Care Quality Commission

Countrywide Care Homes Limited

Croft House Care Home

Inspection report

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20 November 2015

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Ratings

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

Summary of findings

Overall summary

The inspection took place on 19 and 20 November 2015 and was unannounced. The service was last inspected on 10 February 2014, this was a focussed inspection and the service was found to be compliant in the one key question which was inspected.

This inspection was in response to concerns which had been raised by the local authority who commissioned services at the home. These concerns related in particular to the Elderly Mental Infirm (EMI) unit, which offers care provision to up to 24 people with mental health conditions including advanced dementia and people who display behaviour which challenges others. The concerns related to the amount of incidents which had been occurring on this unit where people who used the service were assaulting each other.

Croft House Care home is a large building laid out over two floors. On the ground floor there are two general nursing care units, one with 18 beds and the other with 12 beds. On the first floor there is a small residential unit with 12 beds and the Elderly Mentally Infirm (EMI) unit with 24 beds. On the days of our inspection there were 61 people living at the home.

There was no registered manager in post at the time of our inspection. 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.

There had been a manager appointed to the service and there was a deputy manager, neither were present on either of the days during our visit. The Regional director arrived during the morning of the first day of our inspection and was present for the remainder of the inspection.

We found the standards of care in the service had deteriorated significantly since our last inspection. There were multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We found people's care needs had not been adequately or accurately assessed and there was no care plan in place for one person who lived at the service. People's care plans were out of date and the information did not reflect their current needs or describe the care which required by them or was being given to them.

We found people in the service were not treated with dignity and respect. Some of the people living in the service were unable to access the toilet without assistance and were being left for long periods without access to assistance. Staff did not recognise how people's dignity could be promoted and did not assist people promptly when they needed help, as people did not have access to care bells or were unable to use them.

The people living in the service were not asked for their consent for care to be carried out. The provider and

the staff failed to recognise restrictive practices which were in place. Mental capacity assessments were not carried out for the people living in the service to measure whether they were able to make their own decisions and which decisions they were able to make. Where people's liberty was being restricted there were very few Deprivation of Liberty Safeguards in place.

There were very few risk assessments in place for people in the service and those that were in place were not adequate to identify and reduce identified risks to keep people safe. We found large numbers of people were left in bed as a matter of course, even when they were expressing that they did not want to be in bed. People who remained in bed were not receiving adequate pressure area care and there were incidences of serious pressure areas in the service as a result. People who had pressure area wounds were not receiving the correct treatment to ensure that their wounds would heal, and records of treatment and visits from external health professionals were not detailed.

Staff did not recognise safeguarding incidents that were occurring. There were few safeguarding referrals made to protect vulnerable people living in the service until incidents were highlighted by CQC during the inspection, and those which had been made recently were highlighted by other visiting professionals and had not been instigated by the provider.

We found that some people were left without access to drinks and snacks. We saw that food records were inaccurate and were not filled in at mealtimes, which meant staff could not accurately monitor people's food and fluid intake. We found evidence of weight loss in some of the people living in the service, and people were not being weighed regularly to monitor their weight. We found people who required specialist diets were not receiving these this was particularly in relation to people with diabetes.

There were no processes in place to monitor the performance of the service or to maintain accurate records of the care which was being delivered. We found that there were no records for accidents and incidents which we found referenced in care records. We found that there was no effective leadership within the service.

There were not enough staff to care for people safely and to meet their needs. Staff were not well trained and were not competent in all areas of their roles.

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 or 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.

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.

Safeguarding incidents were not being recognised and reported to the relevant authorities.

There were not enough staff to meet people's needs and keep them safe.

There were no effective risk assessments in place which identified and managed the risks to people living at the home.

People who were cared for in bed were not receiving the necessary care to protect them from pressure areas, and when areas developed they were not well managed – this is evidenced in the report in effective

Is the service effective?

Inadequate

The service was not effective.

The staff who were on duty were sufficiently trained or skilled to meet people's needs.

People's mental capacity was not being assessed and people who should have had a Deprivation of Liberty Safeguard in place did not.

There were restrictive practices in place throughout the service

Is the service caring?

Inadequate

The service was not caring.

Staff whilst caring in their interactions were not able to meet people's needs as they were too busy.

People were not supported to be independent and their independence was restricted by the practices in the service.

People are left in their rooms or in lounges for long periods with no method of calling for assistance and no staff present to

support them.

Is the service responsive?

Inadequate

The service was not responsive.

People's care plans were not detailed or person centred, there was inconsistent and contradictory information throughout the care files.

There was only one planned activity which lasted for an hour, people were bored and isolated for long periods.

Complaints were not always being recorded and those that were recorded were not dealt with adequately.

Is the service well-led?

Inadequate

The service was not well-led.

There was no leadership present in the service, care staff were not given direction or instruction during shifts.

There was no evident management or provider oversight to monitor the quality of the service or identify issues.

The provider was not keeping adequate records, the records were not detailed and did not reflect the care or events which had taken place.

Care Quality Commission

Croft House Care 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 19 and 20 November 2015 and was unannounced. The inspection team consisted of three adult social care inspectors and a specialist advisor in adult safeguarding and mental health conditions, one of the inspectors was only present in the afternoon of day two of our inspection.

We were unable to request a provider information return as the inspection was in response to serious concerns raised by commissioning authorities of the service. During our inspection we looked at care plans and risk assessments for 19 people, six staff recruitment files, complaints, concerns, accidents and incidents records, policies and procedures, records of audits which had been carried out in the last 12 months, safety certificates and daily care records.

We spoke with 23 people who lived at the service, six visitors to the service, eight care staff, two nurses, one cook and the regional director, the unit manager for the residential care unit, a peripatetic manager and a quality assurance manager who was shared across homes in the registered providers group of service.

Inadequate

Is the service safe?

Our findings

We saw that there were not enough staff to safely meet the needs of the people living at the service. People told us "The only thing that bothers me is there is no staff. This morning I rang my buzzer but when they came they just turned it off because they said they had someone in the bath so I had to wait." "Staff are lovely, but they are rushed off their feet." "You can never get staff when you want them. I can usually wait but I shouldn't have to. The staff are nice but they are too busy for me." "When you've had trouble with staff you don't say anything, because they are short staffed." "There are not enough staff, I feel sorry for them, and they must meet themselves coming backward. I want to press the buzzer but I worry about troubling staff when they are so busy."

We observed the care workers who were on duty were poorly deployed throughout the service with no clear direction or leadership. For example there was a delivery to the home which required staff from each unit to collect supplies and move them from the main reception. Staff from each unit were all sent together to carry out this task. We saw that there were six of the available 10 care staff carrying out this task at the same time which meant there were not enough staff caring for people and that if people were calling for assistance there would not have been any staff available to assist them. There were not enough staff to meet people's needs safely because people were routinely left in their rooms, people we spoke with told us that they stayed in their rooms because there were not enough staff to get them up each day, some people told us they were sometimes got up and taken to the lounge but this was not consistent. Staff were delivering one to one or in some cases two to one care in people's rooms, which meant that staff were not visible or accessible for long periods of time. Staff told us that they were sometimes moved between units during shifts, which staff told us meant that some areas of the home were even more short staffed at these times. We saw from care records that people were not being bathed and showered frequently and people told us that they only got a bath if they asked and even then it was only if the staff weren't too busy.

Staff told us that staffing levels had been an on-going issue. On the ground floor there were two units which had 18 and 12 bed occupancies. There were two staff on the 12 bed unit and three staff on the 18 bed unit. Staff told us that the majority of people required care from two staff, which meant that there were no staff available to the other people on those units when they were delivering personal care. Staff told us and the nurses confirmed that the number of staff was dependent on the number of people who lived at the service and the dependency of those people was not factored in. We asked the regional director about staffing levels, they told us that based on the number of people in the home they felt that the staffing levels were adequate. Staff we spoke with told us that the level of staffing was based on the number of occupants and did not take into account the level of dependency. People who used the service and their families confirmed that they had to wait for long periods for staff to attend to them when they pressed their call bells. The family member of a person who used the service told us "(their relative can wait several hours for the toilet when staff were busy; they have a pad on so it is usually alright." A service user told us "I can wait for a bit when I need the toilet, but I shouldn't have to."

This was a breach of Regulation 18 (1) staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke to staff and asked them about their understanding of the safeguarding process and whether they could explain the signs and symptoms they would look for which might indicate that abuse was taking place. Staff did not have a good understanding of safeguarding people, and could not demonstrate that they would recognise signs of abuse. Staff were not clear about how they would report safeguarding concerns. This meant that staff were not recognising safeguarding incidents and were not reporting them to protect people from further harm.

We looked at the accident and incident records for October 2015 and saw that there had been 21 incidents where people who used the service had displayed aggressive or violent behaviour which had involved other people living at the service, all of which should have been recognised and reported as safeguarding matters, but had not been.

We spoke with the nurses on duty who told us they were unaware that they could make a safeguarding referral themselves and that they would not know how to do this. This was particularly concerning as there was no manager in the home on the first day of our inspection. The nurses were also unaware of who they would escalate a safeguarding concern to if they felt that the manager had not taken appropriate action.

We looked at the accident records for the service in detail, and we looked for corresponding accident forms for injuries which we found recorded in daily care records. We found that even in cases where there had been serious injury an accident form was not always completed. For example we identified one person had suffered two serious fractures in 2015 but we could not find an accident form for either injury. This meant that there was no means of tracking how many accidents had occurred and that injuries were not being appropriately reported.

This was a breach of Regulation 13 (1) safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw there were risk assessments in the care records, however these assessments did not identify individual risks, were not accurate and did not match the information contained elsewhere in the care plans. For example in one person's moving and handling risk assessment it stated they needed the support of two care staff and a zimmer frame to mobilise. The person this related to was walking independently using a walking stick throughout our visit. We saw there were call bell assessments in place. In cases where the person was unable to recognise the purpose of their call bell due to cognitive impairment or there was a physical reason why they could not use a call bell, there was no alternative method of calling for assistance. This meant that people were not able to call for assistance when they needed it.

There were personal emergency evacuation plans in place. When we looked at the instruction for each individual due to the level of dependence, the equipment and staff required to move people it became evident that the plans were impractical, as the number of people who required two care staff and equipment to move them could not be met. We discussed this with the peripatetic manager who arrived at the service on the second day of our inspection who told us that people would not be moved as described in these plans under emergency circumstances, and that the plans would need to be amended.

This was a breach of Regulation 12 (1) safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the home was not clean. There was evidence of poor cleanliness throughout the building. We saw that the majority of the chairs in the lounges were stained and some were malodorous. We saw there

were drinks left in people's rooms for long periods and people who were in the lounge were given new drinks but the last one was not always removed. We found there were issues throughout the building with offensive odours, in particular one of the corridors on the ground floor, where there was a very strong odour at each end. Staff did not investigate the source of these odours until we became insistent. We identified that one of the odours was due to poor wound care of a person who used the service, and the other odour was coming from the sluice room, which was unclean. We also found the sluice room on the first floor EMI unit was malodorous and unclean. We found that bathing equipment was heavily stained with faeces in some of the bathrooms. A senior member of staff told us one of the sluices on the first floor was not working correctly and that they 'rinsed out' urine bottles and bed pans as they were unable to take them to the ground floor sluice.

In the ground floor lounge there was a patio door which had a 'do not use' sign on it. We asked staff about this and were told that the door was broken and 'dropped off the runner' if opened, staff could not remember how long the door had been out of use.

This was a breach of Regulation 15 (1) premises and equipment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst we saw that most of the time the administration, storage and disposal of medicines was safe, this was not always the case. On the first day of our inspection we observed that a member of staff had left a packet of newly delivered medication on top of the medicine trolley and unattended for a period of 10 minutes in one of the corridors. This medication could have caused significant harm to a person if they had taken it. We took this medication to the regional director and reported the incident on the morning of the first day of our inspection, we checked at the end of the second day of our inspection, there had been no incident form or investigation completed in respect of this matter, which should have been reported to the local authority safeguarding team. The regional director confirmed that there had not been any action taken in respect of the incident and felt that the member of staff 'felt bad enough'.

The nurses we spoke with told us that they spent all their time administering medication to the people who used the service, because there was no-one else who was able to assist with these duties. The nurses told us that people had wounds which needed to be dressed and other nursing tasks to attend to, but they did not have time to do them as a result of the time it was taking to carry out the medication rounds. We found that because people's mental capacity had not been assessed the administration of medication could not be in line with this legislation, and people's assessments of their abilities to make decisions about their medication were not accurate as a result.

This was a breach of Regulation 12 (2) (g) safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
We looked at the recruitment processes which were in place. We found that the recruitment which had taken place was safe and that all necessary pre-employment checks had been carried out in line with the organisations recruitment policy. This included references being sought from previous and employers and a disclosure and barring service (DBS) check to ensure that people were suitable to work with vulnerable people.

Inadequate

Is the service effective?

Our findings

People said the food was 'generally alright' or 'satisfactory'. People told us "I've really enjoyed my dinner." "That was tasty, I really enjoyed It." and "I'm not bothered for mine." "The food tastes nice but it is always soft, I don't like my potatoes runny like they serve them here. I know some people need that kind of diet but I don't and I have to eat what's made here."

The Care Quality Commission (CQC) monitors the operation of the Mental Capacity Act 2005 (MCA) and specifically on the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. 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 the least restrictive option 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 procedure for this in care homes and hospitals is called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We looked at the records in relation to Deprivation of Liberty Safeguards (DoLS), which are measures which need to be put in place to protect the rights of people who have been assessed as not having capacity to keep themselves safe and need to be restricted to maintain their safety and well-being. We found that a large number of the people who used the service had some level of cognitive impairment. People had not been assessed to gauge what decisions they were capable of making and whether a best interest decision was needed to keep them safe and whether DoLS needed to be in place. We saw there were only four people in the service who had the correct DoLS authorisations in place. On the first floor EMI unit there were people who displayed behaviour which was challenging to others who had been assessed as requiring one to one care for up to 24 hours per day despite this particularly restrictive practice, these people did not have a DoLS in place

We saw people were being deprived of their liberty in all cases in the service as the home had a locked door, which gave people no ability to leave should they want to. There were extensive restrictive practices in place throughout the service. For example the residential unit had a locked door, when we asked the regional director why this was they said it was because Croft House Care Home used to be a unit which looked after people living with dementia and they had not removed the lock.

We saw that most people were restricted in their movements as they were unable to mobilise independently and there were not enough staff to assist them to move around. We saw two people who were sat in chairs which were very deep which would prevent them from getting up, as their feet were not able to reach the ground, we saw their feet were dangling without support for long periods.

We saw the few people who did get up from bed and were sat in the lounge or dining room on one of the ground floor units were unable to move from their chairs due to mobility issues. We saw that people were calling out for staff to assist them and that there were no staff available to respond to them. We intervened and went to find staff; this took time as staff were not visible as they were in people's rooms delivering care.

In the care files we looked at we saw that none of the people had been asked for or had given their consent to their care and that there was no evidence that they did not have the mental capacity to do so as there was no assessment of their mental capacity in their records. We saw instances where people who had no cognitive impairment had signed consent for some things but not others. For example they had signed to say the service could take their photograph, but a member of staff had signed a consent form on their behalf to use equipment to assist them to bathe, this showed that people were not being given the opportunity to make their own choices and give consent for care. We saw that staff had signed consent for people throughout the care files we reviewed; we did not see instances where family members had been asked to give their consent if the person who used the service was not able to.

This was a breach of Regulation 11 (1) need for consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw some of the people who used the service had particular communication needs, as they were unable to verbalise their wishes and preferences. One care plan stated the person communicated using a communication board. We saw no evidence this board was available to the person or in use throughout our visit. We observed some staff ignoring people when they attempted to communicate their needs. For example a person who had little verbal communication was ignored by staff when they were trying to gain their attention, this happened at lunchtime on both days we were present.

This was a breach of Regulation 9 (1) person centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed mealtimes during our inspection. We saw all staff were involved in the service of meals and they were also responsible for clearing up after meals. We saw people who required assistance were given their meals first and most people were given their meals in their rooms. We asked some of the people who were eating in their rooms why they ate there, only one person told us that it was their choice; the other people told us they were not asked if they wanted to move to the dining room. We saw a small number of people sat at the dining tables and two people who were sat in armchairs in the lounge were not offered the choice to move to the table and were served on small tables where they were.

We saw there were soft diets being served, however in one person's case this was mashed potatoes and gravy on both days. The person was telling staff that they wanted to have the same as everyone else on the second day which was fish and mashed potatoes but was told by staff that they were not allowed that meal. Staff were not able to explain why this person was to have mashed potatoes and gravy again and could not have fish, and we could see nothing in their care records which explained why this would be the case. We saw other people who were prescribed a soft diet were able to have the same meal as people who were on a standard diet on this day.

We saw from people's care plans that some people had specialist dietary requirements, for example there were several people who were diabetic and required a low sugar diet to help control their blood sugar levels. We saw that it was detailed in their care plans that this was a requirement of their daily care, yet we saw people who had diabetes were given large quantities of pure fruit juice which was high in sugar throughout our visits. On one occasion a person with diabetes had only sweet food and fruit juice for their main meal of

the day. We spoke to the kitchen staff and looked at the drinks which were in stock; we found that none of the fruit juices were low sugar alternatives. This meant the service were not providing a diet which met people's needs and by doing so were increasing the risk to some people's health.

We found that some people who remained in their rooms all day were left without access to drinks or snacks for periods between meals, as there were none present in their rooms when we visited them. In one case there was a sign which stated the person must have access to a drink at all times, there was no drink present when we spoke with them. We raised this with care staff that brought the person a drink.

This was a breach of Regulation 14 (1) meeting nutritional and hydration needs of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw some people had lost weight. There was little information to evidence what had been done to refer these people to dieticians or to fortify their diets to ensure that they did not continue to lose weight. We saw no evidence that staff had contacted people's GPs to identify if there were any underlying conditions which may be responsible for their weight loss. We saw when we looked at people's care records that some people were not weighed regularly and some people had not been weighed since April 2015 despite their care records showing they should be weighed monthly.

This was a breach of Regulation 9 (1) person centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found some of the people we spoke with were unwell and required medical attention, which had not been sought in a timely manner. There was an example of this where a person had extensive pressure wounds which required attention. A request for a specialist nurse to make an urgent visit was not made until we asked for this to be done as soon as possible.

We looked at the daily records of some of the people who remained in bed; we saw there was little evidence of pressure area care. This is essential for reducing the risk of developing wounds for people who have reduced circulation due to inactivity, and imperative for people who have current pressure area wounds which need to heal. We asked for but were not provided with any evidence of re-positioning charts which showed that staff were regularly changing the position of people who were unable to re-position themselves to relieve pressure on vulnerable areas. We asked staff about this and they confirmed that these documents were not in place.

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

We found there were areas of the building which were not being used. For instance on one side of the ground floor there were three lounge areas. There was a garden room which had been closed and remained closed as it had been filled with clothes that the services' laundry had not been able to return to people who lived in the home. There was a room which was signposted as a conservatory, which was a lounge, we saw this room used only briefly on the first day of our inspection when there was an entertainer playing the piano in there. After this activity the room was empty and the door remained closed. There was also a conservatory which was cold and uninviting, we used this room for some of the time we were in the service and saw that none of the people living in the service attempted to use the space. This meant that despite there being facilities in the home for people to sit together and socialise these areas were not being used, as people were not assisted to leave their rooms and use these areas.

We found some areas of the home were very cold. This was particularly evident in the lounge/dining room on the ground floor and the corridor on the EMI unit. We asked the administrator about this and the maintenance person came to sort out the heating. They found that the radiators had been turned off in the lounge and that there had been windows opened upstairs. The maintenance person explained to us that this happened regularly as the staff became hot and adjusted the temperature to meet their needs, they did not consider the impact this would have on people who were immobile. We saw that staff were not recognising the needs of the people who used the service who were cold, for example there was a person who was visibly cold in the lounge when we raised the issue about the heating, and were asking for a blanket.

Whilst some of the people we spoke with told us that they felt that staff were knowledgeable and skilled, we found that this was not always the case. Staff we spoke with were not able to explain some fundamental processes they should have been aware of further to the training they had received. For example how they would recognise and report a safeguarding concern. Staff told us that their training was e-learning, and that whilst they had completed this they did not feel that it was helpful in preparing them for the practical aspects of their roles. Nurses told us that they had requested essential training, for example venepuncture and catheterisation, they had not been provided with this training.

We asked staff if they received regular supervision, and staff told us that they did, the records which we reviewed confirmed that this was the case. However when we asked if these sessions were helpful and useful we got a mixed response. Some staff felt they had gained from the sessions and they had been positive, whilst others told us there was no point to the sessions as nothing ever came of them. All staff confirmed that they had an annual appraisal which looked at their personal development; again some staff reported that nothing came from these discussions.

We saw the environment was not meeting the needs of people who were living with dementia or other mental health conditions, there was very little to occupy people and the signs in the home were not helpful to people. For example on the ground floor, the names on people's doors were not at eye level and were in extremely small print, which meant that they were not helping people to identify their own room. The unit manager for residential care told us that the signs were better on the EMI unit, and whilst we saw that there were surrounds on the doors in the EMI unit which brought the eye to the name, the writing was still very small. There were no photographs on people's rooms to help them identify themselves. Some of the doors did not have signs to say what the rooms were, which meant that people who were living with dementia would find it difficult to identify specific rooms for example the toilet when they needed to.

Inadequate

Is the service caring?

Our findings

People we spoke with told us the care staff were kind and caring, but that they were always too busy to have a chat. One person told us "My trousers were back to front this morning, and I asked for assistance, the staff member insisted that they were ok, but I knew they weren't because they weren't comfy." Another person said, "I would like a bath more often, I only get one if I ask and staff have time."

On the second day of our inspection we saw a person in a chair in the lounge on the ground floor, calling out for help. We noticed the chair they were seated in was not appropriate for the person's needs as they were left with their legs dangling without support. The seat was very deep which meant that they were in an enforced reclined position due to the shape of the seat. We responded to this person and they asked us for their glasses. We asked a staff member about the glasses and were told they were probably in the chair, another member of staff then said "they haven't been used for ages, not since (person) came out hospital, same as their bottom teeth." We checked the person's room with staff and found there were no bottom dentures and only an empty glasses case. This person told us when we asked them about their dentures "I do miss my teeth at the bottom."

On the first day of our inspection we saw a person who used the service talking to a member of staff who had been shopping for them. The member of staff gave the person some tissues, a multipack of crisps and a multipack of sweets. The member of staff said "I know you didn't ask for these but I thought you might like them." We noted on the second day of our visit that the person was giving away the sweets telling people "I can't eat them I am diabetic." We checked the person's file and found that they were diabetic and required a low sugar diet. We were concerned about this incident because the member of staff had spent the person's money without their permission on these items, and also because they had not considered their needs when making the purchases, which had they not been able to realise that they should not eat the sweets could have put them at risk. We brought this matter to the attention of the regional director.

Throughout our inspection we saw that the care staff were caring in their interactions with people who lived at the home, however we saw and staff confirmed that they did not have time to spend with people other than to carry out essential care tasks, and they were unable to meet everyone's needs. A member of staff told us "If someone can dress themselves and they don't take too long then we let them do it."

Care staff told us that they passed a lot of tasks to the nurse on duty, when we asked them why they did this they told us because it was the nurse's role. This included basic duties for example calling a GP surgery and requesting a visit. This meant that these duties were not being carried out in a timely manner as there was only one nurse on each floor, when we asked the nurses about this they felt that care staff should make these calls, there was no clear guidance on who was responsible for which duties which meant that tasks were delayed and missed altogether.

This was a breach of Regulation 18 (1) staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked staff how they maintained the cultural and religious needs of people who use the service, staff told us that they did not have anyone with particular needs as far as they knew. We did not see any references to peoples cultural and religious needs being met in the care records we saw.

People who used the service told us that there were not included in any of the planning for the service, this included choices of meals and activities. We asked people if they had been involved in the planning and writing of their care plans. People told us they did not know what a care plan was and they had not seen them.

We asked the quality assurance manager about residents meetings and they told us that they have not been taking place. We asked people who lived in the home if they ever had meetings and they said they did not. This meant that the people in the home and their relatives or representatives were not being asked for their opinions and preferences about how the home was run.

We saw that there were times when people's privacy was not respected. An example of this was a person who was given their insulin injection in the lounge. This involved them taking their arm out of their clothes in this communal area whilst there were other people present. Another example was of a nurse bringing a person some medication during lunch on the first day of our visit. The nurse told the person very publicly what the medication was for and what it would achieve.

At lunchtime on the first day of our inspection we saw a member of staff was showing round a volunteer who was commencing voluntary work with the service the following week. The member of staff stood in the dining area in earshot of all the people who were eating their lunch and described in detail each person's their conditions and limitations to the visitor.

We saw that there was very limited independence, and this was only evident in people who were able to mobilise independently. We did not see staff encouraging people to do things for themselves as their interactions were short and task orientated, for instance if someone needed a drink and had limitations in being able to manage a cup the staff would do this for them rather than encourage them to do this for themselves.

We found that people were not always kept clean and saw people who were wearing dirty clothes and whose fingernails were very dirty.

This is breach of Regulation 10 (1) dignity and respect of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we arrived at the service and spoke with the most senior member of staff available we asked if there were any people living at the home who were at the end of their life and required specialist care as a result. We were told there were no people at the end of their lives currently in the service. When we reviewed people's records and spoke with staff and visitors we found that there were some people who were living with terminal illnesses. When we checked their care records we found that there was very little evidence of their wishes and preferences for the end of their lives, as these had not been discussed with them or their family members where appropriate.

This is breach of Regulation 9 (1) person centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did not see any evidence of people in the service having access to advocates to help them make

decisions with which they needed support. We asked staff about advocacy, staff were not aware of the need for advocates for people who did not have family to support them to make decisions, but told us that every person at the service had family support.

Inadequate

Is the service responsive?

Our findings

We spoke to people who used the service and they told us, "I'm fed up of being bored; they need to do more for us in that respect. There is nothing to do here except sit here all the time. It's boring day after day. I can't see the television as I am partially sighted so it's just shapes; there is nothing else to do. I don't go out apart from the summer when I can go in the garden, and the staff never talk to me." Another person who had been calling for help for some time told us "It's disgraceful, tell the director; I am bored, just sat here. If I go to bed what then? I can't move for myself so what can I do about it?"

We saw that care was not person centred. We looked at people's care records and saw they were lacking in detail, contained contradictory and conflicting information in a lot of cases and did not give a clear picture of the individual who they related to. For example in one care file we saw that the person was diabetic, in some sections the records showed that it was Type I and other showed Type II, however there was no definitive answer to this conflicting significant medical information.

Some care plans contained a pen picture (life history) which was lacking in detail and gave very little information about the life the person had led and what was important to them. Care planning was disorganised as there was no structure to the information which had been gained and lacked any evidence of people's preferences. We saw there was also inaccurate information in the care records. For example in one person's file where the person was diabetic, their care plan stated they ate a normal diet. There was another example which showed a person had been recorded as their skin being intact in a skin viability assessment, yet the person had open sores to both legs which were being cared for by nurses. This meant that care staff were unable to understand the needs of the people in the home as they were not clearly identified and this lack of clarity could place people at risk of harm.

We found the care described in people's care records did not match the care we observed. We saw in one person's care file that they had significant issues with their sight and needed to wear glasses at all times and for there to be adequate light. We saw the person was without their glasses which we found to be in the sink in their room, and there were issues with the lighting in the corridors in the home as there were bulbs which were not working and had not been replaced. This meant that the risk of falls for this person was increased significantly as they were independently mobilising without supervision.

We saw evidence staff were reviewing the care records each month; however we saw that staff wrote word for word what staff the previous month had written. We saw no evidence the information had been checked and was accurate and current. For example we saw one care file where a person had been assessed for their risk of falls. The assessment had been completed incorrectly the first month as risks factors had been omitted; this gave a result of medium risk. On checking the information contained in the file and using this to re-score the assessment tool we found that the result was very high risk as the omissions included a significant history of falls which raised the risk significantly. The incorrect score had been repeated each month at review without being checked or corrected.

We saw people had an assessment before being admitted to the home, which collected basic details about

the person and their medical history. These assessments were not consistent with the information which was in the care plans in all cases, and there was contradictory information present. For example in one pre-admission record there was a recorded Waterlow score of 22 which had been provided by the hospital on discharge. A Waterlow score is a tool used to determine how high the risk of someone developing pressure areas is, depending on factors which are known to increase the risk. The member of staff had completed the same assessment and had scored this as 12 which was a significantly lower risk. When we checked the score against the information in the person's care records the initial score would have been correct, as some of the risks had not been scored correctly by the member of staff. This meant that the person was not being adequately monitored to prevent pressure areas as they had not been identified as being of particularly high risk.

This was a breach of Regulation 12 (1) safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw a plan of activities displayed in the reception area of the home; this was for a previous month. During our inspection we saw there was one planned activity in one of the ground floor lounges which was a person who came in to play the piano for an hour. We saw there were some staff on the first floor that were making some effort to entertain people, and we saw there were some staff working on some puzzles with a small group of people. We did not see any evidence there were other planned activities and we saw people were left with nothing to occupy them for long periods. People told us that they were bored and fed up.

We saw that most people were alone in their rooms for very long periods and some people were in their rooms at all times. We saw people were isolated and they told us that they were lonely and unhappy. Some of the people we spoke with told us they did not want to remain in bed or in their room and that they wanted to be up and out with other people. One person who used the service's care plan showed that they liked to go outside and smoke. This person was not assisted to do this during the two days we were at the home. This meant that the provider was not recognising people's individuality and was restricting their choices as they were unable to leave their rooms, they were also not respecting people's rights to make their own choices.

We saw that one person who had been admitted to the service in October 2015 did not have any care plans in place, there was some very basic information on the person, but there had been no assessments of their needs or care plans created to inform staff how the person needed to be cared for.

This is breach of Regulation 9 (1) person centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Family members of one of the people who used the service that we spoke with told us that they were unhappy with the care which was being provided and that they had complained about multiple issues. When we looked at the complaints records we could not see any evidence that the complaint had been recorded or managed appropriately using the providers process and in line with their policy. We saw there were a small number of complaints in the file, which whilst they had been responded to, there was no evidence of what investigation had been undertaken, what the outcome of the investigations had been, and the responses which had been sent did not address the concerns which had been originally raised.

This is breach of Regulation 16 (1) receiving and acting on complaints of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did not see that the service had made any provision for people to be able to transition between services

easily. For example there were no forms which would give important information to a hospital if the person needed to be admitted as an emergency, this meant that the staff at the hospital would not have the information they needed to care for the person well when they arrived.

Inadequate

Is the service well-led?

Our findings

The service did not have a registered manager at the time of our inspection. The previous registered manager had left, and whilst the provider had employed a new manager they were not yet registered with the Care Quality Commission. People we spoke with told us "I don't know who the manager is, I haven't seen them. And "When I came here the manager at the time left and I haven't seen anyone since."

On the first day of our inspection, we asked to see the manager and were told that the manager and the deputy manager were not on duty and that the only person who was in a managerial position on duty that day was the residential unit manager. The staff contacted the regional director who came to the home later in the morning. We were concerned that despite the serious concerns which had been raised by the commissioning authorities to the provider, the home was left without an overall manager, as the residential unit manager was only responsible for their own unit. The regional director was aware that neither the manager nor the deputy manager were going to be present and had not arranged for any management cover in their absence.

We saw throughout our visit that there was no leadership of the staff who were working in the home. We found that there were no visible staff for long periods, yet at lunchtime they all arrived together into the dining room and were all serving lunch until the meal was finished. The staff then disappeared and were not visible again throughout the afternoon. Staff told us "we have a fairly new manager, not sure how long they have been here. I have only spoken to them once." Another said of the new manager "I haven't had a lot to do with them."

We spoke with staff and we found there was a 'them and us' approach between the first and ground floor staff, with staff telling us that they were resentful if they were asked to move between the floors as their perception was not one of an overall team. Care staff were unanimous in their belief that all tasks relating to requesting GP visits, speaking to people who called about people's health, and administering medication were solely the responsibility of the nurse on duty. There was no provision for any of the care staff to be trained to assist in the routine administration of medication, the nurses spent most of their time administering medication which meant they did not have time to carry out more specialised tasks for example treating the pressure wounds which people had. The result of this was that dressings were not being changed as frequently as they should have been which was increasing the risk of infection.

During the two days of our inspection, we found no member of staff was able to answer our questions and provide us with updates on people who we had raised concerns about. There was no-one available who knew the service well and we struggled to gain the information we needed to build a clear picture of how and when some pressure areas had developed, and how some of the accidents and injuries we found had occurred and how long ago they had happened. We did find that some of the information given to us in relation to people who used the service was inaccurate. For example we were assured by the quality assurance manager that a person had been admitted to the service with all the pressure areas they currently had. We found evidence that this was not the case and that they had been admitted with only one area of concern.

We did not find any evidence from speaking with staff they felt any accountability for the issues which we identified, and staff consistently blamed the higher level staff and the manager who had left the home recently.

We asked staff about the provider's vision and values, staff were not able to tell us what these were. Staff told us that they felt that they were doing the best they could under difficult circumstances and that they did not have time to care for people, other than to try to meet their personal care needs.

We found the systems in the home for managing records were not consistent with the registered providers standards or practices which were across their group of residential and nursing services. The regional director told us that they had been aware of this poor practice prior to the previous manager leaving the home. We found that paperwork was not consistent and as a consequence the regional director struggled to find the information we asked for as it was not stored in line with the organisations policies and procedures.

We found record keeping was of a very poor standard, with daily records not giving vital information about the care which had been given or the well-being of the person they were written about. For example we saw one person's daily records which simply said "Spent day going for cigs and in their room." This meant that visiting professionals could not see what had happened with people they were visiting, for example whether they had been unusually sleepy or confused, and that there was little information about what was happening in the service each day.

We asked to look at the auditing which had taken place over the past 12 months. We found that whilst there had been sporadic auditing taking place until July 2015, there had been none carried out since this time other than a partially completed medication audit which was dated August 2015. This meant that the management team were unable to identify issues within the service and were not taking action to address them.

We discussed the lack of oversight with the regional director, who responded that they had been carrying out monthly visits. We did see some evidence of these visits; however they were basic and did not look at the service in the detail required to identify the systemic failures we found during our inspection. The regional director when asked about the current position of the home told us that whilst it did require work, it was not to the degree we had found and were presenting to them. This meant that the provider had failed to maintain oversight of the quality of the service they were delivering, and had allowed failings to remain as they had not been identified and corrected.

This was a breach of Regulation 17 (1) good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw there was significant evidence that the provider had failed to notify the Care Quality Commission of incidents which had taken place, which under the terms of their registration they had a duty to report, this included serious injuries where fractures had resulted and high grade pressure areas had developed. There was also evidence there had been a large number of incidents where people who used the service had hurt other people in the home which had not been reported correctly.

This was a breach of Regulation 20 (1) Duty of Candour of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.