Care Quality Commission

Loxley Health Care

Loxley Court

Inspection report

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Date of inspection visit: 11 November 2014
Date of publication: 10/03/2015

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?	**Inadequate**

Overall summary

As a result of concerns raised by the local authority an inspection took place on 11 November 2014. This was an unannounced inspection which meant the staff and provider did not know we would be visiting. The service was last inspected on 1 May 2014 and was meeting the requirements of the regulations we checked at that time.

Loxley Court is a nursing home that provides care for up to 76 people. It is a purpose built care service. At the time of the inspection the provider had made a voluntary decision not to admit any further people to the service.

There were 47 people were living at the service. The service has three floors; the ground floor unit is primarily used for people who have behaviour that may challenge others.

The registered manager for this service was no longer in post and not managing the regulated activities at this location at the time of the inspection. The registered manager was in the process of cancelling their registration. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

Summary of findings

One of the provider's senior homes managers was acting as the manager of the service. The acting manager told us they were actively recruiting new staff to work at the service. In the meantime, the service was using agency and bank staff whilst they recruited more permanent staff.

During the inspection we found that some people's daily records were not being updated on one of the units and were being filled in later in the day. Staff explanation was they were too busy supporting people and there were two agency workers on the unit who did not know people or their care needs well. Staff were unable to confirm whether several people had actually received the care they needed. For example, two people who required repositioning regularly to reduce the risk of them developing pressure sores but we could not evidence this had occurred. This showed that the service was not meeting requirements to ensure that a sufficient number of suitably experienced staff was available to meet people's needs.

People told us they felt "safe". Some people who lived at the service had complex needs and we were not able to verbally communicate with them so they could share their views and experiences with us. Our observations did not identify any concerns regarding safeguarding of people who lived at the service. Most of the relatives spoken with felt their family member was safe.

Staff had received training in safeguarding vulnerable adults as part of their induction training. Our discussions with staff told us they were aware of how to raise any safeguarding concerns.

We saw evidence that checks were undertaken of the premises and equipment. However, we found that daily checks were not undertaken to ensure air mattresses were set correctly. For example, we found one air mattress did not have the correct settings prescribed for the person.

People told us they were treated with dignity and respect. Relatives spoken with told us they felt their family member was treated with dignity and respect. During the inspection we observed positive and a few negative interactions between people and staff. We observed staff giving care and assistance to people. They were respectful and treated people in a caring and supportive way. However, we saw a few interactions where people were not treated with consideration or respect. For example, a staff member discussing a person's behaviour that may challenge others in front of other people.

The service did not have appropriate arrangements in place to manage medicines to ensure people were protected from the risks associated with medicines.

Robust recruitment procedures were in place and appropriate checks were undertaken before staff started work. This meant people were cared for by suitably qualified staff who had been assessed as suitable to work at the service.

People spoken with told us they were satisfied with the quality of care they had received and made positive comments about the staff. Relatives spoken with also made positive comments about the care their family members had received and about the permanent staff working at the service.

Individual risk assessments were completed for people so that identifiable risks were managed effectively. There was evidence of involvement from other professionals such as doctors, opticians, tissue viability nurses and speech and language practitioners.

People's nutritional needs were monitored and actions taken where required. People's preferences and dietary needs were being met.

Staff told us they enjoyed caring for people living at the service. Permanent staff were able to describe people's individual needs, hobbies and interests, life history, likes and dislikes and the name people preferred to be called by.

Staff received induction training for their roles. However, some staff refresher training was overdue which meant staff had not been supported to maintain their skills and develop their knowledge. Staff had not received regular supervisions and appraisals which meant their performance was not formally monitored and areas for improvement may not have been identified. This meant the service did not ensure staff received appropriate training, professional development, supervision and appraisal.

Summary of findings

On the day of the inspection three people had been supported to go on a trip to the butterfly park. During the inspection we observed musicians playing in one the units; relatives told us they regularly visited the service.

The service had a complaint's process in place and had responded to people and/or their representative's concerns, investigated them and taken action to address their concerns.

The service had not held regular meetings with people living at the service and/or their relatives or representative. This meant people and/or their relatives or representatives did not have sufficient opportunities to be kept informed about information relevant to them.

The provider had not ensured there were effective systems in place to monitor and improve the quality of the service provided. This meant they were not meeting the requirements to protect people from the risk and unsafe care by effectively assessing and monitoring the service being provided.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this 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?

Requires Improvement

Some areas of the service were not safe. The service had not made sure there were sufficient staff with the right knowledge and experience to support people.

The service did not have appropriate arrangements in place to manage medicines to ensure people were protected from the risks associated with medicines.

People told us they felt "safe". Staff were aware of how to raise any safeguarding issues. People had individual risk assessments in place so that staff could identify and manage any risks appropriately.

Is the service effective?

Requires Improvement

Some areas of the service were not effective. Staff had not been supported to deliver care and treatment safely and to an appropriate standard. Staff refresher training was overdue so staff had not been supported to maintain and update their skills and knowledge.

The service had policies and procedures in relation to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). However, people had not been appropriately supported to make decisions in accordance with the MCA.

People's dietary needs were accommodated. There was evidence of involvement from other health care professionals where required, and staff made referrals to ensure people's health needs were met.

Is the service caring?

Requires Improvement

Some areas of the service were not caring. During the inspection we saw positive and a few negative interactions between people and staff. We observed staff giving care and assistance to people and they treated people with dignity and respect. However, we saw a few examples where people were not treated with consideration or respect.

People and relatives made positive comments about the staff and people told us they were treated with dignity and respect.

Permanent staff working at the service knew people well and were able to describe people's individual likes and dislikes, hobbies and interests, their life history and personal care needs.

Summary of findings

Is the service responsive?

Some areas of the service were not responsive. We found some people did not have access to a call buzzer to call for assistance during the day or night. Two people in their rooms had access to a call buzzer but we found staff had not ensured the person could reach their call buzzer to call for assistance.

Staff handovers enabled information about people's wellbeing and care needs to be shared effectively and responsively.

We found the service had responded to people's and/or their representative's concerns and taken action to address any concerns.

Requires Improvement 

Is the service well-led?

The service was not well-led. People's and/or their representatives views had not been actively sought to enable people to share their experience of their care.

The acting manager had recently undertaken a number of staff meetings to review the quality of service provided and to identify where improvements could be made. However, we found robust action had not been undertaken when concerns had been raised.

The checks completed by the operations manager, acting manager and deputy manager to assess and improve the quality of the service had not effectively ensured people were protected against the risk of inappropriate or unsafe care.

Inadequate 

Loxley Court

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.

The inspection took place on 11 November 2014. This was an unannounced inspection which meant the staff and the provider did not know we would be visiting. The inspection team consisted of two adult social care inspectors, a specialist advisor and an expert by experience. The specialist advisor was a registered nurse who was experienced in the care of 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. The expert by experience had experience of older people's care services.

Before our inspection we reviewed the information we held about the service and the provider. For example, notifications of deaths and incidents. We also gathered information from the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We used a number of different methods to help us understand the experiences of people who lived in the service. We spent time observing the daily life in the service including the care and support being delivered. We spoke with four people living at the service, five relatives, a senior homes manager who was the acting manager, the operations manager, the deputy manager, two nurses, two care workers, a domestic worker, an administrator and the cook. We looked round different areas of the service; the communal areas, the kitchen, bathroom, toilets and with permission where able, some people's rooms. We reviewed a range of records including the following: seven people's care records, nine people's medication administration records, three people's personal financial transaction records, three staff files and records relating to the management of the service.

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Is the service safe?

Our findings

People spoken with told us they felt 'safe' and had no worries or concerns. One person commented: "I have never seen anybody being mistreated". Most relatives spoken with felt their family member was in a safe place. However, one relative told us they were concerned about their family member's safety because of the different levels of need of people on one of the units. They were worried that their family member may be more susceptible to the risks associated with behaviour that may challenge from other people as their family member was very frail and immobile. They were also concerned about the number of different agency staff working at the service who did not know their family member well and would make sure they were safe.

We found that some people who lived at the service had complex needs and we were not able to verbally communicate with them so they could share their views and experiences with us. From our observations we did not identify any concerns regarding safeguarding of people who lived at the service.

The operations manager told us that a dependency assessment had been completed earlier in the year by the former manager but they were unable to locate a copy of it. This is a tool manager's use to calculate the number of staff they need with the right mix of skills to ensure people receive appropriate care. For example, the number of nurses and number of care assistants for each unit. Staff spoken with told us that some people's supports needs had increased on their unit. Three people who were currently being provided with residential support on one of the units were being reassessed for nursing care as their needs had changed.

The acting manager told us they were actively recruiting new staff to work at the service. For example, eight nurses. In the meantime, the service was using agency and bank staff whilst they recruited more permanent staff to the service. Permanent staff spoken with told us agency staff working at the service did not know people well so it was difficult to provide continuity of care. One staff member told us they spent a lot of time 'back-tracking' when bank/agency staff covered shifts. Staff comments about the staffing levels in the service included: "I am stressed out", "I wake up in the middle of the night worrying", "I can spend up to one hour administering medication to one person", "the unit is too heavy" and "when priorities change, residents don't get sufficient basic care and staff have no time to chat with them".

During the inspection on one of the units we found that people's daily records were not being completed and one person didn't have any daily records in place. We found that these records were being completed retrospectively by staff. It is important that an accurate record of a person's daily care is recorded at the time the care is given. Staff were unable to tell us whether two people had received the support that was required in their care plan. Both people needed to be regularly repositioned to reduce their risk of developing pressure sores. One of the people also needed to have regular observation checks in bed to minimise their risk of falling out of bed. We noted on their records that on the 10 November 2014 the person had fallen out of bed onto a crash mat by the side of their bed. Both people were unable to tell us whether they had received the care they needed. The explanation given by staff was that there were two agency staff working on the unit who did not know people well. This showed that there were not enough staff who knew the needs of people living at the service so that consistency of care was provided. These findings evidenced a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

During the inspection we observed staff administering medication to people. We saw that staff had a patient and caring approach whilst supporting people. However, we found that people were not protected from the risks associated with medicines because the service did not have appropriate arrangements in place to manage medicines. During the inspection we looked at the systems in place for managing medicines in the service. This included looking at people's Medication Administration Records (MARs).

We identified some concerns in the sample of MARs checked. One person had been prescribed a medication which needed to be administered four times a day. Staff had not signed to confirm they had administered the medicine on one occasion. We checked the person's medication and saw one dose had not been administered. A medication error had not been reported by staff so that appropriate action could be taken. For example, contacting the person's GP for advice. The service medications error procedures stated that any error in the management or

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Is the service safe?

administering medication must be reported to the homes manager immediately. This was to ensure that the safety and welfare of individuals was maintained at all times. We spoke with the deputy manager who told us they would speak with staff regarding the omission.

Two people had been prescribed a cream. We found that topical creams charts were not being used to ensure the cream was administered correctly. A topical creams chart tells staff where a cream needs to be applied. Without these charts being in place we were unable to ascertain whether the creams were being administered correctly. The two people were unable to tell us.

One person had been prescribed a transdermal patch to alleviate pain and for it to be replaced every seven days. We noted that on the 2 November 2014 when it was due to be replaced, it was recorded in the person's records that a patch could not be located to be removed. This told us the person may have experienced pain due to a patch not being in place. We spoke with the acting manager who assured us that daily checks would be put in place to ensure the person had a prescribed transdermal patch in place as required.

We found the information and guidance in place for staff to follow about medicines when they had been prescribed to be given 'when required' needed to be more detailed to ensure people were given their medicines safely and consistently. For example, one person had been prescribed a medicine for agitation. The guidance in place did not provide staff with enough detail about the behaviour the person may exhibit when they were agitated so they could assess when the medicine may be required to be given. We also saw on two people's records that when a drug had been given for agitation, staff had not recorded whether the drug had been effective. This information is important as it helps assess how well the medicine is working for the person. These findings evidenced a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The service had a process in place for staff to record accidents and untoward occurrences. We saw examples of these records within people's care records. We spoke with the operations manager who told us they used the provider's key performance reporting process 'the stats' to regularly review any incidents in the service. This helped them to identify any trends and prevent recurrences where possible.

We looked at people's care records. People had individual risk assessments in place so that staff could identify and manage any risks appropriately. The purpose of a risk assessment is to identify any potential risks and then put measures in place to reduce and manage the risks to the person. We found one person's fall risk assessment had not been reviewed after they returned from hospital after sustaining a fall. This meant the measures in place may not effectively reduce the risk of a reoccurrence. We spoke with the acting manager who told us they were in the process of completing a review of each person's care plan and associated risk assessments. They told us they had completed around seventy five percent of the care plans and risk assessment reviews and showed us a sample they had completed.

The service had a process in place to respond to and record safeguarding vulnerable adults concerns. We saw the service had information regarding the process to follow but they did not have a copy of the local authority safeguarding adult's protocols. We spoke with the acting manager who told us they would obtain a hard copy to ensure staff had access to the procedures to follow to report any events and safeguard people from harm.

Staff had received training in safeguarding vulnerable adults as part of their induction training. The staff handbook contained a range of information for staff including the following: use of media, gifts and gratuities. It was clear from discussions with staff that they were aware of how to raise any safeguarding issues.

We reviewed staff recruitment records for three staff members. The records contained a range of information including an application form, interview records, Disclosure and Barring Service (DBS) check, references and employment contract. We also saw evidence where applicable that the nurse's Nursing and Midwifery Council (NMC) registration had been checked. This told us that people were cared for by staff who had been assessed as being suitable to work at the service. The administrator also showed us evidence that nurses' NMC registrations were checked regularly by the service.

We spoke with the administrator at the service; they showed us the service's system to manage people's personal allowances. The administrator told us the service paid for any expenditure. For example, for the hairdresser or the chiropodist. We looked at three people's personal allowance records and saw where monies had been paid in

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Is the service safe?

by a relative or a representative that a receipt had been issued. We checked the balance of three people's personal allowances and they were correct. We found there were satisfactory arrangements in place to record people's financial transactions to safeguard people at the service from financial abuse. The administrator told us one person living at the service managed their own monies and they could take money out of their personal allowance and keep it in their room. We spoke with the operations manager and acting manager who assured us that a risk assessment would be completed to ensure measures were in place to protect the person from financial abuse.

We spoke with the housekeeper who showed us the cleaning schedules for each area in the service. Hand gel was available in communal corridors. We saw the communal bathroom and toilets were clean and tidy. However, we noticed unpleasant aromas in communal areas in the service and in a few people's rooms. For example, in one person's room the ensuite area was clean and smelled pleasant but there was an unpleasant odour emanating from the carpet in the bedroom. We noticed the carpet in the corridor and lounge of the ground floor unit was 'sticky' under foot. We spoke with the housekeeper who told us the carpets in the service had been cleaned regularly but not as frequently due to unexpected staff absence. They also told us the ground floor unit's corridor carpet was being replaced later on in the week and they would arrange for the lounge carpet to be deep cleaned.

During the inspection we noticed a pathway to a fire exit on the ground floor was not fully clear and could slow down the progression of getting to safety quickly if there was a fire. For example, there was equipment used by laundry staff being stored in this area. We also found that on two occasions a cleaning trolley was left unattended in this area. The housekeeper told us that people did not normally access these areas; however we saw that an activities room was located nearby. We spoke with the housekeeper who told us they would speak with staff about maintaining a safe environment.

There was a system in place for staff to record any areas in the service that needed attention and a maintenance worker was employed by the service. We saw evidence that checks were undertaken of the premises and equipment. For example, nurse call system and a mattress check. The operations manager told us that as a result of the mattress check completed in October 2014, eleven mattresses had been ordered. However, we found one person's bed had an air mattress overlay without a substantial foam mattress underneath to ensure they were comfortable and did not feel the bed rails through the mattress.

Requires Improvement

Is the service effective?

Our findings

People spoken with told us they were satisfied with the quality of care they had received. One person commented: "staff are looking after me really well". During the inspection we observed staff explaining their actions to people and gaining consent. For example, we observed staff approaching people and telling them they were going to move them in the hoist and checking they were ready to do that.

Relatives spoken with told us they were satisfied with the quality of care their family member had been provided with and were fully involved. One relative commented: "[family member] has been in a number of care homes, this is the one I prefer, [family member] likes it here".

The Mental Capacity Act (MCA) 2005 is an act which applies to people who are unable to make all or some decisions for themselves. It promotes and safeguards decision-making within a legal framework. The MCA states that every adult must be assumed to have capacity to make decisions unless proved otherwise. It also states that an assessment of capacity should be undertaken prior to any decisions being made about care or treatment. Any decisions taken, or any decision made on behalf of a person who lacks capacity must be in their best interests

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and report on what we find. The safeguards are part of the MCA and aim to ensure that people are looked after in a way which does not inappropriately restrict their freedom.

In two care records we looked at we found that the MCA Code of Practice had not been followed. For example, the care plans reviewed contained 'global' capacity assessments stating that people lacked capacity to make decisions about all aspects of their care. None of the records within these files made reference to the specific decision to be made. This meant that people had not been appropriately supported to make decisions in accordance with the MCA.

We found conflicting information in one person's care plan regarding their capacity to make decisions which again evidenced that the MCA Code of Practice had not been followed. For example, the person had been assessed as having capacity to make decisions. However, we found a best interest decision was in place to administer medication covertly but there was no evidence that a capacity assessment had been undertaken prior to this decision being made. These findings evidenced a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There was some evidence of personalisation in people's rooms but we found the level of personalisation varied across the units. For example, one person's room in the ground floor unit looked like it was unoccupied and just had two boxes of incontinence pads stored in it. There was dementia friendly signage on people's doors but we found a few rooms which were occupied did not have people's names written on them.

In people's records we found evidence of involvement from other professionals such as doctors, opticians, district nurses, tissue viability nurses and speech and language practitioners. The service had a written and verbal process in place for the staff handover at the end of a shift on each unit. The acting manager told us they used the handover sheets to monitor any incidents within the service, to ensure appropriate action was taken.

We spoke with the cook. They showed us a sample of people's records kept in the kitchen for the catering staff to refer to. These records included details of people's likes and dislikes and whether they required a specialised diet and/or soft diet. For example, if they needed fork mashable food. We saw there was a choice of food available at meal times for people living at the service..

People could choose to eat their meals in the dining room or in their room. During the inspection we saw staff assisting some people to eat or offering reminders and prompts for others to eat more or drink. In one of the dining rooms we observed a member of staff helping to direct agency staff telling them which people needed support to eat.

Equipment was available in different areas of the service for staff to access easily to support people who could not mobilise independently. We saw where people needed support with a hoist, that each person had a hoist sling with their name on it. However, we found that daily checks were not undertaken to ensure air mattresses were set correctly. For example, we found one air mattress was not set on the correct setting as prescribed for the person. During the inspection the mattress setting was changed to ensure the person was supported appropriately and to

Is the service effective?

reduce their risk of developing pressure sores. We spoke with the operations manager and acting manager, they assured us that staff would receive training to enable them to complete daily air mattress checks and these checks would be recorded.

The acting manager used a staff training spread sheet to monitor the training completed by staff. We reviewed the service's training matrix and looked at staff records. We saw that staff were provided with a range of training relevant to their role. The training covered a range of areas including: moving and handling, fire safety, infection control, safeguarding vulnerable adults, Mental Capacity Act 2005, Deprivation of Liberty Safeguards and health and safety.

The operations manager told us staff should receive refresher training on an annual basis. However, we found that some staff refresher training was overdue. For example, fifteen staff member's moving and handling training was overdue and twenty staff members safeguarding vulnerable adults training was overdue. One staff member had not received refresher training in moving and handling since 2010 and one staff member had not received a medication assessment since 2009. We spoke with the operations manager and the acting manager who told us they had identified this was an issue and action was being taken to bring staff training up to date.

Staff spoken with gave us mixed views on whether they felt supported at work. For example, one staff member said "it is the best home I have ever worked in and the head office facilitates and encourages training". Whereas another staff member told us they loved working at the service but felt unsupported. They expressed how challenging it was to provide continuity of care due to the level of agency and bank staff working at the service. It placed them and other staff under additional stress and increased their work load.

The acting manager had a supervision schedule in place. Supervision is the name for the regular, planned and recorded sessions between a staff member and their manager. It is an opportunity for staff to discuss their performance, training, wellbeing and raise any concerns they may have. The schedule showed that some staff had not received regular supervisions. For example, the last supervision for seven staff was in May 2014. The acting manager told us they had identified that staff had not been receiving regular supervision. They told us that a senior member of staff from another service was completing supervisions with staff.

We could not find any evidence that staff had been provided with an annual appraisal in the last 12 months. It is important for staff to have an annual appraisal as it is an opportunity to review the staff member's performance and to identify their work objectives for the next twelve months. The staff handbook stated the following: "your performance will be reviewed on a regular basis throughout your employment. You will also have annual meetings with your line manager to formally consider your performance during the preceding year and to agree on future work objectives". This told us that staff had not been adequately supported to develop their skills and deliver safe care to an appropriate standard. These findings evidenced a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found the way people were supported who had behaviour that could challenge others varied across the units. For example, we looked at one person's care records. We saw listed the person's different behaviours, what this looked like along with clear guidance for staff to follow to support the person. We found behaviour monitoring charts were being completed to look for what could have triggered the behaviour and to look for patterns in people's behaviour. We looked at the care records of a person in the first floor unit who had behaviour that could challenge others. The person's care plan did not list the person's different behaviours or what this looked like and what staff needed to do to manage this. Their behaviour was not being monitored to look for triggers or patterns. This told us there was a risk that some people's behaviour was not managed consistently and the risks to their health, welfare and safety were not managed.

Requires Improvement

Is the service caring?

Our findings

People spoken with made positive comments about the staff and told us they were treated with dignity and respect. One person commented: “staff are very friendly just want a few more of them”. We saw that staff also made sure people’s dignity was maintained whilst supporting them. For example, by making sure people were appropriately covered whilst they were using the hoist to transfer them.

Relatives spoken with also made positive comments about the staff. Their comments included: “it gets five stars for me this place, really good staff” and “the regular staff know [family member] and are brilliant”.

We saw people could choose where to spend their time. For example, two people in the ground floor unit had decided to stay in bed and get up later. On another unit we observed staff checking on those people who were still sleeping to see if they were ready to get up. Some people had chosen to stay in their rooms or to sit in one of the lounges. Other people liked to walk up and down the corridors. Relatives spoken with told us their family member could choose when they wanted to get up and go to bed.

In the reception area of the service there was a range of information available for people and/or their representatives. This included: service user guide, Alzheimer’s society, complaints information and advocacy service. Advocacy is a process of supporting and enabling people to express their views and concerns, access information and services, defend and promote their rights and responsibilities and explore choices and options.

The acting manager told us there were two dignity champions at the service. A dignity champion is someone who believes passionately that being treated with dignity is a basic human right, not an optional extra. They believe that care services must be compassionate, person centred, as well as efficient, and are willing to try to do something to achieve this. It was clear from our discussions with staff that they enjoyed caring for people living at the service. The permanent staff spoken with were able to describe people’s individual needs and likes and dislikes and the name people preferred to be called by.

During the inspection we spent time observing how people and staff interacted in different units within the service. We saw examples of positive interactions between people and staff. For example, explaining the different options available to eat for breakfast and giving the person time to make a decision. We also observed that staff adapted their communication style to meet the needs of the person they were supporting. For example, staff crouching down so they were on the same level as people who were seated.

However, we observed on a few occasions where people were not treated with respect and supported in a caring way. For example, we observed a staff member discussing a person’s behaviour in front of other people and with a negative undertone. Information about people should be treated confidentially and respected by staff. We observed a staff member monitoring a person’s behaviour in one of the lounges. They were stood most of the time with their arms folded watching the person. They did not make any effort to interact with the person but answered questions when they were directed at them. The person’s cup of tea had been left so they could not reach it and the television was on a very low volume so it was difficult to hear. We asked the person if they could hear the television and they told us it was on a bit low. The staff member turned up the volume and then continued to stand beside the person.

Requires Improvement

Is the service responsive?

Our findings

During the inspection we noted that some people did not have access to a call buzzer to call for assistance during the day or night. The explanation given by staff was that "they wouldn't or couldn't use them". We spoke with one person who was living with dementia who did not have access to a call buzzer. It was clear from our discussion they understood what a call buzzer was and how to use it. They told us they had to shout if they needed any help from staff. Their comments included: "I would love to have a call buzzer" and "you do without because there is nobody to hear you". During the inspection when we visited two people in their rooms who had access to a call buzzer, we found staff had not ensured the person could reach their call buzzer to call for assistance. We spoke with the operations manager and the acting manager who told us that a call buzzer should be available except where it presented a risk to the person.

People's care records showed that people had a written plan in place. We found the level of detail in people's care plans varied. We found examples where people's care plans were highly detailed. An account of the person, their personality and life experience, their interest, their religious and spiritual beliefs had been recorded in their records. We found examples where the care plan did not have a full account of the person. This could lead to an increased focus on the person's condition rather than the person behind the diagnosis and potentially develop into caring for 'what', rather than 'who'. We found most people's care plans had been reviewed regularly and in response to any change in needs.

The acting manager told us they were in the process of reviewing each person's care plan documentation. We found people's daily records were not being consistently updated as the care was given. It is important that accurate daily records are kept to ensure people experience appropriate care and to monitor their wellbeing.

We found there was a record of the relatives and representatives who had been involved in the planning of people's care. Relatives spoken with told us they were involved in their family member's support planning. For example, one relative described how their family member's health status had changed recently and this had resulted in a change in how they were supported during the day. Relatives also described how staff sought advice when the needs of their family member changed and involved external healthcare professionals in their family members care. For example, one relative told us their family member saw the GP as necessary and staff reported back to them after the visit. Another relative described how staff had involved relevant healthcare professionals when their family member's swallowing had deteriorated.

On the morning of the inspection three people went to a butterfly park with the activities worker.

The acting manager told us there was one activities worker currently working at the service however in the past there had been two. During the inspection we saw a group of musicians playing in one of the lounges. We were told by relatives that they came to play at the home regularly. There was a music machine for sensory stimulation in one of the lounges in the service. There was an activities board displayed on each floor of the service with details of the planned activity for the day. However, staff told us that these activities did not always happen. One staff member commented: "it would be much better if there were more activities like there used to be".

The complaints process was on display at the service. We reviewed the service's complaints log. We found the service had responded to people's and/or their representative's concerns, investigated them and taken action to address their concerns. People spoken with told us they did not have any concerns or complaints and if they did they would speak with staff or a family member. One person commented: "I would tell the manager if I was worried". Relatives spoken with told us they were aware of how to complain and who to speak with. One relative told us that they had made a complaint about their family member's laundry and an attempt had been made to improve this.

Inadequate

Is the service well-led?

Our findings

The registered manager for the service was no longer in post and not managing the regulated activities at this location at the time of the inspection. They were in the process of cancelling their registration. One of the provider's senior homes managers was the acting manager for the service. They told us they visited the service regularly during the week. There was a deputy manager in post at the service. The operations manager told us they were in the process of recruiting a new manager for the service.

Although checks were completed at the service by the acting manager, deputy manager and operations manager, we found these checks had not effectively ensured people were protected against the risk of inappropriate or unsafe care.

We found the service had not sought the views of people living at the service on a regular basis. It is important that services regularly seek the views of people so they can share their experience of their care. Those experiences are listened to and are taking into account so improvements can be made. Relatives and people spoken with were not aware of any relative or residents meetings taking place, nor could they recall being asked to give feedback on the service. One relative spoken with told us there was no manager at present and they felt the service needed a manager who would listen. They felt their views and concerns regarding the changes made on one of the units (to place people requiring residential care and nursing care together) hadn't been listened to by the former manager.

In the activities team meeting minutes dated 7 July 2014 it stated that the activities worker would write to relatives asking them if there was a better time for meetings to encourage people to attend. We were not provided with any evidence to show this action had been completed or minutes to any meetings that had been completed with people living at the service and/or their relatives or representatives.

We found staff had not been properly supported to enable them to deliver care to people safely. A robust monitoring process in place to ensure staff received refresher training to maintain their skills and knowledge was not in place. The acting manager had identified this as an issue and taken action.

During the inspection we noted that some staff were not wearing badges at the time of the inspection. People living with memory impairment may not always remember a staff member's name. Wearing name badges enables visitors to the service to clearly identify staff they have spoken with or the staff on duty.

Although we were told by the acting manager that three people receiving residential care were being reassessed because their support needs had changed, we found a dependency assessment had not been undertaken to reflect people's changing needs. A dependency assessment helps ensure there are sufficient numbers of staff with the right skills and knowledge working on each unit during the day and night.

The acting manager had held a range of team meetings in October 2014. This included a night staff meeting, a heads of department meeting and a care staff meeting. Staff meetings ensure that key information from all aspects of the service is gathered and shared in order to enable the service to continually improve and reduce the risk of unsafe care and support. We looked at the minutes for the care staff meeting dated 29 October 2014. We saw that a range of topics had been discussed regarding the performance of the service. These topics included the environment, cleaning, activities and hospital transfers. During the meeting concerns had been raised about sensor mats and air mattresses not being plugged in and staff knowledge about air mattress settings. During our inspection we found that regular checks had not being undertaken to ensure equipment was being used correctly to protect people from the risk of inappropriate care. We also found there was still issues with the environment in the home. Having an environment that does not smell pleasant does not demonstrate respect for people.

We reviewed the minutes of the night staff meeting dated 15 October 2014. We saw a range of topics had been discussed including people's repositioning charts, staff handovers and staff training. In the meeting, concerns were raised that one person's repositioning charts were not being completed fully. During the inspection we found concerns regarding the completion of people's daily records. This told us the service had not ensured that people were receiving the care and support they required in line with their care plan.

We looked at the medication audit completed by the operations manager in September 2014 as part of their

monthly check. The check had included looking at whether guidance to follow about medicines when they had been prescribed to be given as 'when required' was evident in medication administration records. We found the check had not effectively identified that the information and guidance in place for staff to follow needed to be more detailed to ensure people were given their prescribed medicines safely and consistently. We also looked at the medication audit completed in October 2014 by the deputy manager. Our findings during the inspection showed that some of the areas identified for improvement in the audit had not been effectively actioned. It is essential to have a robust system of audit in place in order to identify concerns. Also to record the actions taken to make the improvements and changes needed to ensure medicines are managed safely. These findings evidenced a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The acting manager was aware of their responsibility to inform the CQC about notifiable incidents and circumstances in line with the Health and Social Care Act 2008. There was a process in place to ensure incidents were monitored to identify any trends and prevent recurrences where possible.

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 Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing How the regulation was not being met: The health, safety and welfare of people who used the service were not safeguarded because there was not sufficient experienced staff to meet people's needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines How the regulation was not being met: People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment How the regulation was not being met: The health, safety and welfare of people who used the service were not safeguarded because there were not suitable arrangements in place for obtaining and acting in accordance with the consent of service users in relation to their care and treatment.

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	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision How the regulation was not being met: People were not protected against the risks of inappropriate or unsafe care or treatment because the provider did not have effective systems to monitor the quality of the service provision.

The enforcement action we took:

A warning notice was issued