South Yorkshire Care Limited

Cathedral Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 2 March 2016 and was unannounced.

Cathedral Nursing Home is registered to provide accommodation and nursing and personal care for up to 38 older people or people living with dementia. There were 37 people living at the service on the day of our inspection.

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have the legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured proper and safe management of medicines; did not ensure the service was clean and properly maintained; did not work within the requirements of the Mental Capacity Act 2005; did not ensure that people were treated with dignity and respect and there were weaknesses in the monitoring of the quality of the service. You can see what action we told the registered provider to take at the back of the full version of the report.

The Care Quality Commission is required by law to monitor how a provider applies the Mental Capacity Act, 2005 and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way. This is usually to protect them. The management and staff understood their responsibility and made appropriate referrals for assessment. Five people at the time of our inspection had their freedom restricted under a DoLS authorisation.

People's safety was not always maintained, because staff did not always follow safe medicine administration guidance, putting people at risk of harm. There were not always enough staff on duty to meet people's care needs in a timely manner. Also, the provider did not always ensure that the service was consistently clean and that safe infection control procedures were adhered to.

People were cared for by staff that were supported to undertake training to improve their knowledge and skills. People were provided with regular and home cooked meals. Although people had their healthcare needs identified, they were not always referred to healthcare professionals such as their GP and dentist. Staff did not always seek consent from people for their care and treatment and did not fully understand the key requirements of the Mental Capacity Act 2005.

Staff did not always involve people in decisions about their care. People were not always treated with dignity and respect and staff did not challenge poor care practices. People were not enabled to pass their time in a meaningful way and were not supported to maintain their independence. Staff provided care

centred on tasks rather than on the person's needs and preferences.

There was no evidence of visible leadership and the registered provider did not have effective systems in place to monitor the quality of the care and treatment people received.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staff did not always follow correct procedures when administering medicine.

People were not always cared for in a clean environment.

There were not always enough staff on duty to keep people safe.

Staff had access to safeguarding policies and procedures and knew how to keep people safe.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not fully understand the key requirements of the Mental Capacity Act 2005.

People were not always referred to healthcare service for treatment and ongoing support.

People were cared for by staff that were supported to undertake further training to carry out their roles and responsibilities.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always involve people in decisions about their care.

People were not always treated with dignity and respect

Is the service responsive?

Requires Improvement

The service was not always responsive.

People received care that was task orientated rather than person centred.

Staff did not support people to take part in meaningful activities

and pastimes.

A complaints policy and procedures were in place but people and their relatives were unsure how to complain.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider did not follow up on quality checks and audit to ensure that identified risks were managed.

The service did not have a positive culture that was person-centred and empowering.

People were not cared for by staff who were supported to drive forward improvements.

Cathedral Nursing 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.

The inspection took place on 2 March 2016 and was unannounced. The inspection team was made up of two inspectors.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. We used this information to help plan our inspection.

We also looked at information we held about the provider. This included notifications which are events which happened in the service that the registered provider is required to tell us about.

During our inspection we spoke with the registered manager, the deputy manager, the provider, a registered nurse, four members of care staff, the head cook, two housekeepers, ten people who lived at the service and five visiting relatives and friends. We also observed staff interacting with people in communal areas, providing care and support.

We looked at a range of records related to the running of and the quality of the service. This included two staff recruitment and induction files, staff training information, meeting minutes and arrangements for managing complaints. We looked at the quality assurance audits that the registered manager and the provider completed. We also looked at care plans for seven people and ten medicine administration records.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection in July 2015 we identified that the registered provider did not always support the safe administration of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sent us an action plan which set out how they planned to address the areas highlighted, including taking the medicine trolley on the medicine round and the registered nurse or senior care staff to wear a red tabard when administering medicines.

On this inspection we found that although the registered manager and deputy manager had addressed our findings with registered nurses and senior care staff at supervision sessions to prevent a repeat of the concerns identified, we found other areas of practice that required improvement.

We found that the provider continued to be in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that medicines were not always given safely. For example, the registered nurse put six tablets at once into a person's mouth. The person was unable to swallow them whole and had to chew their tablets to swallow them. There was a risk that the medicine may not work properly or be harmful if they are not swallowed whole. We also witnessed two occasions when the medicine trolley was left unattended and there was risk that people could access medicines. For example, a person's medicines were left on top of the trolley when the registered nurse returned to the dining room to obtain additional supplies of drinks.

We looked at medicines administration records (MAR) for 10 people and found that they had a photograph for identification purposes and any known allergies were recorded. However, there was no information about how they preferred to take their medicines. When a person received their medicine covertly, this was discussed and approved by their GP, but there was no recorded evidence that the pharmacist had been involved.

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

There were processes in place for the ordering and supply of people's medicines to ensure they were received in a timely manner and out of date and unwanted medicines were returned promptly. Staff had access to guidance on the safe use of medicines and the medicines policy. However, the temperature in the clinical room where medicines were stored and the medicine fridge were recorded on several occasions to be above the safe limit. Staff who administered medicines told us that they had completed medicines training and had their competency to administer medicines checked. We found that when people received medicines that required their health to be monitored regularly, that the necessary checks had been completed.

The registered manager had achieved "train the trainer" status for infection control. This meant that the registered manager was competent to train staff in infection control. Furthermore, staff had access to an infection control policy and guidance on safe infection control and cleanliness practices. However, we found that staff were not following the policies.

We looked at all areas of the service and found evidence that standards of cleanliness were not maintained and people were not protected from the risk of cross infection from contaminated equipment. For example, we saw soiled toilet cleaning brushes, lime scale on taps, damaged toilet seats, and soiled and damaged bathing equipment that increased the risk of bacteria growing and spreading.

There was a risk that people or members of staff could come in contact with body waste, such as urine. The upstairs sluice was kept locked and a registered nurse told us that staff carried waste from upstairs to the ground floor sluice. Furthermore, we saw a laundry bag that contained soiled linen lying on a bedroom floor and an overfull bag of soiled linen in a bathroom.

The sinks in the downstairs sluice were heavily soiled, and the guidance on the safe cleaning and storage of commode basins and mops was not followed. This imposed a risk that bacteria could grow. For example, we saw a mop soaking in a mop bucket and commode basins soaking on a draining board.

One person asked for a cup of coffee and a member of care staff placed a cup of cold coffee in the microwave to reheat. We brought to the attention of the staff member that the inside of the microwave was soiled with gravy and a potato chip. The staff member was unsure of what action to take and asked the inspector what to do. We noted that the member of staff was wearing protective plastic gloves that were torn.

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

Some people told us they felt safe living in the service. One person said, "I have my door open and always see the staff. They check me at night." Another person said, "Oh yes, the staff make me feel safe in my room and there is no one here to frighten me." However other people shared a negative experience of safety when in their bedroom. For example, one person told us that a person of the opposite sex often entered their room uninvited at night and on one occasion dropped their trousers. They said, "I shout at them, but it sometimes takes a lot of persuading." They told us they no longer asked staff for assistance as they took about 15 minutes to respond and they did not appear concerned or able to do anything about it. They added, "Staff just tell you to shout at them and they will go."

The provider had policies and procedures in place to support staff to prevent people from avoidable harm, potential abuse and help keep them safe. Most staff had an awareness and understanding of the signs of abuse and knew who to report their concerns to. One member of staff said, "They may be a bit down or nervous. I would report any signs to the nurse or manager. We can also report to CQC or safeguarding. I have a copy of their numbers." Staff had been trained and the provider had policies and procedures in place.

There were systems in place to support agency nurses when they were the senior member of staff in charge of the service. They were provided with important information such as, telephone numbers for on-call staff, personal evacuation plans for people and next of kin contact details. However, people may be at risk in an emergency situation as the information was not up to date as there were details for 36 people but there were 37 people residing in the service.

Staff had access to a contingency action plan to support them in an emergency situation such as a fire or flood and a local hospital had been identified as a place of safety to evacuate people to. Staff had access to on-call senior staff out of hours for support and guidance.

Risk assessments had been completed for nutrition, dehydration, pressure ulcers, and the use of bed rails. Most risk assessments had been reviewed monthly, however, care plans to reduce or control risk to people were not always personalised and were not helpful in identifying the issues specific to the person. For example, one person was assessed at risk of falling out of bed and required bed rails. However, their care had contradictory information and stated that the person was at risk of climbing over the bed rails. We saw that bed rails were not in use and the person had a mattress on their floor to be used as a crash mat.

We found that people were not always protected from environment risks. We noted that a ground floor fire exit was blocked because a mechanical hoist was being charged in that area. In addition, people were not protected from trip hazards. For example, pressure relieving cushions were lying on the floor in the conservatory, the hall carpet leading to the dining room was threadbare and the floor to the dining room was on a slope and there was no written or pictorial signage to warn people of this. Furthermore, we saw that staff reported broken and damaged equipment in a maintenance book, however, there was a time delay in action taken to make safe.

People and their relatives shared with us that there were not always enough staff to meet their needs in a timely manner, especially if they needed assistance from two members of staff. For examples some people spoke of lengthy waits to go to the toilet or return to their bedroom when they asked for assistance. One person said, "They [staff] always have a reason." Another person, in an upstairs bedroom told us that they were unable to summon staff support when they needed it, because their call buzzer had not been working for some time. They said, "They [staff] know about it and have told me the electrician is coming." We asked how they obtained assistance and they replied, "I have to wait until someone appears. It's just random." A relative told us that their loved one, "Had to wait for things," and gave the example of a two hour wait to go to bed. When we asked staff about the staffing levels one replied, "Sometimes people have to wait but we get to everything in time."
We observed that call bells left unanswered for over 10 minutes during the morning when staff were assisting people to get up out of bed. The registered nurse stopped their medicine round several times to undertake other tasks that could have been delegated to other members of staff, such as telephoning the GP practice to request visits.

We found a lack of organisation and it was unclear how staff had been allocated to care for people in different areas of the service. We saw that people had a 41 page general assessment tool with dependency scores. However, these were incomplete, not dated and the scores were not always recorded. We were therefore unable to determine what level of input a person required from care and nursing staff. We shared our concerns with the registered manager who informed us that they did not use a dependency tool to calculate staffing levels or skill mix, but depended on the number of people living with a dementia type illness or being cared for towards the end of their life.

We looked at two staff personal files and saw that here were robust recruitment processes in place that identified all the necessary safety checks to be completed to ensure that a prospective staff member was suitable before they were appointed to post.

Requires Improvement

Is the service effective?

Our findings

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We spoke with care staff about their understanding of MCA and found that they did not fully understand the principles. For example one member of care staff did not understand that they must act in a person's best interest and said, "To make decisions for them when they can't and to keep them safe."

People's consent to care and treatment was not always sought by staff, although we did see where one person was unable to give their consent to have their photograph taken that a relative had signed on their behalf. However, we did not see that consent had been requested when a person had bed rails in place. Where a person lacked capacity to give their consent staff did not fully follow the principles of the Mental Capacity Act 2005 (MCA). For example, we did not see a two stage capacity assessment and best interest meetings were not undertaken to ensure that the decision being made was the right one for that person. We raised this with the registered manager and deputy manager who confirmed that capacity assessments were only carried out when a person was visiting their bank, and were not completed for bed rails, photographs and medicines or to reside at the service. They failed to understand that the requirements of the MCA apply to all aspects of a person's care.

We saw where a person had lacked capacity to consent to their care that they had appointed a member of their family to act as their Lasting Power of Attorney (LPA). A LPA is someone registered with the Office of the Public Guardian to make decisions on behalf of a person who is unable to do so themselves. However, we did not see any evidence in their care file that their LPA had been involved.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We noted when a person had a DoLS authorisation in place there was no evidence that mental capacity assessments had been completed for aspects of the person's care other than a capacity assessment and best interest's decision in relation to the covert administration of their medicines. We did not see any mental capacity assessments in any of the other care records that we reviewed despite some records stating the person did not have capacity to make decisions for themselves.

Overall, the provider had not always properly trained and prepared their staff in understanding the requirements of the MCA and DoLS.

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

We checked any conditions on DoLS authorisations to deprive a person of their liberty were being met. We

found that the provider had followed the requirements in the DoLS and five applications had been submitted to the local authority and had been approved. Furthermore, we saw that the provider had complied with the conditions of the DoLS. A member of care staff who was providing one to one support to a person being cared for under a DoLS authorisation told us that they did not fully understand DoLS as they had not received training.

Staff were provided with mandatory training in key areas, such safeguarding, infection control and dignity. In addition, several staff were supported to work towards a nationally recognised qualification in adult social care and some staff had undertaken additional training in specialist subjects such as the care of a person living with dementia. One member of staff spoke about the benefits of dementia training and said, "It helps me understand their little ways and their needs are different from the next person's." In addition staff received training pertinent to their roles. For example the housekeeping staff had attended training in the control of substances hazardous to health (COSHH) to ensure cleaning products and detergents were used safely. New staff completed an induction programme. One recently appointed member of care staff told us, "I had a two day induction, and I have a workbook to do in my own time. I am constantly learning every day. I shadowed another member of staff for two days."

All staff received supervision six times a year with a senior member of care staff or a member of the management team and also had an appraisal twice a year. We looked at supervision records for two members of staff and found that discussion into their training needs and professional development was weak and ineffectual. For example, in response to "future training needs" a member of staff had answered, "anything that is going."

People told us that the food was good, but some people told us that they did not know what was on the menu. On person said, "The food is very good. We don't know what it is, it's always a surprise, but it's better than [the name of a local hotel]. You can have a drink of squash with it." One person said, "There is always plenty of food and I am always satisfied with what is provided." We did observe one person ask a member of care staff what they had been served for lunch.

People were supported to eat their meals without being disturbed. The service had a protected mealtime policy and there was a notice near the main entrance requesting that visitors do not interrupt people between 12 midday and 1.30pm. We saw that this was observed and people were able to eat their emails without unnecessary interruptions.

At breakfast time we saw one person had fallen asleep at the dining table with their breakfast in front of them. Several staff passed through this area but did not offer to assist the person. The person therefore did not eat their breakfast. We observed mid-morning that people were not provided with a drink and there were no drinks available in the main lounge or conservatory for people to help themselves. We mentioned this to a member of care staff who replied, "They're not out at the moment."

We spoke with the head cook, who told us that seasonal changes were made to the menus and salads were available in the summer. All meals were homemade and made with fresh ingredients. They were aware of people's food likes and dislikes, special dietary needs and food allergies. We saw that people with swallowing problems had their food pureed and when a person was at risk of losing weight their meals were fortified with milk. In addition, we saw that staff maintained a record of what they had eaten on a food intake chart.

We saw that there was a four week menu plan for the lunchtime meal and people were offered a choice of main course, except on a Sunday when they had a roast dinner for lunch. However, the head cook told us

that there were always alternatives to the menu available such as a baked potato. People had shared their concerns about the food at a recent "residents" meeting. We saw that some people thought the meals were rushed, menus were always the same, and there was too much food served on their plate. The head cook told us that they had acknowledged feedback from people and they now provided smaller portions.

A record was kept of the reason for all appointments and visits people had with health and social care professionals. However, we saw that the provider did not always take action when a person required support from health care professionals. For example, we saw recorded in one person's care file that they had loose teeth and had recently lost three teeth. There was no follow up action plan in place for this person to see their dentist or advice for staff on oral hygiene if the person lost further teeth. In addition, we found that when a person had significant unintentional weight loss they were not referred to their GP or dietitian for investigations or nutritional support. For example, recent weight loss for one person was 7 kgs in six months and another person lost 6 lbs in two months.

In response to increasing requests to provide care for people near the end of their life nursing staff had worked in partnership with a person's GP and medicines had been prescribed in anticipation of deterioration in their condition to ensure that they were free from pain and distress. Furthermore, the Marie Curie nursing service support nursing staff to give people slow release pain relief through a device called a syringe driver. The deputy manager told us that the service had achieved the Gold Standards Framework (GSF). The GSF is a national training programme developed to enable nursing and care staff to deliver a gold standard of care for all people in the last years of life.

Requires Improvement

Is the service caring?

Our findings

One person's relative told us that they were concerned because when they arrived they found that their loved one's clothing had ridden up leaving them exposed. They also said the person had been wearing the same clothes for several days. Another visitor shared their concerns because their friends clothing frequently went missing and they often saw them wearing garments that did not belong to them.

The deputy manager was the nominated dignity lead and had been assessed as competent to train staff in all matters related to maintaining a person's dignity. However, we did not see evidence of this in practice. For example, we saw one person sat on an armchair in their bedroom with their trousers round their ankles. Their bedroom door was propped open; they were calling out for help and attempting to get out of their chair. We asked a member of care staff to assist them, as we were concerned that the person was at risk of falling if left unattended. A member of staff confirmed that the person was at risk of falling and had a sensor mat on the floor by their chair to alert staff if they stood up. However, we found that the sensor mat was not plugged in. Two members of care staff then attended to the person. We observed another instance where a person's dignity was not respected. We passed their bedroom and their door was propped open, the person was visible from the corridor and we saw that they were in bed and naked from the waist down.

There was a notice board in the dining room with dignity pledges. People had made comments about how they would and would not like to be treated. One comment read, "I really don't like being called dear." Another comment said, "I am old but not deaf." However, we heard staff use terms such as dear and darling, and several staff spoke with people in raised voices. Furthermore, we heard staff shout comments to people across the dining room, such as, "Do you want chocolate" and "Are you alright" rather than addressing people in a personal and discreet way.

We saw that care staff approached mealtimes as a task to be completed rather than a pleasant social experience for people. At breakfast time one person was sitting facing a blank wall, there was no interaction from staff. They had a chocolate pudding, however, staff did not offer to protect their clothing and their clothes were soiled from the chocolate pudding. Another person was assisted to sit at a table with the remains of other people's breakfast not cleared away. We noted that most people were assisted to the dining table 40 minutes before lunch was served and the tables had not yet been set for lunch. People who were at risk of soiling their clothing with food spills were provided with a plastic apron, similar to the ones care staff wore when delivery personal care, rather than a napkin or linen tabard. We saw that when care staff assisted a person to eat their meal that they stood over them, rather than sit down beside them at eye level. A member of care staff told us that a person who required assistance to eat their meal was referred to as "a feed." This language was disrespectful and showed a failure to recognise people as individuals. In addition, we observed that tables were set with plastic tablecloths, and people received their drinks and dessert from plastic tableware. This took away people's choice about how they would like to eat their meals and indicated an assumption that people could not manage crockery safely. We found a similar experience at tea time. Care staff assisted people to the dining table one hour before tea was due to be served. People did not have access to a drink during this time.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although staff told us that they understood issues around maintaining confidentiality we saw that confidential information was not always stored safely. For example, we saw daily care logs that were easily accessible in the dining room.

We received mixed feedback from people and their relatives about the care they received. For example, one person said, "The carers are very good. I have nothing but praise for them." Another person told us, "They are excellent really and very patient." In contrast another person told us, "I am not happy here at all. I don't feel I fit in although I try hard enough." They added that they felt bullied by one of the staff and said, "Last week [staff member's name] grumbled at me so badly because I wouldn't join in the skittles, but I couldn't because I can't stand. I don't get on with them. I have had quite a few run ins with them." A visitor told us a person had been "told off" for pressing their call bell and a complaint was being made about this. Another visitor told us, "I think it's alright here. The staff are lovely and do their best." However, they went on to say that their relative had not settled into the service and said, "No one speaks to him. He likes to have a chat with people."

We found that some staff did not have the skills to build caring relationships with people. For example, we observed one person who was sat at the dining table waiting for their evening meal become distressed as they attempted to stand up from their wheelchair unaided. We were concerned for their safety and informed a member of care staff twice before they attended to the person. The member of staff approached the person from behind and startled them; this added to their distress. The staff member did not comfort the person or ask if they could help them, instead they moved them away from the dining table and positioned them beside the unattended nurses' desk without explanation.

We found that staff did not always show concern for a person's welfare in a caring and meaningful way. Some people had care plans in place for "behaviours which challenged". However, the care plans tended to describe their behaviour but did not provide guidance for nursing and care staff on the ways to support the person when they were distressed or agitated. One behavioural care plan contained some statements which were subjective and judgemental, such as, "Very demanding at times. Very childlike and will demand things. She will state untruths to her family and care workers."

We looked at the care files for seven people who used the service and found that it was difficult to find the information we needed to be able to deliver care to people. People had several tools in their care files designed to gather their views about their needs and preferences, such as their pre-admission assessment, and documents called "This is me" and "Life story." However, we saw that they were either blank, partially completed or did not accurately reflect their care needs.

Requires Improvement

Is the service responsive?

Our findings

Relatives told us they were not kept up to date with changes to their loved one's condition unless they asked. Furthermore, people and their relatives told us that they had not been involved in the development or review of their care plans and we did not find any recorded evidence of involvement in the care plans we reviewed. However, staff told us they discussed the care plans with the people themselves and other staff when they were carrying out a review.

People had their care needs assessed and care plans were introduced to outline the care they should receive. However, we found the content of the care plans was basic and confusing and reflected daily care routines rather than a person's individual care needs. Some care plans were not kept up to date and did not always record a true account of a person's care needs. For example, one person was assessed as at risk of dehydration, their care plan recorded that they were to have "sufficient liquid" but did not state how much or how often. Their care plan review stated "to encourage fluids" therefore their care plan did not provide care staff with the level of information they needed to respond to the person's care needs.

Furthermore, people did not always receive personalised care in response to their individual needs. For example, we saw where a person had a commode in their bedroom for use at night that they had been provided with a commode suitable for people who were obese. However, this person was not obese; we were told that it was the only commode available. Another person was sat in a recliner chair in the conservatory. We heard them repeatedly call out, "Help me. Please help me." We noted that the person was distressed and in pain. We brought our concerns to the attention of a senior member of care staff who explained, "This is the safest chair, if in a wheelchair she can fall out, she sits back, but we cannot lift the leg rest as it hurts her legs." The senior carer did not ask the person what they wanted help with, but placed a blanket over the person and tucked it under their chin and down their sides of the chair and the person was unable to move. The senior member of care staff then told us, "To stop [the person] walking about." When the staff member moved away, the person once again called out for help and continued to call for help for a further 30 minutes.

We found that there was very little social stimulation or interaction from staff and most people did not have anything to do to occupy them. The activity coordinator was on annual leave and no planned activities had been arranged in their absence. We saw that this was discussed at the last "residents" meeting, and people had voiced that there was nothing to do when the activity coordinator was on leave. The minutes recorded the type of activities that people liked to do. We found that some people who spent their time in their bedrooms had bird feeders outside their bedroom window to occupy them. A couple of people told us that they liked to keep up to date with the news and received a daily newspaper.

We noticed that the intention to share information with people, their visitors and staff was not always maintained. For example, there was an information sharing board in the dining room for the employee of the month and the names of key workers allocated to people, however the information was not provided. In addition, we saw that another information board to help orientate people was not kept up to date. The date on the board was Thursday 25 February 2016, rather than Wednesday 2 March, the pictorial menu with the

daily choices had not been changed for two days and the activity programme on display was for the previous week.

We saw that staff exchanged information about a person's care needs and wellbeing at shift handover. Information shared included if the person had slept well, if they had been seen by their GP and if they had any booked appointments to attend.

We saw that in addition to the main television lounge and the conservatory that there was quiet lounge with a large tropical fish tank. However, people were unable to access it as it was being used to store bed frames and a wheelchair. People told us that they never went outside for fresh air or for their own pleasure. One person said, "I'd like to go out but I've never been offered the opportunity." Another person said, "I miss going out in the fresh air. I am not allowed to go out on my own. Somebody has to come with me. I would have to wait, they are always so busy." Staff confirmed that there were no trips out from the service.

We saw that visitors could leave their feedback on the service in a comments book near the main entrance. Ten visitors had left comments since July 2015; all thanked the service for the care that their relative had received.

Most people had a copy of the complaint's policy in their bedroom. However, the relatives of people who had recently moved into the service were not provided with information on how to make a complaint. Staff told us that if a person made a complaint to them they would pass it on to the registered manager or the nurse in charge.

One person told us that they would not make a complaint and said, "I am frightened of the backlash." another person spoke about the consequences of reporting a member of care staff. They said, "I was in bed and asked to roll over. I couldn't do it quickly enough and they pushed me up against the wall." The incident had been discussed with the staff member and the person added, "Every time it is their turn to get me they say, keep yourself steady as I don't want to smash your head against the wall. And talk about me dropping her in it." We shared this person's concerns with the registered manager. We noted that at the previous "residents" meeting people had raised concerns that some staff could be rough when delivering care.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection in July 2015 we identified that the registered provider had not notified us of safeguarding incidents and when Deprivation of Liberty Safeguards had been authorised. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sent us an action plan which set out how they planned to address the areas highlighted.

On this inspection we found that the registered manager had notified us of safeguarding incidents and when Deprivation of Liberty Safeguards had been authorised and was no longer in breach of this regulation.

At our previous inspection in July 2015 we identified that systems to assess, monitor and improve the quality and safety of the service were not effective. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sent us an action plan which set out how they planned to address the areas highlighted.

On this inspection we found that systems to assess, monitor and improve the quality and safety of the service were not effective. For example, in November 2015 a questionnaire had been sent to people, their relatives, members of staff, district nurses and GPs. However, the provider and registered manager had not collated the responses to identify themes and trends and action plans had not been introduced to address concerns. A meal audit had been completed in September 2015 and identified that the picture menus needed to be changed daily and that crockery needed to be clean. However, this process was not effective as there were no timescales or evidence that the actions had been completed.

Toilets, shower rooms and bathrooms had a daily cleaning checklist that was to be signed when the area had been cleaned. However, it was difficult to work out how often the cleaning was carried out as most of the checklists had not been completed during the previous two weeks.

We found the actions plans for the infection control audits carried out in January and February 2016 did not provide appropriate guidance on actions to be taken. For example, the January audit recorded, "carpets need cleaning", but did not identify which carpets and all action plans for the February audit recorded, "inform cleaner". In addition, the audits used a scoring system, but we found the scores were not tallied up and there was no way of identifying trends or signs of improvement from one month to the next. Care plan audit action plans from October 2015 did not clearly record that improvements had been made. For example, actions had been identified, but there was no record that action had been taken and there was no timescale for completion.

People were invited to bi-monthly meetings chaired by the activity coordinator. We read the minutes from the meeting held in January 2016, attended by seven people. We saw that people had a voice and their thoughts on mealtimes and activities were recorded. However, we found no evidence that their thoughts on activities had been acknowledged. The registered manager did not routinely attend the meetings with

people unless concerns had been raised. In addition, some people were unclear about who the registered manager was and one person said, "I don't know who it is. They have not introduced themselves." One relative said, "We haven't been given a lot of information. We have to go and ask. The door to the office should be open. It is always closed and this is a barrier to communication."

Staff meetings were held for different staff groups including, kitchen staff, night staff and care staff. We read the minutes of the staff meeting held in November 2015, attended by 14 members of staff and saw that topics for discussion included dirty showers chairs and laundry issues. These same issues had not been resolved as we identified them on this inspection.

We saw that staff worked independently of each other and not as a team. Although there was a registered nurse on duty there was a lack of overall leadership and guidance for staff. Care responsibilities and other duties were not effectively coordinated nor identified nor were risks. . For example, a fire door from the dining room to a bedroom corridor was propped open throughout our inspection and was not closed by the registered nurse or other staff on duty. A sign on the door read, "Make sure door closed at all times." We raised this with the registered manager who said, "Staff know it should be kept closed. I'm always telling them." However, the registered manager did not take any action to address this themselves and it was left open.

We found that although staff were allocated training courses that the registered manager did not follow up that staff had actually attended or obtain feedback on what they had learnt to improve care to people. For example, a member of care staff had been allocated a place on a Deprivation of Liberty Safeguards and Mental Capacity Act 2005 training day, but had not attended, the registered manager failed to check the attendance list. This meant that they did not have systems to assure themselves that staff were appropriately trained to fulfil their roles.

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

Staff told us that they were aware of the whistleblowing policy and procedures and told us that they would report their concerns to the registered manager or senior member of staff on duty. However, some staff were not aware who they could share their concerns with outside the service, such as CQC or that their identity would be protected. Most staff told us that they found the registered manager approachable and could speak with them if they had a concern. One staff member said, "Absolutely approachable, they are all approachable, and the seniors are quite good to be fair. I don't wait for my next supervision session if I have a concern; I raise it at the time."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	People were not always treated with dignity and respect. Regulation 10(1) (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	Care and treatment was not provided with the consent of the relevant person. Regulation 11(1) (3) (4)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Medicines were not always managed safely. Regulation 12 (1) (2) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment
Treatment of disease, disorder or injury	The premises and equipment were not clean, secure and properly maintained. Regulation 15(1) (a) (b) (e) (2)