understanding of the Deprivation of Liberty safeguards (DoLS.) We observed staff depriving people of their liberty as a means to safeguard them but correct procedures had not been followed.

Although providing care for people living with dementia, the home was not designed or adapted or staff trained to effectively support people.

Is the service caring?

Requires improvement

People were not always caring.

People who lived at the home and their relatives spoke highly of the staff and all confirmed that the staff were caring. This was supported by most observations of interactions.

Caring relationships were sometimes hindered by the lack of staffing and the staff focus being upon carrying out tasks.

Summary of findings

The registered provider had completed some good work to ensure that equality and diversity was embraced within the home.

The registered provider had failed to ensure that privacy and dignity was maintained at all times. We found that bathroom locks were not working throughout the building.

Is the service responsive?

Requires improvement

The service was not always responsive.

People who lived at the home, their relatives and health care professionals all provided positive feedback about service delivery. Some people said that complaints were dealt with effectively.

The registered provider had completed some person centred work with one individual but we failed to see this happening throughout the service.

There was a lack of established activities on offer to people who lived at the home and people spent the majority of their day sleeping in the lounge.

Is the service well-led?

Inadequate

The service was not well led.

The registered provider was not responsive to change and improvement.

The registered provider had failed to ensure that a positive working culture was fostered and promoted.

The registered provider had failed to meet all improvements that were required at the previous inspection.

The registered provider had failed to implement appropriate systems to monitor the quality of the service and to keep people safe.

Scaleford Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health & Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Heath & 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 was an unannounced inspection carried out over two days on 29 January 2015 and 02 February 2015. The team consisted of an adult social care inspector, a specialist advisor with a background in nursing and an Expert by Experience (ExE.) An ExE is a person who has personal experience of using or caring for someone who uses this type of care service. The adult social care inspector returned to the home (unannounced) for a second day to complete the inspection process. Prior to the inspection taking place, information from a variety of sources was gathered and analysed. This included notifications submitted by the provider relating to incidents, accidents, health and safety and safeguarding concerns which affect the health and wellbeing of people.

Before the inspection, we asked the provider to complete 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. The provider returned the PIR and the information was considered when planning the inspection.

To gain a balanced overview of what people experienced when using the service, we also liaised with the Local Authority Contracts and Commissioning Team, the Local Authority safeguarding team and Healthwatch to obtain their views regarding service provision. The Local Authority confirmed that they were liaising with the provider at present to encourage improvements in service provision. The local authority safeguarding team also confirmed that they had been involved in a number of safeguarding investigations relating to the safety and well-being of several people who were using the service.

Information was gathered from a variety of sources throughout the inspection process. We interviewed six staff members at the home. This included the registered provider, the care manager, two floor managers, one care assistant and the chef.

We also spent time with people who lived at the home to see how satisfied they were with the service being provided. We observed interactions between staff and people to try and understand the experiences of the people who could not verbally communicate. After the inspection we also spoke with four relatives to discuss how satisfied they were with the care provided. We also discussed the quality of service provision with visiting health professions who were commissioned to attend to the health needs of people who lived at the home.

As part of the inspection we also looked at a variety of records at the home. This included the care plan files belonging to six people who lived at the home and recruitment files belonging to five staff members. We also viewed other documentation which was relevant to the management of the service.

We also looked around the home in both public and private areas to assess the environment to ensure that it was met the needs of the people who lived there.

Inadequate

Is the service safe?

Our findings

We spoke with people who lived at the home. Most people told us they liked living there and that they felt safe there. One person said that they had lived at the home for over three years and felt safe in the environment.

We also spoke to relatives who all said that they were happy with the service provided. One relative said, "My relative always looks comfortable and happy around staff. If they didn't feel safe, they wouldn't be able to tell us, but we can tell. We know from the way they act, that they are comfortable and happy." Although relatives and people who lived at the home felt that people were safe this did not reflect our findings.

Our preplanning work identified that the provider had a higher than average number of safeguarding alerts on record. We spoke with staff to assess their knowledge on how to report and respond to abuse. All staff were aware of what constituted abuse and how to report it. Staff said that they would not be hesitant in reporting abuse should they see it occurring. One staff member said, "If I thought someone was being abused, I would go to my manager. If they did nothing about it I would go to CQC."

Although staff informed us that they would report all safeguarding concerns, we identified several areas of concern during the inspection. This suggested that some staff did not have the full understanding of safeguarding. We therefore raised a safeguarding alert in relation to the risk management with the local authority about this matter.

All the staff we spoke with were aware of whistleblowing and the right to report it. One person said, "I wouldn't hesitate, I would report things straightaway if I thought they weren't right."

One staff member said that there was a person who lived at the home who displayed behaviours that challenged. This person had assaulted other people who lived at the home. On at least two occasions people sustained serious injuries following an assault from the perpetrator. The staff member said that although the registered provider had systems in place they could not guarantee that people who lived at the home were always safe.

This was a breach of Regulation 11 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010, [now regulation 13 of the Health and Social Care Act 2014. (Safeguarding service users from abuse and improper treatment.]

One person had minimal interaction and was left to walk throughout the home at will and unsupervised. Other people were limited to the lounge area of the home and their bedrooms were locked. This meant that this person could not go into their rooms but neither could they.

A staff member said that people's safety was sometimes restricted due to staffing levels being low. The staff member said, "We could probably manage [the residents] behaviours more effectively, if we had more staff."

We looked at four weeks rotas. They showed that there was no record of when the registered provider or care manager was working. Staff were unsure when the registered manager and the care manager would be in. The rota for that day showed four care staff to support up to 23 people with a variety of needs. One staff member on duty was new and it was their first day. Each staff member was working a 13 hour shift. Long shifts, working in an intensive environment can be physically and emotionally demanding on staff and can lead to staff sickness and high stress levels, which may impact on service quality. We saw and were told that this was occurring within the home.

At the previous inspection in September 2014, we found that there was a breach in staffing levels and the registered provider was required to complete an action plan to address this. We asked the registered provider about current staffing levels and they informed us that they tried to have four staff on shift each day. When we looked at the rotas we found that on nine out of 28 days when there were only three care staff on the rota.

The registered provider said that they had reviewed staffing levels. However the organisational risk assessment had not been reviewed since May 2013. This risk assessment clearly stated that there would be two managers, two care staff, one cook and two domestics on duty. No senior managers were recorded on the rota; they said that the risk assessment was not up to date. This meant that the staffing levels did not meet the risk assessment criteria set out by

the registered provider. Care staff were completing domestic work as part of their job role as there were no domestic staff recruited. This took the care staff away from their role in caring for people.

When we asked about the new starter the registered provider said that in the first few days they were expected to be supernumerary. However on the rota they were showing as part of the staffing levels. At 1:20pm the staff member finished their shift early and the staffing level dropped to three staff members to support 23 people.

We spoke to staff about the staffing levels. Staff said that they were 'stretched' and that staffing levels were poor. One staff member said, "We do some lone working. We have an alarm that we use in emergencies but it's difficult at times, help is at hand if you need it but people don't always come as quickly as they should as they are also busy."

Another staff member said, "Staffing is poor. We have to work extra shifts to cover the vacancies. We are made to feel guilty if we don't pick up extra hours." One staff member confirmed that they worked a high level of hours. This was supported by a copy of the rota, which showed over a two week period three members of staff worked in excess of fifty hours on each week. Working such long hours can impair people's ability to carry out their role effectively.

We spoke with the care manager about the quality of information stored in people's personal files and highlighted that documents were not completed as required. The care manager said that it was their job to review and audit the care plans but they said that this does not occur as often as they would like to due to problems with staff shortages. The care manager said that they often had to carry out more "hands on" tasks because of the staffing problems they were experiencing.

After breakfast we noted that 18 people who lived at the home were moved into one lounge. The care manager said that this occurred to safeguard people from being 'attacked' by a person who had behaviour that challenged the service. However we found feedback from a relative's survey completed in 2014, before this person moved in. This suggested this practice was a long term routine. It was difficult therefore to ascertain whether or not this practice was long standing as a means to suit staffing levels rather than under the auspice of "protecting people." Regardless of this the registered provider should provide ways of managing the person's behaviour that challenged without restricting all other people in the home.

We raised our concerns about staffing levels with the registered provider. The registered provider said that "they had tried everything" to recruit and retain new staff to increase staffing levels. The registered provider could not demonstrate how they had tried to achieve this.

This was a continued breach of regulation 22 of The Health & Social Care Act 2008 (Regulated Activities) Act 2010, [now regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.]

As part of the action plan after the last inspection the registered provider had agreed that their management hours and the hours of the care manager would be added onto the rota. We found that this was not occurring as stated and that rotas failed to have their hours included. We asked the registered provider for a photocopy of these rotas. When they were returned they had added the senior staff hours onto the rota. The registered provider failed to give an appropriate answer as to why they had done this.

We found that people were not safe because they were not protected by safe recruitment of staffing at the home. Effective systems were not in place to make sure that staff were only recruited who were safe and suitable to work with vulnerable adults.

We looked at six staff personnel files to assess the recruitment practices in place for other staff. Files did not contain all the information required to ensure safe vetting procedures were in place. Two staff members had not declared their full employment history. The registered provider had not investigated further to ensure that they were confident about these members of staff's previous work history and practices. This meant that the registered provider had failed to protect people from unsafe recruitment processes because employees past work history had not been thoroughly checked.

During the inspection we overheard a staff member telling a person who lived at the home that it was their first day working at the home. Later that day, we noticed the member of staff leaving the home. When we asked the member of staff why they were leaving the home early they told us that the registered provider was sending them home as their Disclosure and Barring Service (DBS) checks

Is the service safe?

had not been received. A DBS certificate allows an employer to check the criminal records of employees and potential employees to assess their suitability for working with vulnerable adults. A valid DBS check is a statutory requirement for all people providing a regulated activity within health care. This prevents people who are not suitable to work with vulnerable adults from working with such client groups. This meant that this member of staff was working unsupervised with access to vulnerable people. We had observed the new member of staff supporting people to carry out tasks unsupervised.

When we looked at this staff member's file we found that in addition to not having a DBS check in place the registered provider had not sought references. This meant that she had no knowledge of the person's character and abilities in previous employment.

When we asked the registered provider about this, they told us that this was an oversight and had never happened before. We looked at employment files belonging to other staff and noted that previously all staff had a DBS check prior to starting to working in the home but not always references.

We asked the registered provider for the recruitment policy relating to the service. The registered provider told us that the home did not have a policy in place. This meant that the registered provider did not have recorded processes and systems in place to ensure that only staff are recruited who are suitable to work with vulnerable adults.

The registered provider said they routinely sought references as part of the recruitment process for new employees. When we checked, not all employees had received references before they commenced work. In one file we found that the registered provider had only obtained one reference which was a telephone reference. They had not recorded the name of the person they had spoken to or the date of the conversation. The only information they had recorded was "Lovely, kind, reliable." In another person's file there were no references in place. These poor practices meant people were not always protected from unsuitable staff working in the home.

This was a breach of Regulation 21 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010, [now regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.]

We spoke with a health professional who had given input to the home in the past twelve months and had made recommendations to minimise the risk of cross infection. It was evident from our findings that these recommendations had not been consistently applied. The registered provider did not have effective audit systems in place to adequately manage infection control.

When we looked around the home we found that communal bathrooms were dirty. We found one toilet with faeces on it and faeces on the wall. In one bathroom we found communal towels for people to use for bathing. This poses a risk as people can be exposed to cross infection from using communal items. Bathroom walls were stained. We also found a set of weighing scales which were stained and dirty and a commode that was soiled with faeces.

We found that the carpet in the dining room was stained and in need of cleaning. The linen cupboard which stored bedding for people using the service was disorganised with pillows stored upon the floor and were stored alongside a hoover.

We found a stained mattress in one bedroom. Three bedrooms had unpleasant urine odours in them. A senior staff said, "These people are incontinent during the night. There is nothing much we can do. We can't replace the carpet with lino as it would be a slip and trip hazard. We try to keep it clean as best we can." The registered provider had failed to address the continence needs of these individuals.

This was a breach of regulation 12 of the Health & Social Care Act 2008, (Regulated Activities) 2010, [now regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.]

It was evident from the infection control issues we identified that staff were unable to maintain standards of cleanliness as well as provide support to people living at the home. Despite us informing the senior staff member of the infection control issues on the first day of inspection these had not improved when we returned four days later.

We looked at records relating to fire safety and fire equipment. These records demonstrated that fire alarms, fire call points and equipment checks were carried out regularly. We found that the fire risk assessment in place had not been reviewed. This reduced the effectiveness of the fire safety.

Inadequate

Is the service safe?

We noted that a gas safety record was last completed in 2011 was out of date. The registered provider said that the gas safety record had not been completed as the registered provider had recently replaced the boiler and it came with a twelve month guarantee. The registered provider was unable to provide us with any gas certificates to support all other gas appliances within the home. We also found that annual portable appliance (PAT) testing for all electrical equipment was out of date. This meant that the registered provider had not ensured safety checks were carried out to assist with keeping people safe.

This was a breach of regulation 16 of the Health & Social Care Act 2008 (Regulated activities) 2010, [now regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.]

We observed staff giving medicines. They received training before administering medicines. However we saw they did not always administer this safely. We watched the staff member give a number of people their medication at the same time. This increased the risk of people being given someone else's medication. The staff member left boxes of medicines unsupervised on a dining table where people using the service were sat.

We looked at Medication Administration Records (MAR) and we saw that there were gaps in recording. Nine MAR sheets had gaps on them where creams had been administered but not signed for. We spoke with the registered provider said that they had already dealt with this and showed information to support this.

We found that one person's breakfast and lunchtime medication was given within an hour and twenty minutes of each other. The registered provider had not checked whether this was safe or considered how two doses so close together may affect the person.

We looked at medication that required to be stored in a fridge. The registered provider did not have a separate fridge for storing medication but had a secure box that was stored inside the main fridge. We found that all creams were not stored appropriately in the secure box but were stored on top of the box alongside food stuffs.

This was a breach of regulation 13 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010, [now regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.]

Records showed that there was a number of occasions on which staff and people had been assaulted by people who used the service. We asked the registered provider for all accidents and incidents that had occurred in the past three months but they were unable to supply them. Accident forms were completed and stored in individual files but the registered provider did not hold a central recording system of all accidents. This meant that the registered provider was unable to review and evaluate the number and types of accidents that had occurred as a means to improving the quality of the service.

We also found that accidents and incidents were not always recorded accurately and appropriately. One person's care notes documented that this person had been assaulted by another person using the service. When we looked at the other person's notes there was no mention of this incident in the other person's file. This meant that information relating to serious incidents was not always recorded.

We spoke with the registered manager about plans for evacuation and emergencies as we were concerned about the level of staffing cover during the night. There was a heavy reliance upon people using the stair lift to get downstairs and the registered provider did not have any other equipment that would assist them in evacuating people down the stairs in an emergency. The registered provider assured us that there was a plan in place for fire and that the policy was not to evacuate people from the home but to do a parallel evacuation between the two sides of the home. The home was equipped with smoke doors to allow the provider time to carry out the evacuation. We viewed a comprehensive risk assessment document that detailed this.

Inadequate

Is the service effective?

Our findings

People we spoke with said that they were happy with the care being provided. One person said "The care is good. The home is as good as care homes can be."

One of the relatives we spoke with said that the staff at the home were very good at communicating with them. Whenever there had been any incidents or their relative was not well they were clearly informed of all updates. The relative said, "They always tell me what has happened to keep me updated. I don't have to worry about that. The service is great."

Although people and their relatives using the service said that the care they received was good. We found that effective care was not always delivered.

A number of people were admitted to the home with pre-admission information that suggested that the people had behaviours which challenged. Despite these behaviours being identified prior to admission the registered provider failed to put effective systems in place to manage the behaviours and provide effective care. On two occasions this led to a rapid breakdown of a placement and the individual's had to move on to other services. This caused significant upset for the people and their families.

We asked staff about how they dealt with behaviours which challenged. Members of staff said that they were not equipped to deal with challenging behaviour and stated that they worked in a difficult environment. One staff member said, "We aren't trained to support people with challenging behaviours, the stress of it all gets to you at times." One staff member said that they had received half a day's informal support from the care manager. Another staff member confirmed that they had not received any challenging behaviour training. One staff member said, "People were fearful of working with [person who challenged the service] so they just phoned in sick," as a means to avoid dealing with behaviours which challenged. Records showed that on one day, there were three separate incidents where one person assaulted staff.

We asked the registered provider about how staff were trained to deal with behaviours which challenged. After acknowledging that staff were not trained in this area, the registered provider said, "There is not much I can do; I offer them a shoulder to cry on."

The three senior managers at the home had received some training for management of challenging behaviour. No other staff had completed any challenging behaviour training. This lack of training was reflected in staff performance and their inability to deal with behaviours which challenged the service.

Training records showed us that the registered provider had not commissioned any training for physical interventions. Physical intervention is sometimes required to safely diffuse any challenging situations. We asked the registered provider about their policy for physical interventions including restraint. The registered provider told us that the home did not have a policy for such and did not restrain people. However we noted that staff had recorded in one person's file that staff had used restraint to take control in three separate incidents.

In order to monitor staff training progress the provider maintained a training matrix. The staff training matrix showed that there were 18 staff employed in the home. A training matrix can be used to develop workforce planning to ensure that staff are trained and equipped with the necessary skills. However the training grid did not reflect the staff shown on the rota and did not show dates on which training was completed. This meant it did not show when training was out of date or refresher training was required.

Fifteen of the staff members had national vocational qualifications (NVQ's) in care, which was positive. However we found that specialist training that would not be covered within an NVQ and was essential for their role was incomplete. Only 10 of the 18 staff had received a fire safety lecture. Only the senior managers and care manager had any training in diabetes awareness despite there being people at the home who were diabetic. The cook at the home did not have an up to date food hygiene certificate despite them handling and preparing food.

We spoke with staff about the induction that they received at the start of their employment. One staff member who had worked for the company for two months confirmed that they had only received two days shadowing at the beginning of their employment. They had not received any induction or training but said that they had been given some information relating to infection control and the Deprivation of Liberty Safeguards (DoLS).

Inadequate

Is the service effective?

This was a breach of regulation 23 of the Health & Social Care Act 2008, (Regulated Activities) 2010, [now regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.]

The provider had ensured that 12 of the 18 staff had received one day dementia awareness training; however we failed to see that this training had been put into practice. There were no measures to improve well-being and independence for people living with dementia. There was a lack of signage around the home for people to distinguish rooms. We overheard one staff member asking another staff member to take a person to the toilet "so that he does not get lost." The main lounge had a flowery patterned carpet. We observed people attempting to bend down and pick the flowers off the patterned carpet in the main lounge. Patterned carpets can affect people living with dementia's spatial awareness and can contribute to falls. Environments that are designed specifically for people living with dementia can decrease agitation and behaviours which may challenge.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the registered manager. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivations of Liberty Safeguards (DoLS) are part of this legislation and ensure where someone may be deprived of their liberty, the least restrictive option is taken.

Although the home had policies in place in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), the registered manager and management team did not have a working knowledge of them. Only three staff had received some training in Mental Capacity Act awareness and Deprivation of liberty safeguards.

The Mental Capacity Act provides a statutory framework to empower and protect vulnerable people who are not able to make their own decisions. In situations where the act should be, and is not, implemented then people are denied rights to which they are legally entitled.

We were informed by a health professional that they had carried out some work with one person at the home that the registered provider and staff had demonstrated little knowledge of how to assess people's capacity. Consequently we found that not all people who lived at the home who lacked capacity had capacity assessments in place.

Throughout our visit we noted that almost every resident was sitting in one lounge throughout the day. People were unable to leave the lounge without a staff member to escort them. The lounge where everybody sat was constantly supervised by one staff member. Of the 23 people who lived at the home 18 were made to sit in the lounge. The care manager explained that this policy was in place to safeguard the 18 people as these people had been identified as vulnerable and susceptible to being targeted by another resident who had challenging behaviour. The individual with behaviours which challenged was described as "Wandersome" and it was best to leave this person to wander the home whilst containing everyone else. We spoke to the registered provider about this and they failed to see that they were unlawfully depriving people of their liberty and that this was not the least restrictive option.

We found that one person's care file had a capacity assessment in place from a health professional. This assessment clearly stated that this person did not have capacity and this person was unable to make decisions regarding their health. However we found care records that showed that when this person was ill, the staff asked this person if they wanted to see a doctor and he declined. The staff accepted his view and did not take into consideration his capacity or lack of it. The staff failed on this occasion to act in the best interests of this person and call a doctor. Consequently, this person's health deteriorated significantly and they were then admitted to hospital. Not understanding the concept of capacity on this occasion meant that effective care was not provided at this time.

We also found a number of restrictions in other people's care notes that may have amounted to an application to deprive an individual of their liberty but there was no evidence that an application had been made. One person had restrictions in place relating to smoking, expressing their sexuality and contact with family. We also noted that one person was secured into a wheelchair with a lap belt for over an hour. We spoke with the registered provider

about their responsibility under the Mental Capacity Act 2005 and the need to apply to deprive people of their liberties. The registered provider had little understanding of this legislation or up to date case law.

This was a breach of Regulation 18 of the Health & Social Care Act 2008 (Regulated Activities) regulations 2010, [now regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.]

People we spoke with said that the food provided was good. One person said that there was always a variety of food to eat. We observed breakfast and lunch being served. At breakfast time the dining room was cold and did not make the environment a pleasurable place to sit. The thermometer in the adjoining room showed that the temperature was only 18 centigrade. Staff were heard asking people if they wanted to move to the lounge immediately after finishing their breakfast as the room was cold.

The daily menu for the day was displayed outside the kitchen however there were no pictures illustrating the meals to assist people with limited reading ability, so this was of limited use to them.

We saw that the chef had not up to date training in food hygiene. Information we received prior to inspection informed us that the home had recently had an inspection from the HSE (clarify) which showed that the hygiene of the kitchen needed improving. This meant that the chef did not have the required skills to ensure that the kitchen was cleaned to a high standard. We were given drinks on inspection in badly stained, dirty cups.

People were offered soup and shepherd's pie and vegetables, followed by a desert. The chef told us that people were offered alternatives if they did not like what was on offer but there was no evidence of this during lunchtime. Portions were plentiful and no one complained about the meal. Three people said that lunch was good. Lunch time meals were served on blue willow patterned plates, rather than plain plates contrasting with the table. Patterned plates can be confusing to people living with dementia and can inhibit eating.

Whilst people were eating lunch, we observed the cook going around the room asking people what they would like for their evening meal. People were verbally offered a choice of soup or sandwiches. For people living with dementia no alternative cues were used to enhance communication, (i.e. pictures of food.) Similarly, there were no other cues available at tea time to remind people what they were eating.

Staff support was good over lunch time and people were served in a timely manner. We were informed by the cook that special diets were catered for and saw that alternative sweets were offered at lunchtime.

We observed people being offered drinks and biscuits throughout the day. This meant people were given enough fluids and snacks.

Staff confirmed that they undertook regular formal recorded supervisions with the registered provider every three months but could request extra supervisions with the registered provider if they wished. Supervision is a one to one support meeting between individual staff and a management team member to review their role and responsibilities. We saw evidence of supervision records being maintained by the registered provider. Staff also confirmed that they had appraisals in place, with goals being set for them by the registered provider.

We recommend that the service finds out more information, based on current best practice, in relation to the specialist needs of people living with dementia.

Requires improvement

Is the service caring?

Our findings

People who used the service spoke highly of the staff and described them as very caring. One person said, "I have lived here for three years, it's alright. All the staff are lovely."

Relatives also said that the staff were very caring. One person said, "The carers are great. The staff are lovely; nothing is too much trouble for them." Feedback from one relative through a relative survey in 2014 said that staff were, "Kind and compassionate."

Although feedback from people and relatives was positive we found a focus on task orientated care rather than person centred care. This did at times inhibit caring relationships from developing. We saw one staff member sitting in a lounge. The staff member was more concerned with completing paperwork rather than interacting with people. There was little meaningful activity going on and the staff member failed to look for ways to enhance the interactions between people. This left people sleeping in their chairs without any stimulation.

We saw one person standing up from their chair and was visibly upset. The individual told the staff member that their trousers were too big for them. The individual was then told there was nothing that they could do about it as their trousers were in the laundry and that there were no others available until later. This left the person upset and the staff member had failed to promote this person's dignity. The registered provider said that this person did not have much clothing and they were looking into this. However the member of staff could have taken the time and been more supportive in this instance.

Although staff told us that they promoted independence at all times we failed to see this happening on a regular basis. People were not permitted to leave a lounge without being escorted and whilst in the lounge they were not offered any choices as to what they wanted to do. There were not enough chairs in the lounge to accommodate people and people were left in wheelchairs for long periods of time.

We asked the registered provider about people having access to advocacy. The registered provider said that they had used advocacy services in the past. However on one occasion this resulted in negative outcomes where the advocates had made complaints against the staff to the local authority. They said they were reluctant to use such services again. There was no supporting literature about the home that enabled people to access advocacy that gave people information about advocacy. This restricted people's access to advocacy services.

Privacy and dignity was not maintained at all times. We found that bathroom locks did not work on any of the bathrooms. This meant that people could not have guaranteed privacy when using the bathrooms. We also observed one person having their eye drops administered at the dining room table in front of everyone else.

This was a breach of regulation 17 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 [now regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.]

Throughout our inspection we saw mixed interactions between the staff and people using the service. Most interactions were positive. We saw staff encouraging communication with people by using open questions. This showed that staff were interested in people, as well as generating discussion. We heard staff members asking people, "Did you sleep well?" and "Are you ready for a new day." People were comfortable in staff's presence as they laughed and joked and were relaxed in people's company.

Staff interviewed showed a genuine interest in caring for people but felt that this was often hindered by the lack of time available.

We found some staff that went "the extra mile." One person who lived at the home was on end of life care and very poorly. Staff member stayed on extra hours to sit with this lady in the latter stages of her life so that she was not alone. The staff team ensured that her end of life care was very person centred and meaningful to her. This included working closely with the health care professionals and hospital staff to ensure that the individual was at the home as she had wished for the end of her life.

The provider had completed some good work to ensure that equality and diversity was promoted within the home at all times. One staff member said, "It's important that we get to know people and understand that everyone is different." We looked in one person's file and noted that the staff had addressed an issue of discrimination with this individual. The individual had arrived at the home with

Requires improvement

Is the service caring?

some strong beliefs about ethnicity and race. This was addressed in an appropriate manner to ensure that the individual was aware that whilst such beliefs were acknowledged they were not tolerated in the home.

Requires improvement

Is the service responsive?

Our findings

Three people who lived at the home said that they knew how to complain and would feel comfortable in doing so. One person said, "If I ever need to complain, I just mention it to the staff."

Relatives we spoke with all said that the registered provider responded positively to any concerns that they may have. One relative said, "Oh yes, nothing is too much trouble for the staff." Another relative said, "Staff will listen, if I ask them to sort something out they will get on with it. I know it will get done."

The registered provider had a complaints box in the reception for people to complete if they wished. This was readily accessible to all visitors. Although people reported that complaints were dealt with effectively we found that on two occasions where there had been significant complaints made there was no evidence of these being logged and monitored. The registered provider told us that they did not have systems in place to monitor and log formal complaints. Consequently there was no evidence to show that these complaints had been investigated and systems within the home had been reviewed as a result of the complaint.

Although the registered provider had a system in place for people to complain we found that not all people who lived at the home were aware of their right to complain. One person said that they were unhappy with not having their own bathroom and said, "I just get on with it, there's nothing else I can do." We found no evidence of the provider holding any 'residents' meetings to discuss complaints and concerns or to receive feedback from people who lived at the home.

Although files contained behavioural monitoring charts there was no evidence that these were being completed accurately by staff. Behavioural monitoring charts allow staff to report all inappropriate behaviours which can then be analysed to see if there is any meaning to the behaviour. This allows services to plan more appropriately to minimise any triggers that may cause challenging behaviour and allows for systems to be put in place to reinforce positive behaviours. One person's care plan file demonstrated clearly that this person had significant behaviours which challenged. The community mental health team had implemented behavioural monitoring forms to complete but there was no evidence that these had been completed by staff. This meant that inappropriate behaviours were not effectively recorded and reported on.

We found that assessments which would have had bearing on a person's health and care plan were not always completed or acted upon. One care plan had been reviewed but had no dates on to say when it had been reviewed. Another care plan showed that an individual had been weighed as per their care plan but there was no evidence to show that the provider had evaluated the weight loss and sought help from other health professionals. Another person had a falls risk assessment in place but this had not been reviewed for over a year.

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2010 [now regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.]

We asked people living at the home about activities that were provided. One person said that activities "were ok at the home." Another person said, "We sometimes have an entertainer come in." Although two people were happy with activities we found little evidence of regular activities taking place.

Whilst we were visiting the home there was a lack of appropriate activities offered throughout the day as a means to occupy people. People were sat in the lounge, mainly asleep. There was no activities plan and no evidence that activities had been provided. One staff member told us, "I wish we could do more activities. It's interesting spending time with the residents."

Although the registered provider said that people have one to one activity sessions we failed to see these occurring.

Although the registered provider caters for people with dementia, we failed to see little evidence that dementia friendly activities were on offer to enhance the lives of the people living at the home. We noted that the provider had done some reminiscence work and had old items of equipment in the home and photos on the wall but these were located in the dining room, in an area where people did not have ready access to.

The care manager said that people were encouraged to be involved in carrying out tasks around the home to keep them occupied. However we did not see this happening.

Requires improvement

Is the service responsive?

When we asked the care staff about people being involved in tasks, we were told that people could not possibly do this due to health and safety and not knowing, "Where their hands had been."

This restricted way of thinking prevented person centred opportunities to occur and consequently meant that people were not involved actively in the running of the home. Involvement in such tasks can promote self-esteem, reduce isolation and decrease any incidents of behaviour that challenges the service.

We noted that there were books available for people to read and the registered provider said that the community library comes in regularly and swaps the books. Books were appropriate to the age of people who lived at the home and included topics such as "Lancashire attractions of the past" and steam trains. It was difficult to ascertain how many people who lived at the home would be able to use this facility unsupported. We did however see the care manager selecting a book from the shelf to read to people in the communal lounge. We witnessed no other activities occurring during our visit.

We looked at five peoples care records and other associated documentation. We saw evidence that people who lived at the home, and/or their family members had been involved with providing this information. People had care plans in place that covered a variety of topics including, weight, medication, mobility, diet, religion, pain and medication management and personal care. Some care plans had comprehensive information relating to historical but important events in people's lives that had bearing on the person they were today.

Although information was recorded in care plans, we found that staff did not always follow what was in care plans. One person's care plan stated that the person required "stimulating activities to reduce their aggression." We did not see these being offered to the individual throughout our inspection. We were also informed of another person who was to be offered one to one times to distract them from inappropriate behaviours but again, there was no evidence of this occurring and the individual was just left to wander the building.

Person centred planning for individuals who used the service was sporadic. Whilst some files did not contain any person centred planning, we found pockets of work which supported this. The provider had completed some work with one person who was from a different country. The staff had completed some art work with the individual showing photographs of their home country. They had also included some brief phrases that staff could use in communication with the individual.

Risk assessments were in place for all people using the service and covered topics such as falls, smoking and monitoring of weights. Although risk assessments were in place we found evidence in two files that reviews were not always taking place. One person's file stated that a falls risk assessment was to be reviewed in February 2014 but this had not occurred. When we spoke with the registered provider about evaluating falls they informed us that they collated all evidence in a central file and looked over it but do not formally review all incidents to look for themes.

We spoke with a visiting health professional who had visited the home unannounced. The health professional was complimentary about the staff and the service they delivered. The health professional said that they had visited the home that day unannounced and were pleased to see that the care staff were following protocols in relation to one person's care as they were advised.

We recommend that service develops a person centred, flexible way of working, and provides suitable person-centred activities.

Inadequate

Is the service well-led?

Our findings

One person who lived at the home said that the registered provider "Was good at her job."

Relatives we spoke with were all complimentary about the way in which the service was managed. All relatives said that the registered provider was amenable and accessible and were confident that any concerns they had would be dealt with effectively.

Although relatives and people felt that the registered provider was good, we found evidence to suggest that they did not show all the necessary skills and knowledge to manage effectively.

The registered provider had not successfully completed the action plan from 2014 in regards to staffing. Staffing levels had not been reviewed and new staff had not been recruited. This constituted an on-going breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) 2010 which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014. (Staffing.)

Although we received positive feedback from relatives, interviews with staff demonstrated that there was a poor culture within the home. The registered provider had failed to address areas of concern to ensure that a positive and safe environment was developed for both staff and people using the service.

Training and care records showed us that the registered provider had failed to equip themselves and support people to carry out their roles effectively by providing training in how to manage challenging behaviour. This poor management resulted in a high number of incidents where both staff and people using the service were assaulted. The registered provider had failed to address this issue and put systems and training in place to manage and prevent these incidents from occurring.

This was a breach of regulation 23 of the Health & Social Care Act 2008 (Regulated Activities) 2010 [now regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.]

Staff informed us that staff sickness at the home was a major concern. Rotas showed that over a 28 day period, ten of the 18 staff had missed at least one day's work due to sickness.

Staff rota's demonstrated that there was a heavy reliance on staff to cover absence. Staff said they were made to feel guilty if they did not cover extra shifts. The registered provider had not conducted any root cause analysis to determine why sickness levels were so high. Had such analysis been carried out the registered provider could have implemented systems to address this area of concern and reduced the pressure on already strained staff. This meant that the registered provider was working in a reactive manner rather than a proactive manner.

Staff said that the registered provider was approachable and sometimes sought their views but these were not always listened to. Two staff said that they had tried speaking with the provider about the staffing problems but they were not listened to. One staff member said "I have suggested we have a bank of staff but nothing has been done."

One staff member said that turnover at the home was high and people "did not stick around long." This high staff turnover had a negative effect on the culture at the home as staff were expected to train and support new staff as well as carry out their own tasks. This meant that staff were not familiar with the needs of people who lived in the home and people did not know the people caring for them. One staff member said, "Its hard work, people have to gain the trust of the staff before they can have relationships with them. It takes time and causes problems for the rest of the staff." Such a high turnover of staff can contribute to poor outcomes for people using the service.

The provider did not have effective quality assurance systems in place to ensure that high quality care was always achieved. The provider did not hold formal 'residents' meetings to gain feedback and did not carry out annual surveys with people who lived at the home to see how satisfied they were with the service. This meant that the registered provider had failed to look at quality from the prospective of the people using the service.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 [now regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.]

The registered provider had failed to ensure that the premises, services and equipment was well maintained.

There was no formal system in place to manage and identify environmental risks. We identified that PAT testing

Inadequate

Is the service well-led?

of equipment was out of date and the fire risk assessment had not been reviewed. The registered provider had no knowledge of the hole in the ceiling. This meant that actions that should have been completed to promote people's safety had not been reviewed and actioned by the registered provider.

Although the registered provider had completed an annual audit with relatives to assess their satisfaction, there was no evidence that this feedback was considered and acted upon. Relatives had suggested that more activities were required and asked that improvements were made to cleaning but we failed to see that this had happened. This shows that the registered provider was not always responsive to change and improvement.

The registered provider had failed to equip themselves with appropriate knowledge to monitor the care practices at the home. Although the registered provider knew people were at risk of harm they had failed to follow the correct safeguarding procedures.This meant that the registered provider had not responded in a safe and effective way to manage and improve practice where care was poor.

The registered provider was not always transparent. An inspection by the food standards agency in August 2014 found that kitchen hygiene was not up to standard and improvements were required. The registered provider had failed to update the certification in the home. This meant that people and relatives were not kept up to date and informed when service deficiencies were found.

Team meetings were organised but the registered provider said that they did not take place as often as they should do. We saw that there had been two team meetings within one year. Team meetings allow people the opportunity to discuss and share ideas as a means to improve service delivery and solve problems. The lack of these meetings inhibited communications and compounded the negative culture within the home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The registered provider had failed to seek the views of people using the service as a means to regularly assess and monitor the quality of the service. The registered provide had failed to identify, assess and manage risks relating to the health, welfare and safety of people using the service and others who were at risk from carrying out the regulated activity.

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 provider had failed to provide suitable arrangements to ensure that people were safeguarded from abuse. The provider had failed to take reasonable steps to identify the abuse and prevent it before it occurred. The registered provider had failed to ensure that suitable arrangements were in place to protect people using the service from unlawful restraint.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control The registered provider had failed to ensure the people who lived at the home, staff and other people visiting the home were protected against risk of acquiring infection. The registered provider had failed to ensure that the environment was maintained to an appropriate standard of hygiene.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The registered provider failed to protect people using the service against risks associated with unsafe use and management of medicines. The registered provider had failed to keep appropriate records relating to administration of medicines and had failed to ensure that they were stored appropriately.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment The registered provider failed to make suitable arrangements to protect people and others who may be at risk from the use of unsafe equipment. The registered provider failed to ensure that equipment was properly maintained and suitable for purpose.

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 provider had failed to ensure that privacy and dignity of people using the service was promoted and maintained. The registered provider had failed to develop opportunities to enable people to be independent and encourage autonomy.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment

This section is primarily information for the provider

Action we have told the provider to take

The registered person did not have suitable arrangements in place for obtaining and acting in accordance with, the consent of service users, particularly in relation to the Mental Capacity Act 2005 and particularly deprivation of liberty safeguards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers The registered provider had failed to ensure that they had robust and effective recruitment procedures in place to ensure that all people working at the home are of good character and has the skills, experience and qualifications which were necessary for the job.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The registered provider had failed to take appropriate steps to ensure that there was a sufficient number of suitably qualified, skilled and experienced staff on duty at all times.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered provider had failed to ensure that staff were provided with appropriate training to assist them to support people effectively.