Care Quality Commission

Speciality Care (REIT Homes) Limited

Woodlands Care Home

Inspection report

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Ratings

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

Overall summary

This inspection took place on 17, 18 and 22 November 2014 and was unannounced. At the last inspection on 6 May 2014 there were six breaches in regulation which related to respecting and involving people, care and welfare, safeguarding, infection control, records and quality assurance. The provider sent us an action plan which showed improvements would be made by 1 October 2014. At this inspection we found improvements had not been made to meet the relevant requirements.

Woodlands Care Home provides nursing care for up to 87 people living with dementia or with enduring mental health needs. On the first day of our inspection there were 70 people living in the home. Accommodation is provided on two floors in four separate units – Hopton, which accommodates nine people; Mirfield accommodates 11 people; Calder accommodates 26 people and Thornhill accommodates 27 people. Each unit is self-contained with its own dining room, lounge, bathroom and toilet facilities. Bedrooms are single rooms with ensuite facilities. There is a central kitchen and laundry located on the ground floor and a hairdressing salon.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and

Summary of findings

associated Regulations about how the service is run. We had received a notification on 21 July 2014 of the registered manager's absence from the service, which advised the deputy manager was managing the home as 'acting manager' with support from the regional manager. The acting manager was managing the home at this inspection. The regional manager told us they were advertising for a registered manager for the home.

People's safety was compromised in many areas. There were not always enough staff to meet people's needs and keep them safe. People were not kept safe from harm as although staff were trained in safeguarding, some incidents of abuse were not adequately recognised or reported. Standards of cleanliness, hygiene and infection control practices were inconsistent across the home which put people at risk. People's medicines were not always managed safely.

Staff had limited knowledge and understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and were not adequately following the legislation for people who lacked capacity to make particular decisions. For example, the provider had not made an application for authorisation for several people, even though their liberty was being significantly restricted. The acting manager told us this was because the supervising authority had asked them to stagger the number of applications they submitted. However, we have a duty to report on the use of DoLS in care homes and hospitals and we are not required to report on the actions of the supervising authority.

People had access to health services; however their health care needs were not always identified or reported in a timely way. People's care was not always planned or delivered in a way that met their individual needs and preferences. Although some people enjoyed the food, we saw many people were not adequately provided with a nutritious balanced diet or supported to eat and drink enough to meet their nutrition and hydration needs.

Although staff had completed e-learning, staff expressed concerns about the quality of this training in giving them the knowledge and skills they needed to carry out their roles. Staff supervision and support was not provided consistently.

Staff's approach to people varied and whilst we saw some staff were kind, caring and compassionate in their interactions, others were not. In some cases, this meant people were ignored. Similarly, we observed some staff practices which showed a lack of respect for people and did not promote their privacy and dignity. People had little opportunity to engage in meaningful activities. Although there had been a recent event to commemorate the First World War, activity provision was unstructured and provided on an 'ad hoc' basis. People did not have access to information about how to make a complaint and complaints were not always recorded or responded to appropriately.

Leadership and management of the home were weak and poor communication systems meant those in charge were not always aware of what was happening in the home. There were inconsistencies in how care was delivered throughout the home. For example, on Hopton unit we found overall people received the care they needed. However, this was not the case on the other three units and we had particular concerns about the quality of care people received on Thornhill and Calder units. The processes for monitoring the quality of care were ineffective and had not picked up the significant problems we found.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. People were being put at risk as cleanliness and hygiene standards were not maintained, there were insufficient staff to meet people's needs and medicines were not managed safely.

People were at risk of harm as although staff had received safeguarding training, suspected or actual abuse was not adequately identified or reported appropriately.

Is the service effective?

Inadequate

The service was not effective. People's health care needs were not always identified and dealt with promptly. Although staff received training and supervision, their competency and knowledge was not assured through these processes.

Some people enjoyed the food, however meals were not nutritionally balanced, choice was limited and mealtimes were disorganised. People were not always supported to eat and drink enough to maintain their health.

Is the service caring?

Inadequate

The service was not consistently caring. Whilst some staff were caring, kind and engaged with people, others were detached and showed little compassion for people. People who were quiet received little attention from staff.

Some staff practices showed a lack of respect for people and compromised their privacy and dignity.

Is the service responsive?

Inadequate

The service was not responsive to people's needs. Care plans did not provide up-to-date information about people's needs, preferences and risks in relation to their care and support.

There was a lack of organised, meaningful activities for people.

Information about the complaints procedure was not accessible to people. Complaints were not always recorded and responded to appropriately.

Is the service well-led?

Inadequate

The service was not well led. People were put at risk because systems for monitoring quality were not effective.

Leadership was weak and poor communication systems meant nurses and managers were not adequately informed and aware of what was happening in the home

Woodlands 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 checked 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 17, 18 and 22 November 2014 and was unannounced.

On the first day the inspection team consisted of two inspectors, a specialist professional advisor and an expert by experience with expertise in older people. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day of the inspection there were two inspectors and a specialist professional advisor. On the third day there were two inspectors and an inspection manager.

Before the inspection we reviewed the information we held about the home. This included looking at concerns we had received about the home and statutory notifications we had received from the home. We also contacted the local authority, the local clinical commissioning group (CCG), infection control and Healthwatch. We usually send the provider a Provider Information Return (PIR) before the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We had not sent a PIR request to the provider before this inspection.

We used a number of different methods to help us understand the experiences of people who lived in the home. We spoke with 19 people who were living in the home, six relatives, 14 care staff, four agency care staff, four nurses, one agency nurse, one activity staff, two domestic staff, the cook, the clinical lead nurse, the acting manager and the regional manager.

We looked at 16 people's care records, five staff files and the training matrix as well as records relating to the management of the service. We looked round the building and saw people's bedrooms, bathrooms and communal areas.

Inadequate

Is the service safe?

Our findings

At our inspection in May 2014, we were concerned about the cleanliness and hygiene of the home. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider sent us an action plan which stated improvements would be made by 1 October 2014.

At this inspection we found the standards of cleanliness, hygiene and odour control in the home were inconsistent and varied on the different units. For example, Mirfield unit was clean and odour free and staff demonstrated a good understanding of infection control procedures. On Hopton unit, although we identified an accumulation of dust in one bathroom and bedroom, overall cleanliness and odour control were well managed. However, on the other two units there were significant concerns. For example, on Thornhill and Calder units we found four of the bedrooms we visited smelt strongly of urine. Three of these rooms we visited again after they had been cleaned and the odour remained. One bedroom smelt of faeces and had brown stains on the wall and plug socket beside the person's bed. Cleaning staff confirmed they had cleaned the room, however these stains were still present when we visited the next day. In another person's room we saw a used vomit bowl was left in the person's room for two days. We saw one staff member disposed of bodily waste materials into a bag without using any protective clothing such as gloves or an apron and as they placed the bag in a bin the bag split and the staff member's hands were contaminated with the waste. When we spoke with the staff member they acknowledged they should have been wearing gloves and an apron however they said they had not thought they were necessary.

The local authority infection control team carried out an audit of the home in September 2014 and identified areas in need of improvement. We spoke with the infection control nurse who had visited the home four days prior to our inspection to follow up on the home's action plan. They told us the home had made very little progress with improvements. We found there were no suitable arrangements in place to keep the service clean, hygienic and to protect people from infection. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At our inspection in May 2014, we were concerned about how people were safeguarded from abuse. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider sent us an action plan which stated improvements would be made by 1 October 2014.

Staff told us, and records confirmed they had recently received training in safeguarding adults. Staff we spoke with were able to tell us how they would respond to allegations or incidents of abuse, and knew the lines of reporting in the organisation. We also saw evidence which showed the acting manager had notified the local authority, and the Care Quality Commission, of safeguarding incidents.

However, we had concerns about how people were protected from abuse and found in practice staff lacked understanding of what constituted abuse and how to keep people safe. For example, on Thornhill unit we observed one person was locked in their bedroom and saw them turning the door handle trying to get out. We alerted the nurse who confirmed the door was locked and said this was to prevent another person on the unit entering the person's bedroom. When we raised our concerns about the person being locked in the room the nurse unlocked the door. However, we were concerned that the type of lock fitted to the door meant the person could not exit their room without staff assistance. When we looked at this person's care records it showed the person was unable to use their call bell and therefore had no means of calling for assistance while locked in the room. Yale locks were fitted to all the bedroom doors on the unit and the staff had a master key to open them. We discussed this with the acting manager who confirmed she had taken action to ensure that people were not locked in their rooms on any of the units.

On Calder unit one person made an allegation to the inspector and to a care assistant that another staff member had nipped them and been rough with them. We spoke with the nurse, who confirmed she had been informed of the allegation but had not had chance to write this down because she had been so busy. However, she said she would record this and inform managers without delay. The nurse told us the person's allegation was false as they often made false allegations, however, we did not see this documented in the person's file or any measures put in

Is the service safe?

place to protect staff from such allegations. We spoke with the local safeguarding team five days after our inspection to find out if the home had referred this incident to them and they had not.

We saw three people on Calder unit had bruising on their skin; staff were unable to explain how the bruising was caused for two people. The other person had bruising to their face, we asked a staff member how this had happened and they said the person had fallen and banged their face on the table. This accident was not recorded.

We saw another person had been positioned by staff in a low chair near the entrance to the lounge. This person was slumped down in the chair with their legs extended out blocking the entrance to the lounge. We saw another person with a Zimmer (walking) frame trying to get into the lounge repeatedly banged the frame into the person's legs causing them to shout out. Staff came when we asked for assistance and although they removed the person with the Zimmer frame they did not check if the person in the chair was all right or reposition the chair to prevent a re-occurrence.

We spoke with four people on the Mirfield unit and two people on the Hopton unit. Five people told us they felt safe living in the home but one person said: "I'd rather not say, it's all I've got and I don't have another choice." Following our inspection we referred our concerns to the local safeguarding team. We found people were not protected from avoidable harm and abuse. This was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The acting manager told us on all the units there was a mix of people of varying ages, some of whom had mental health needs and others who had dementia. On Calder and Thornhill units we found risks were not always identified or well managed. For example, we looked at the care records for one person who had been in the home nine days. We saw a falls risk assessment had been completed incorrectly as it stated the person had no history of falls yet the local authority assessment showed the person had numerous falls before they were admitted to the home. This meant the person had incorrectly been assessed as low risk, when actually the risks were high. We saw this person had sustained a fall following admission yet the risk assessment had not been reviewed or updated.

Through our observations and discussions with staff and relatives, we found there were not enough staff to meet people's needs or keep them safe. Staff allocation sheets showed staffing numbers frequently fell below the numbers of staff the acting manager told us should be on duty on each unit. Over a sixteen day period we saw there were thirteen days when staffing levels were reduced.

On Hopton and Mirfield one qualified nurse worked between the two units. We found staffing levels on Mirfield unit were not always sufficient to meet the high dependency needs of people. Staff told us four of the 11 people accommodated needed two staff to help them to mobilise and were dependent on one staff to help them with their meals. This meant when the qualified nurse was attending to people on the Hopton unit, there were only two care staff on duty. When these two staff were attending to one of the four highly dependent people, the other people on the unit had to wait for attention if they needed it. We saw this impacted on the quality of care people received at times. On Hopton unit, we saw staffing levels met people's needs as people were more physically independent and less reliant on staff for help to mobilise. Staff we spoke with on these units said they felt there were enough staff to meet people's needs.

The acting manager told us four people had been admitted to Calder and Thornhill units in recent weeks from another care home, although we identified four new admissions on Thornhill unit alone. We found this influx of people with complex mental health needs had an impact on the units and staffing levels were not sufficient to meet everyone's needs. Concerns about staffing levels on both these units were raised by staff and some relatives. Staff told us they felt Calder unit was not adequately staffed and said this meant they could not give people the attention they needed and people had to wait when they were busy with someone else. Two relatives said they felt there were not enough staff to meet people's needs, particularly at weekends.

On Calder unit we saw people had to wait for staff to attend to them and their needs were not met promptly. For example, one person was in their night clothes in the lounge until lunchtime and staff told us they needed to assist the person to be dressed but they were busy attending to others. All of the gentlemen were still unshaven after lunch time and staff we spoke with said they did not always have time to do this, because of more

urgent tasks. We saw the lounge area where people were seated was frequently unattended. People in the lounge area needed assistance, yet staff were not always available to help. For example, one person shouted very loudly for more than ten minutes and was disturbing other people; another person in a posture chair attempted to sit up several times and when they were unable to do so, they went back to sleep. We saw staff were very busy attending to other people in their rooms and they were unable to help others who needed them. On one occasion we heard the cleaning staff alerted the care staff to someone who needed assistance in their room. We had to call for staff to assist one person who was struggling to get dressed in their room.

On Thornhill unit staff told us when there were five or six care staff on duty they could meet people's needs, but if staff rang in sick and they were not replaced then they struggled. There were four care staff on duty on two of the days when we visited. The nurse told us14 out of the 26 people accommodated on Thornhill unit were dependent on staff to assist them with their meals. Although some people had one-to-one support we saw this meant some people waiting for over 30 minutes for their meals as staff had to finish helping one person before they could help another. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found there were safe arrangements in place to manage controlled drugs and for the ordering and disposal of all medicines. There were satisfactory storage arrangements provided in a central clinical room on the ground floor where the regional manager advised medicine trolleys were stored between medicine rounds. We found this did not happen in practice and saw medicine trolleys were kept in the offices on Calder and Thornhill units all day. The temperature in these offices was very warm, although the room temperatures were not monitored. Extremes of temperature can adversely affect the therapeutic properties of medicines. Staff told us that they did not have time to taken the trolleys back to the clinical room after each medicine round.

We observed staff administering medicines and this was carried out sensitively and patiently with people given the support they needed. However, we had concerns about the medicine administration records (MAR) as we found a number of anomalies which indicated people may not have received their medicines as prescribed. We looked at the MARs for six people with the nurse on Calder unit. We saw some medicines prescribed for three people that morning and the previous day had not been signed as given and the nurse told us they had not had time to sign these as they had been interrupted. We saw the nurse filling these records in retrospectively. When we came back to the unit with the regional manager the MARs had been completed and the nurse said she had signed them. One person was prescribed eye drops and the MAR showed these had been refused since 27 October 2014. The nurse and regional manager were unable to locate any records to show the person's GP had been informed. One person was prescribed an anti-psychotic medicine on an 'as required' basis. There was no protocol in place to inform staff in what circumstances this medicine should be administered or the maximum dosage and frequency. The regional manager confirmed there were no protocols in place for 'as required' medicines. The home's medicine policy stated an 'as required' form must be kept with the MARs.

On Thornhill unit we looked with the nurse at three people's MARs. We checked the medicines in stock against the MAR for one person and found discrepancies. For two of the medicines there were more tablets in stock than there should have been which suggested the medicines that had been signed for had not been given. For another medicine there were three less tablets in stock than there should have been, which could not be accounted for. Another person's MAR had not been completed for one medicine for seven days. Although the nurse advised that this person often refused their medicines there was no entry on the MAR to show this was the case.

Most of the MARs included a front sheet which had a photograph of the person as well as information about allergies and their GP; however this information was not present for three of the nine people we reviewed. Three of the nine people we reviewed received their medicines covertly and we saw their care records showed that this had been agreed with their GP. However, there was no information with the MAR to show how these medicines should be administered covertly. The regional manager told us this information was kept in people's care plans, but the home's medicine policy stated this should be documented on the MAR as well as in the care plan. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service effective?

Our findings

Newly appointed staff we spoke with confirmed they had received induction training and shadowed more experienced staff before working unsupervised. However, when we looked at the staff files of three recently recruited staff we found no evidence of induction for two of the staff. One of these staff members had no previous experience of care work and there was no development plan to show how skills and knowledge in care would be gained.

Staff we spoke with told us they received regular training and updates through e-learning. Records we saw showed 90% of staff were up to date with their mandatory training via e-learning. However, there were no systems in place to check staff competencies or knowledge following completion of the training. Some staff said they did not feel e-learning gave them the skills and knowledge to do their job effectively. For example, they said they did not always feel they learned much from this training and there was no knowledge check carried out by senior staff, only a request that training was done. Another staff member said the training was not effective in helping them understand the needs of people living with dementia and they would have preferred more practical based training. Two other staff told us they had received no training in behaviour that challenges others. When asked how they knew how to manage people's behaviours, one said, "It's just common sense really" and the other said, "Other staff showed me what to do."

Most of the staff we spoke with said they received regular supervision and an annual appraisal. Although one staff member said their experience of supervision consisted of ten minutes with the manager going through a tick box form. We reviewed five staff personnel files and found evidence of supervision and appraisals, although this varied in consistency and quality. For example, one staff member had received three supervisions and no appraisal over a two year period. Two other staff members had received two supervisions in a twelve month period, only one of these staff had received an appraisal.

Records we saw showed training in the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) was included in the e-learning modules. However, when we spoke with staff some said they had not received this training and all the staff we spoke with had little knowledge and understanding of this legislation. One staff member said, "I've done the e-learning but it wasn't in depth and I can't tell you anything about either of these (MCA and DoLS)." There was little evidence in people's care records that their mental capacity had been assessed. For example, some sections were partially completed and other sections were blank. Staff we spoke with said they were aware some people could not make complex decisions, although they said they encouraged them to make routine choices about their care.

There was one person on the Mirfield unit who had a DoLS in place and had the support of one staff member at all times. Staff who provided this support had a good understanding of the person's needs and how to manage their care which the daily notes reflected. However, records made in October 2014 showed the person's next of kin had not been informed of the DoLS and there was no further update to show they knew about this decision.

On Calder unit none of the staff we spoke with, including the nurse-in-charge, were able to give us accurate information about whether people were subject to a DoLS. When asked, the nurse said there were 'a few' but later said there 'was one'; yet was unable to identify who or show any documentation to this effect.

On Thornhill unit we saw some people's liberty was restricted. For example, we saw six people had constant one-to-one support from a staff member throughout the day and although we were told two of these people were subject to DoLS, when we checked one person's care file there was no documentation to reflect this. The nurse in charge of the unit told us there were no DoLS in place for the other four people, although she confirmed all four lacked capacity to make the decision about one-to-one support. We also saw two people in posture chairs which were inclined and both had lap belts in place which restricted their movements. The care records for one of these people showed the person did not have capacity to make decisions about their care, yet there was no evidence of best interest meetings or a DoLS. We spoke with the nurse in charge on the unit and they said they were not aware of any best interests meetings or a DoLS application for this person.

On three units we looked at the management of 'Do Not Attempt Resuscitation' (DNAR) orders within people's files and found shortfalls. For example, one person's DNAR form gave a review date of May 2014, yet there was no evidence this had been reviewed. On another person's record the

notes stated there was a DNAR in place, yet there was no DNAR form in their file. On Hopton unit the agency nurse showed us a list of people who had DNAR orders, but we saw this was not up to date. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We observed lunch on all the units over the course of our three day inspection. We found lunch on Hopton unit was well organised. People we spoke with said they enjoyed the food and received the support they needed with their meals. In contrast, on the other three units we found, although some people told us they enjoyed the food, mealtimes were disorganised. Menus we had been shown by the cook showed a nutritional balance, yet this was not reflected in the food served. For example, on one day there was a choice of chicken nuggets, fish fingers or pork pie with mushy peas and chips, on another day the lunch was a burger in a bun or corned beef hash. There were no vegetables and the food looked unappetising. Dessert was semolina or a chocolate bar. Menus were not accessible to people. On Mirfield unit the menu was displayed in the entrance to the unit which meant people who remained in bed had no access. On Thornhill unit no menu was displayed and menus on the tables were in very small print and covered several weeks of meals. There were no easy read or pictorial menus for people living with dementia. Staff told us people made their choice the day before and this was recorded on a list. However, staff could not locate the list when we asked to see it.

On all three units we saw there were delays in people receiving their meals due to the availability of staff and the high numbers of people who required one-to-one support with eating their meals. We saw quantities given to people were decided by staff and there was no consultation with people about how much they would like; they were just presented with the food. We saw two people had a pureed meal. Although the different parts of the meal were pureed and presented separately, staff poured gravy over both meals without consulting with people. There was no communication to tell people what the meal was and when we asked staff they said they did not know. People were served at different times so that some people had eaten before others had been given anything.

On Calder unit we saw many people pushed their food away and did not eat it. Staff told us there were always alternatives, however, no alternatives were offered to people until we raised this with staff. One person was presented with a burger in a bun and struggled to eat the food as they had no bottom dentures. When we alerted staff to this the person's dentures were provided. There was no information in this person's care file to show they had dentures or how their oral care was managed. We observed two people who were asleep and staff said they would try to encourage them to eat their meal when they awoke, yet when we checked with staff in the afternoon they did not know if these two people had eaten anything. There was a food chart completed for one person, but this did not include any lunch.

Staff told us ten people on Thornhill unit had chosen to eat their meals in the lounge or their bedrooms. We saw food was plated up and left on a trolley for over ten minutes. When we asked the reason for the delay, the staff member said they had run out of plates so they had to go downstairs to the kitchen for more. We saw the food was served on cold plates and asked the staff if the food was hot. They said probably not however nothing was done to address this and once the plates arrived the meals were taken to the lounge. We saw people in the lounge were eating their meals from low tables and people struggled to eat their meals without dropping the food. We spoke with one family member who was assisting their relative with their meal. They told us a family member came in each day to help their relative. They said, "It's a bit disorganised today. The food's okay, but (my relative) will eat anything though they didn't used to." On Mirfield unit we saw people who were independent made their own drinks, yet on Calder and Thornhill although drinks were offered at set times people were unable to access a drink independently between these times.

On Mirfield, Calder and Thornhill units we looked at the food and fluid charts for people and saw these contained insufficient information for staff to effectively monitor people's intake. For example, quantities of food and drink were not consistently recorded and there was no evidence of close monitoring when people had been 'offered but refused' food or drink. Fluid charts had daily targets for fluid input and stated fluid intake must be totalled by the nurse every day, but this was not always done. For example, one person had been on a fluid chart for seven days and had failed to reach the prescribed target of fluid intake every day. This was not recorded in the person's care

Inadequate

Is the service effective?

records and staff we asked were not able to tell us what was being done to address this shortfall. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The care records we looked at showed people had been seen by a range of health and social care professionals including GPs, the Care Home Liaison Team (CHLT) and the Speech and Language Therapy (SALT) team. During the inspection we saw the practice nurse visited to give people their flu vaccinations. There was evidence which showed people had been seen by the optician and chiropodist. We saw one person had a detailed end of life care plan which had been developed in consultation with an Admiral nurse (specialist dementia nurse). We spoke with a visiting GP who told us they felt staff were pro-active in contacting them at the early stage of a person's illness.

However, we had concerns that referrals to health care services were not always made promptly when people's needs changed. For example, records showed one person had lost over 7kgs in weight over a seven month period. This person was assessed as being nutritionally at risk and had developed pressure damage. There was no reference to this weight loss in the person's care plan. When we asked the nurse what action had been taken, they said they were unaware of the weight loss. The person had been seen by the SALT team in 2012, but the nurse could find no further evidence to show the weight loss had been identified to any health care professional. We saw in another person's notes an entry recorded two days previously which identified the person had developed a sore area and requested this was reported to the GP in the morning. We asked the nurse in charge what had been done about this and they were not aware of the issue. They later showed us a record they had made requesting staff to contact the surgery on Monday morning.

We found the design, maintenance and décor of the premises had a detrimental effect on the quality of life of people living with dementia or enduring mental health needs. For example, on Thornhill and Calder units the décor was stark and bare with little to occupy or interest people. Although some signage was provided, in many places this had been removed and the screws had been left standing proud in the door. Some push taps in ensuite facilities had not been set correctly so when anyone pushed the tap the water stopped before people could get their hand under the water. Many of the locks on doors were broken. There was no shelving or storage space in the majority of the ensuites. We saw linen trolleys were left in people's bedrooms when they were not being used. The majority of bedroom light switches were located outside the bedroom which meant lights could be operated outside the room without the person's consent. Many of the bathrooms and toilets had no blinds or curtains in place. Although there was frosted glass at the windows this did not fully protect people's privacy and dignity as when lights were on people could still be seen through the windows. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service caring?

Our findings

We found a lack of consistency in how staff approached and interacted with people which was evident throughout the home. We saw some staff were very caring with people and they showed this by taking their time when speaking and listening, using kind faces, appropriate touch and reassurance. In contrast, we saw other staff were less warm in their approach and dealt with people's needs in a matter-of-fact way. This was demonstrated in the way they did not always smile or acknowledge people as they went past them or how they spoke in a more limited way when assisting them with care tasks. For example, on Calder unit on four occasions within a half hour observation we saw staff walked past people in the lounge and ignored them, even though two people showed they wanted attention by trying to gain eye contact or holding out their hand. One person told us, "I'm fed up. You're the only person that has come to talk to me for a very long time. Nobody speaks, they [the staff] just walk by." Relatives we spoke with told us when they visited they often found the lounge unattended and people sitting with nothing to do. Two out of the three relatives we spoke with said they were happy with the care their family members received and they gave praise for the care staff, who they said knew their family members well.

On Thornhill unit we saw staff frequently came into the communal areas but interacted with the same people each time which meant other people, often those who were quiet, had very little contact with staff other than when they needed assistance with care needs. One person told us they did not like it in the home and when asked why said, "You're on your own all the time." We saw a wide variation in how support was provided to people by one-to-one staff on both Thornhill and Calder units. We saw some staff were kind, compassionate and showed a good understanding of needs of the person engaging with them at every opportunity and providing continual observation without overcrowding the person. In contrast, we observed care provided by other one-to-one staff was oppressive with little interaction. For example, we saw one staff member was constantly side by side with the person they were supporting and each time the person moved, the staff member responded asking them what they were doing and placing their hand either on the person's shoulder or back. This did not appear to calm or benefit the person who was continually pacing up and down, which the person's care record showed was what they did when they were agitated.

On Hopton & Mirfield units we saw care staff readily engaged in conversation with people who were able to do so. For example, they talked about holidays, television programmes and music. Staff joined in with friendly banter which was appropriate for some people, However, unless carrying out routine care tasks we noticed staff did not attempt to converse in any way with people who had limited conversational ability. We saw one staff member who assisted a person with their meal and there was no warmth of interaction. The staff member repeatedly loaded the person's spoon with food and although they fed them at an appropriate pace, there was no conversation or friendly facial expressions used to communicate with the person. The staff member was focused on completing the task, rather than helping the person to enjoy a positive dining experience. We saw the staff wiped the person's mouth following the meal and walked away.

We saw some staff practices were respectful and promoted people's privacy and dignity. For example, we saw staff knocked on people's doors before entering and people's privacy and dignity was maintained when carrying out personal care tasks. However, we also found examples of practices which showed a lack of respect for people and compromised their privacy and dignity. For example, on Calder unit at lunchtime we observed a staff member talking loudly across the lounge to a person who was shouting. The staff member mimicked both the words that the person used and their accent in a way that did not respect the person's dignity. We saw there were no curtains in one person's room, which did not promote their privacy, dignity or restful sleep. We asked to speak with one member of staff in a private setting. The staff member took the inspector into a person's room and said the person would not mind us using their room to talk in, but the inspector requested that the conversation should happen elsewhere as the person's consent had been assumed, not sought.

On Thornhill unit we saw some people looked unkempt and were wearing stained and dirty clothing with their hair uncombed. Some men were unshaven although we heard two people tell staff they would like to have a shave. We saw some people were left with food around their mouths

Inadequate

Is the service caring?

long after meals had been finished. We found there was a lack of storage in the ensuite facilities for people to store their toiletries and we saw people's toiletries were stored on a ledge which was on a level with and close to the toilet seat. In one person's room we saw a notice displayed which said, 'I help my 1:1 tidy my wardrobes and drawers, please keep it clean and tidy'. We found the room smelt strongly of urine and some of the person's clothes were piled up on the floor of the wardrobe. Relatives we spoke with told us they were satisfied with the care and found their relatives were well groomed when they visited. However, one relative said sometimes they found their relative had food around their mouth but when they raised this with staff it was dealt with.

One person's care record showed they had a limited understanding of English as this was not their first language and on occasions interpreters had been to visit. This person had limited social interaction with other people due to the nature of their health needs. A member of staff from another unit came and acted as an interpreter whilst the inspector spoke with the person about their care as there was no permanent staff member working on the unit who spoke this person's language. This staff member told us they only worked on the unit to cover staff shortages. The nurse in charge said that on average once a week a staff member with these language skills worked in this particular unit. This meant the rest of the time communication with this person was limited.

We found limited evidence to show that people were actively involved in making decisions about their care and support. On Hopton and Mirfield units one person told us staff supported their independence. They said it was important to them to be able to go shopping or out to lunch with the activities staff and we saw this took place on the day of our visit. Another person told us staff helped them if asked, but encouraged them to do things for themselves as much as possible. On the other two units, although we saw people were offered some choices, such as if they wanted to play dominoes or wanted a drink, these were limited. People's independence was not actively promoted and was limited by restrictions in the environment. For example, the dining rooms on Calder and Thornhill were locked when not in use and there were no facilities for people to make themselves a drink. People's rooms were kept locked and staff held the keys which meant people could not access their rooms without staff assistance. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service responsive?

Our findings

Our discussions with care staff showed an understanding of people's needs, however we saw the delivery of care was task orientated rather than focussed on the needs of the individual. For example, on Thornhill unit a list was displayed in the nurses' office which showed which day people were to be bathed and at what time of day. When we asked the nurse how this was decided they said it was in people's care records, yet care records we reviewed did not reflect this. On Mirfield unit we saw a person who had had a shower was put back to bed with wet hair. The window next to the bed was open and the person's hair made their pillow wet and cold. Staff we spoke with gave differing accounts about why the person's hair had not been dried. One staff said, "We do sometimes dry it, it depends how busy we are and what else we have to do as well." They said if other tasks needed doing on the unit, they did not always have time to dry the person's hair. The other staff said the person did not like having their hair dried and this made them distressed. However, this information was not noted in the person's care records. We saw following our discussion with the care staff, the person was helped to dry their hair.

We looked at people's care records across all four units and found a lack of person-centred care planning. We found it was difficult to identify people's current needs as the files contained old and out of date information which had not been removed and included notes dating back to 2010 which were no longer relevant. Although some information, such as daily notes were up to date, other records were not accurate and gave conflicting information. For example, one person's record had information that stated they had a normal diet and were at low risk of choking, whereas other information stated they were at high risk of choking and aspiration. Another person's care plan stated to weigh weekly, yet the last weight recorded was 12 October 2014 and their nutritional care plan had not been reviewed since September 2014. This person's records showed they had been assessed as being nutritionally at risk and they had a pressure ulcer.

We found there was scant information about the care needs of people who had recently been admitted to the home. For example, one person had been in the home nine days, their initial assessment was incomplete; there was no care plan for personal hygiene although assessment information from the local authority showed they needed support with washing and dressing. The person had a diagnosis of Alzheimer's, yet the mental capacity assessment was blank and there was no information in the communication care plan. For another person who had been in the home ten days, there was limited information and staff had taken little regard of what information was in the file. For example, the record stated the person wore glasses, yet we saw they had no glasses on and staff did not know where these were. The information said 'sits on pressure cushion' yet we noted they were seated without one, and 'limited speech', yet we had coherent conversations with this person. There had been few assessments carried out in relation to this person's needs. Another person who had been in the home seven days when we looked at their care records had no nutritional care plan, although records showed this person had lost 10.4kgs in weight in just over three months.

People's care records throughout the home provided a lack of clarity about how people who were unable to use a call bell would summon help. On both Calder and Thornhill units we found many of the rooms had no call bell leads. On Calder unit staff told us if people did not have a call bell then it was because they would be unable to use one and they may have a sensor mat in place instead. However, we spoke with two people, who both said they would know how to use a call bell, yet there was none available. One person said, "They [the staff] don't let me have my call thing. What's the point having one? They play hummer with me if I ring for them". We spoke with one relative whose family member had a call bell but was unable to use it as they did not understand how or why to press the button. The relative expressed concern as when they had visited they found their family member needed staff assistance yet had been unable to summon it. We saw there were hourly check sheets in this person's room. However, these were not up to date or filed consecutively, with some records undated, so it was not possible to see if checks had been carried out.

On Thornhill unit staff showed us sensors installed in each bedroom which were activated outside people's rooms. They said when the sensors were activated they detected any movement made by the person in the room and triggered an alarm. We asked the nurse how the sensors were used and they told us they were mainly used at night when they were switched on for everyone. We saw no risk assessments in place in the care records we reviewed for

Is the service responsive?

the use of these devices. Some people on Mirfield unit were unable to reach their call bells yet there was no information in their care records about this. One person we spoke with said, "I can use my buzzer, but I try not to. They [the staff] don't like it if I buzz for non-emergencies." They told us they often felt the need to use the toilet but staff preferred them to wait at least two hours in between visits to the toilet 'because that's best for me', yet we did not see this information reflected in the person's care plan. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw information about people's social and life history was sparse and care records gave little information about the person, other than their health and care needs. One person's life history section contained their date of birth only. Another person's preferences and choices care record stated 'Good day – peace and quiet, can of beer, visits from family. Bad day - noise, not seeing family'; the rest of the form was blank. We looked at this person's journal which staff told us was where activities were recorded. Recent activities consisted of chats, visits from family and on one occasion throwing a ball with staff. We looked at the journal for another person who staff told us spent all their time in bed. Over a ten day period the record showed no activities had taken place. We spoke with this person each day we visited and they told us how much they enjoyed talking with us and said, "I don't see many people, love."

The acting manager advised three activity co-ordinators were employed for a total of 66 hours per week. We spoke with one of these staff who told us the home had a minibus which two of the co-ordinators were able to drive. They said they took people out as often as possible but said the majority of people could only go out one at a time due to their complex needs. They told us they used the minibus to take people to GP and dental appointments and would then take them for lunch or a coffee afterwards. They told us there had been a 1940s and World War One themed concert the previous weekend which people attended from all the units. They said one person who was a George Formby fan responded to the ukulele player by speaking for the first time in the home. Two relatives we spoke with told us about the concert. The activity co-ordinator told us the activity programme was flexible and included one-to-one reading, games and chatting. They said different kinds of music were played in each unit and a film, musical or nostalgic drama was often put on for people. They said the home was creating a sensory room for people and were waiting for the equipment to be delivered.

Our observations over the three days we were present in the home showed there were few organised or meaningful activities for people. There was no information on any of the units about activities. On Mirfield unit we saw many people remained in bed although we saw staff invited people to get up. Two people who were seated in posture chairs were placed in front of a television that played music. We saw they alternated between waking and sleeping but staff did not interact with them other than to assist with their physical care, such as giving them a drink or a snack. One person had a key to their room and they showed us their personal belongings and items they had bought whilst out shopping. They told us they were looking forward to having family visitors the following day.

On Hopton unit, we saw one person had their fingernails painted and another looked at a magazine with staff. When we asked one person about activities they said, "There's nothing at all." They told us in the past they had helped the home's handyman to move furniture and had done a bit of gardening. They said they used to go to a day centre, but did not go now. They mentioned a trip to the Dales when they had visited a pub. On one of the mornings we saw staff set up a karaoke machine and we saw one person danced with a staff member while other people watched and sang along to the music.

On Calder and Thornhill units we saw there was some brief play with balloons and a soft ball which involved a small number of people in the lounge. We saw some staff played dominoes with people, on one occasion in a small group and at other times on a one-to-one basis. On Calder unit people were seated around the lounge area with little to do and limited interaction from staff. The television played music, though none of the people responded to show they were listening. One person held a plastic puzzle and said they had no idea what to do with it. Another person had dominoes in their room and said there was no one to play these with. On Thornhill unit the communal areas were noisy as the television in one room competed with the radio playing in the adjoining room. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service responsive?

The regional manager told us the complaints procedure was displayed on the noticeboard on the ground floor of the home, but not on any of the units. They said there was an easy read version of the procedure but this had not been provided to people. The regional manager said people were given a service user guide when they first came into the home which contained details about how to make a complaint. Two relatives we spoke with said they had not seen the complaints procedure but said they felt if they spoke with a member of staff their concern would be dealt with appropriately. The regional manager showed us the electronic system where all complaints were recorded. We looked at three complaints which the regional manager was investigating. We saw correspondence for two of them which showed acknowledgement letters had been sent as well as further correspondence outlining the investigation being undertaken. We were unable to see any correspondence sent in relation to the third complaint as the regional manager told us this had been sent directly from head office.

We asked to see correspondence relating to a complaint we had been informed of in September 2014 and had discussed with the acting manager at the time. The complaint also raised safeguarding concerns which we had referred to the local safeguarding team. The acting manager told us they had not recorded this on the home's electronic system as either a safeguarding or a complaint and there were no records they could show us in relation to this complaint. We asked to see correspondence relating to another complaint which had been received in January 2014 and the deputy manager was unable to locate any records relating to this complaint. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service well-led?

Our findings

The home had a registered manager who left the post in July 2014. The deputy manager took over as 'acting manager' and was managing the home at this inspection. The regional manager told us the clinical lead nurse had been taken off the units and was now office based and supported the acting manager in their role. The regional manager said they were advertising for a registered manager for the home.

The acting manager and the clinical lead nurse confirmed they did not work 'out on the floor'. The acting manager told us there were no unit managers and each unit was managed on a shift by shift basis by the nurse-in-charge. We found there was a lack of consistent leadership throughout the home and staff were not clear about their roles or responsibilities. For example, when we visited at the weekend there were no managers working and although there was a senior manager on call, the nurses we spoke with were unclear who was in charge of the home. The nurses told us it was usually the nurse who worked on Hopton and Mirfield units who was in charge, however this nurse told us they had just returned to work after four weeks leave and said, "I don't know what is going on in the home. There is supposed to be someone in overall charge, but I don't know who." A visiting GP we spoke with said they felt standards at the home were not very good and described communication as a 'shambles' as the information they had been given had not identified which unit the person was on that they had been called to visit. They described having to visit three units before being able to locate the person.

We found ineffective communication systems meant nurses and managers were often unaware of what was happening in the home. For example, neither the nurse-in-charge of the unit, the acting manager or clinical lead nurse were aware that one person had a pressure ulcer, even though this had been recorded in the person's care records seven days earlier. The acting manager told us the nurses on each unit completed a daily report, which was passed to management, detailing any events or incidents that had occurred over a 24 hour period. We looked at the daily reports for all the units for one day and found two were only partially completed and the other was blank. The clinical lead nurse told us the report had not been completed for Mirfield and Hopton units as there had been agency staff on duty. We heard the acting manager take a phone call asking about an incident that had happened in the home overnight. The acting manager and clinical lead nurse were not aware an incident had occurred.

The acting manager told us they had clinical governance meetings with the nurses; however no meetings had taken place since the acting manager had commenced in post in July 2014. The acting manager told us meetings with staff were held via group supervision sessions as well as formal meetings. Notes we saw from one of these meetings were brief and just listed the issues discussed.

We saw minutes from the last residents meeting which was held in June 2014. The acting manager told us these meetings were ad hoc and not planned on a regular timescale.

Although the home had systems in place to assess and monitor the quality of service provision we found these were ineffective and had failed to identify and address the serious issues and concerns we identified at this inspection. For example, we looked at a sample of care plan audits undertaken in July 2014. We found some had no names or dates on them and others just contained the initials of the person. Although the audit forms showed actions that needed to be addressed, the registered manager and acting manager were unable to tell us if these had been met and had to trawl through people's individual care files to ascertain if this had happened. Similarly none of the managers present at the inspection were able to interrogate or extract information from the datex system to show how accident, incidents and complaints were analysed and reviewed. The acting manager showed us a separate monthly accident analysis form, however this contained minimal information and a lack of thorough analysis. For example, the form showed over a three month period one unit each month had a significantly higher number of accidents than the other units, yet this had not been identified in the audit. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found people's care records were not accurate and lacked proper information about their care and treatment. Many of the care plans, risk assessments and care charts we reviewed were not up to date and it was difficult to ascertain people's current care needs. This put people at risk of inconsistent and inappropriate care as their

Inadequate

Is the service well-led?

individual needs were not clearly identified or the support they required from staff. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services Service users were not protected against the risks of receiving inappropriate or unsafe care or treatment as service users' needs had not been assessed and the planning and delivery of care did not meet individual needs or the welfare and safety of the service user Regulation 9 (1) (a) (b) (i) (ii)

The enforcement action we took:
Enforcement action

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers Service users were not protected against the risk of inappropriate or unsafe care as the operation of systems was not effective in enabling the registered provider to regularly assess and monitor the quality of services or to identify, assess and manage risks relating to the health welfare and safety of service users and others who may be at risk. Regulation 10 (1) (a) (b).

The enforcement action we took:
Enforcement action

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse The registered provider did not have suitable arrangements in place to safeguard service users from the risk of abuse by means of identifying the possibility of abuse and preventing it before it occurs and

This section is primarily information for the provider

Enforcement actions

responding appropriately to any allegation for abuse. The provider did not have suitable arrangements in place to protect service users against the risk of unlawful control or restraint. Regulation 11 (1) (a) (b) (2) (a)

The enforcement action we took:
Enforcement action

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control The registered provider did not ensure service users, persons employed or others were protected against the risk of acquiring an infection by the effective operation of systems to prevent, detect and control the spread of infection or the maintenance of appropriate standards of cleanliness and hygiene of the premises. Regulation 12 (1) (a) (b) (c) (2) (a) (c) (i)

The enforcement action we took:
Enforcement action

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The registered provider did not have appropriate arrangements to protect service users from the risks of the unsafe use and management of medicines. Regulation 13

The enforcement action we took:
Enforcement action

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs The registered provider did not protect service users from the risk of inadequate nutrition and hydration and did not provide a choice of suitable and nutritious food

This section is primarily information for the provider

Enforcement actions

and hydration in sufficient quantities to meet service users' needs or provide support to enable service users to eat and drink sufficient amounts for their needs. Regulation 14 (1) (a) (c)

The enforcement action we took:
Enforcement action

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises Service users were not protected against the risks of unsafe or unsuitable premises due to a lack of security of the premises and inadequate maintenance of the premises. Regulation 15 (1) (b) (c)

The enforcement action we took:
Enforcement action

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services The registered provider did not have suitable arrangements in place to ensure the dignity, privacy and independence of service users; to enable service user to be involved in making decisions about their care or treatment; treat services users with consideration and respect; express their views; provide opportunities, encouragement and support to promote their autonomy, independence and community involvement. Regulation 17 (1) (a) (b) (2) (a) (c) (ii) (g)

The enforcement action we took:
Enforcement action

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

This section is primarily information for the provider

Enforcement actions

Treatment of disease, disorder or injury	The registered provider did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to their care and treatment. Regulation 18

The enforcement action we took:
Enforcement action

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints The registered provider did not have an effective system in place for identifying, receiving, handling and responding appropriately to complaints; ensuring service users had information about the complaints system in a suitable format; ensuring complaints were fully investigated. Regulation 19 (1) (2) (a) (c)

The enforcement action we took:
Enforcement action

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records The registered provider did not protect service users from the risk of inappropriate or unsafe care by means of an accurate record for each service user including appropriate information and documents relating to their care and treatment. Regulation 20 (1) (a)

The enforcement action we took:
Enforcement action

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing

This section is primarily information for the provider

Enforcement actions

The registered provider had not ensured sufficient numbers of suitably qualified, skilled and experienced persons were employed to ensure the health, safety and welfare of service users at all times. Regulation 22

The enforcement action we took:
Enforcement action