

Ackworth House Limited

Ackworth House Nursing Home

Inspection report

The Beach
Filey
North Yorkshire
YO14 9LA

Tel: 01723 515888

Website: www.ackworth-house.co.uk

Date of inspection visit: 19 August 2014

Date of publication: 04/11/2014

Ratings

Overall rating for this service

Inadequate



Is the service safe?

Inadequate



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

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service. The inspection took place on 19th August 2014 and was unannounced. At our inspection in

September 2013 and again in January 2014 we had identified breaches of regulations relating to care and welfare, the management of medicines, staffing levels and meeting nutritional needs. Following this the provider sent us an action plan telling us about the improvements they intended to make. During this inspection we looked at whether or not those improvements had been made. We found that improvements still needed to be made in regard to management of medicines, care and welfare

Summary of findings

and staffing levels. We also found additional areas of concern in relation to the environment, quality assurance and completion of records. At the last inspection on 18 January 2014 we asked the provider to take action to make improvements in relation to meeting nutritional needs and we found this action had been completed.

Ackworth House is a care home providing nursing for unto 43 older people with a physical or sensory impairment. The main building is a converted hotel with four floors. At the rear of the home there is a newer extension over two floors. The home is situated along the beach front in the small seaside town of Filey. At the time of our visit there were 29 people living at the service. The acting manager, who was also a director of the company which owned this service, had been in post since the previous manager left the service in December 2013. They had applied to become registered but had not been successful in their application. 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. They continue to act as manager until suitable person is employed to be the registered manager.

Although people told us they felt safe we found that this service was not providing consistently safe care. We found staffing levels appeared good but there were a high proportion of agency staff and account had not been taken of people's needs and other factors when deciding on staffing levels which meant people's safety was compromised. We found people's care plans did not always reflect their care needs and risk assessments were not always in place. There were areas within the service which were odorous and dirty. We found the service did not meet the requirements of the Mental Capacity Act 2005 (MCA) and associated Deprivation of Liberty Safeguards (DoLS). Some people at the service were not able to tell us if their freedom was restricted but we could see that there were no recorded decisions about why, for

instance, those people did not go out in the fresh air. The MCA and DoLS require providers to submit applications to a 'Supervisory Body' for authority to restrict people's liberty. It was clear from paperwork we inspected that this had not been done and that staff did not fully understand the requirements or principles of the MCA.

Medicines were not always managed safely for people. There were discrepancies in numbers of tablets available and number of tablets given. Medicines were in use that were out of date and were not always stored safely.

The service was not effective. People we spoke with told us that they felt well cared for but one relative expressed concern about staff skills and knowledge. Staff had received an induction when they began working for the service but supervision was not up to date. There were gaps in staff training. People's identified health needs were not always met and some people did not have risk assessments in place which meant that staff had not always identified when people needed additional support. Nutritional needs were met but we saw people had varied experiences at mealtimes. Some relatives told us they felt that people living at the home did not receive the support they required to eat and drink. There had been no adaptations made to the environment to help people maintain their independence..

People had a mixed experience with staff. They told us that some staff were kind but some focussed on tasks rather than the person. People were not always involved in planning their own care. There were no activities seen to be taking place although we were told that some were planned. People using the service told us there were no regular activities.

There was no registered manager at this service and there was no consistent leadership.

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?

The service was not safe.

Although people told us they felt safe we found this service was not providing consistently safe care. We found staffing levels appeared good but there were a high proportion of agency staff and account had not been taken of people's needs and other factors when deciding on staffing levels which meant people's safety was compromised.

We found people's care plans did not always reflect their care needs and risk assessments were not always in place.

We found the service did not meet the requirements of the Deprivation of Liberty Safeguards (DoLS). Some people at the service were not able to tell us if their freedoms were restricted but we could see that they did not have clearly recorded best interest decisions in their care files. This meant that in order to protect the rights of people who had limited capacity to make their own decisions applications should have been made to a supervisory body.

Medicines were not always managed safely for people and records had not been completed correctly.

There were areas within the service which were odorous and dirty.

Inadequate



Is the service effective?

The service was not effective.

People we spoke with told us that they felt well cared for but one relative expressed concern about staff skills and knowledge. Staff had received an induction when they began working for the service but supervision was not up to date.

Peoples identified health needs were met and staff contacted healthcare professionals if they needed additional support. Some people 's care plans did not have risks identified.

People's nutritional needs were met but they did have varied mealtime experiences. Some people felt that their relative did not receive the support they required.

The environment was not suitable for people living with a dementia or for those who wished to maintain their independence. There were no adaptations such as signage or coloured handrails. There was nowhere that a person could make a drink themselves.

Requires Improvement



Is the service caring?

The service was not caring.

Requires Improvement



Summary of findings

People told us that most staff were kind to them but some had a different experience.

Staff appeared task focussed although we did observe some staff had a good rapport with people.

People were not always involved in planning their own care and we found people receiving end of life care did not have the appropriate paperwork in place which meant that staff had not taken account of their wishes.

Is the service responsive?

The service was not responsive

We did not find this service responded to people's care needs promptly and we heard one person's call bell ring for fifteen minutes. This meant people's needs were not attended to in a timely way and their dignity could have been compromised.

Reviews were not regularly carried out by the staff and most people had not been involved in any review of their care.

Complaints had been logged and responded to in line with the service policy and procedure but there was no evidence of learning from complaints.

We observed no activities taking place and although we could see some activities advertised they were infrequent. People told us that there were very few activities organised which meant that there was a risk of social isolation for some people.

Requires Improvement



Is the service well-led?

This service was not well led.

There was no registered manager at this service.

People told us that they felt the leadership of the service could be improved.

Care provided to people was not always guided by best practice

Inadequate



Ackworth House Nursing Home

Detailed findings

Background to this inspection

We inspected the home on 19 August 2014. We looked at all areas of the home including people's bedrooms with their permission, we looked at care records and associated risk assessments for seven people, we observed medication being administered and inspected 12 medicine administration records (MAR). We observed a lunchtime period in the dining room and observed people being helped with their meals in their bedrooms. We used the Short Observational Framework for Inspection (SOFI) because there were seven people living at the home who were living with a dementia. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. During the course of our inspection we spoke with seven people who lived at the service, seven relatives, six staff, the clinical lead nurse, the two directors and two health care professionals who visited people on the day of our inspection.

The inspection team consisted of an adult social care inspector, a pharmacy inspector, a specialist professional advisor, whose specialism was in occupational therapy, and an expert by experience who had experience of palliative and end of life care. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed all the information we held about the service. We considered information which had been shared with us by the local authority and looked at safeguarding alerts that had been made. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We spoke with the local authority about this service.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Is the service safe?

Our findings

This service was not safe. When we inspected this service in September 2013 we found people were not always protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage people's medicines. At this visit we saw that although people told us they felt safe, there were no improvements and the same issues highlighted in September 2013 were repeated. There had been five medication errors at the service over the last twelve months which related to people not receiving medication in a timely manner, returns of medication and roles and responsibilities of staff. This showed that the service was not learning from previous errors and making improvements to the management of medicines putting people at risk of harm.

The records which confirmed the administration of medication or application of creams and other topical preparations were incomplete. Incomplete record keeping means we were not able to confirm that these medicines were being used as prescribed.

When we checked a sample of 'boxed' medicines for six people alongside the records we found most did not match up so we could not be sure if people were having their medication administered correctly. For instance one person prescribed medication for epilepsy should have been given four tablets over the course of twenty four hours. There were 112 tablets received into the home, 52 tablets recorded as given on the medicine administration record (MAR) so there should have been 50 tablets left. There were 52 left and no explanation had been given for this on the MAR. This meant that this person may have missed two of their tablets which could have had an adverse effect on their health.

People were not protected against the risks associated with covert administration of medication. This is when medicines are given in food or drink to people unable to give their consent or refuse treatment. When one person had medicines administered crushed and mixed with food no records were available to show how the decision to administer this medication in this way had been reached. No guidance had been sought from the pharmacist to make sure that these medicines were safe to administer in this way.

Medicine for another person was crushed and administered in another liquid medicine even though the risk assessment said that medicines should not be mixed. Care staff could not confirm that this medicine was safe to administer in this form.

We looked at the guidance available about medicines to be administered 'when required'. Although there were arrangements for recording this information we found this was not kept up to date and information was missing for some medicines. This meant there was a risk that staff did not have enough information about what medicines were prescribed for and how to safely administer them.

Records were kept of room temperature and fridge temperature in the treatment room, however there were gaps in these records. On the day of our visit the temperature was 9.5 degrees centigrade, and on three other recorded occasions the fridge temperature was over 8 degrees centigrade which was higher than recommended for the storage of medicines. This meant there was a risk that medicines may be stored above the temperature recommended by the manufacturer and may not have been safe to use.

We saw that three ampoules for one person, with a short shelf life once opened, were still being used past the recommended date of expiry. This meant that staff could not be sure this medicine was safe to administer. We asked staff to dispose of these immediately.

We found the controlled drugs, which are medicines which may be liable to misuse, were stored appropriately. Additional records were kept of the usage of controlled drugs so as to readily detect any loss.

We found that the service's arrangements for the management of medicines did not protect people. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At our previous visit we had found staffing levels were not planned in line with the needs of people who lived at the service. At this inspection we found there had not been improvements.

The provider was unable to demonstrate that a needs analysis or risk assessment had been carried out to determine the staffing needs for this service on any given day. When asked about how they responded to absence they said, "It is usually sickness and we can't get cover".

Is the service safe?

During our visit the provider was trying to cover a shift for the following day and when we left during the evening they had still not covered the shift. The provider told us that one person would cover despite them having told us that they had worked in excess of 60 hours and the next day should have been their rest day. We checked this person's staff file and there was no agreement signed by the member of staff to work over the prescribed limit described in Working Times Regulations. This meant that staff were not working in accordance with working times legislation.

On the day we visited there was one nurse on duty and seven care staff. In addition there was a chef, a kitchen assistant, a person working in the laundry, a person who gave out drinks and helped when people needed support to eat and drink and two cleaning staff. The staff numbers appeared to be sufficient but the complexity of different people's conditions and the layout of the building combined together meant that staff struggled to meet people's needs effectively. Three of the staff were from an agency and only one of them had worked at this service regularly. It was necessary for more experienced staff to supervise the agency staff. In addition a person was admitted to the service during the day which exacerbated the problem. All of these factors meant that the safety of people who lived at the service was compromised.

During the inspection the team could not find staff to speak to them and were not visible in the communal rooms throughout the day. An example of this was when we heard a person call out from a lounge on the ground floor in the evening. We went to look for a member of staff and there were no staff on the ground floor. No one came back to that floor until the owner walked into the building and we asked them to arrange for someone to check on this person. There was no means of calling for assistance which would alert staff in different parts of the building from the ground floor. This meant that people were left with no support for long periods.

Every person spoken with said there weren't enough staff. People told us, "There are never enough, and they don't stay.", "There can't be enough staff when you think how long you have to wait when you ring the bell", "You have to be patient, they're run off their feet", "I wouldn't recommend it; there aren't enough staff."

One member of staff told us, "It has happened a few times that there is only one nurse and three carers on duty". When we spoke with the provider they told us that they

always aimed to have two nurses and seven staff on duty and that the staff levels on the day of inspection were correct. When we checked the staff rotas we could see there were variations in staffing levels particularly on a weekend. We could see there had been occasions when there were three or four care staff although sometimes there were five and the rotas showed that there was one nurse on duty for each shift. This meant that people were not being safeguarded because they were not always supported by the number of staff described by the provider as "normal staffing levels".

We found that the arrangements for staffing did not safeguard people. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

During our inspection we saw that people were left in their chairs for long periods with no position change. When we checked one person's care plan it said this person should have had regular positional changes in addition to having pressure relieving aids in place. We did not see any staff assist them between 9.15am and 1pm at which point we left the area they were sitting in. We did see that they were sat on a pressure relieving cushion.

When we spoke with staff about this they told us the person was "having their hair done" but we had seen this had been done early in the morning. We spoke to the person's relative and they said, "(relative) is sat in her wheelchair for long periods". A different staff member told us, "We normally put them in a comfy chair but it's not done today because we are too busy". This meant that people in wheelchairs who were left for long periods were at risk of pressure damage. We have made a safeguarding alert to the local authority about this person.

We saw people were not always supported according to their needs by staff and that care plans did not reflect those needs. For instance we saw a person who was nursed in bed and had no clothing on. There was no call bell close by and according to the fluid chart they had received no oral liquids between 5pm the previous evening to 9am on the day of our inspection. Some changes had been made by the GP to the level of fluid they should receive but when we checked the care plan it had not been updated with any changes. We have made a safeguarding alert to the local authority about this person.

Is the service safe?

There had been a recent incident at the service when one person was asked to go to bed by a member of staff. When they said they did not want to they were told, “If you don’t go to bed now I won’t be back. I don’t have time for this.” This was reported and investigated by the local authority. We spoke with the service user who said things had improved recently but they believed that was because of the visits by local authority staff

The provider completed their provider information return (PIR) and told us they had made no Deprivation of Liberty safeguards (DoLS) applications to the local authority. In March 2014 a supreme court judgement made it clear that if a person lacking capacity to consent to arrangements for their care, is subject to continuous supervision and control and is not free to leave the service they are likely to be deprived of their liberty. We were told that seven people with a dementia lived at Ackworth House Nursing Home who were not able to leave without assistance. This meant that the provider was not protecting the rights of service users by arranging for an assessment to be carried out which would test whether or not those people were being deprived of their liberty and whether or not that was done so lawfully.

We saw that some service users were unable to consent to care and treatment and had a mental capacity assessment completed but it was not always clear what decision was being tested. The Mental Capacity Act 2005 (MCA) says that before care and treatment is carried out for someone it must be established whether or not they have capacity to consent to that treatment. If not, any care or treatment decisions must be made in a person’s best interests. In one person’s file the decision under question was ‘New assessments process’ and the outcome was that the individual lacked capacity to consent to ‘Long term or to do with well-being and care’. This meant that decisions required were not clear and questions were not clearly written or records completed properly. This told us staff were not working within the principles of the MCA by doing everything to empower service users to make as many decisions for themselves as they could and recording those decisions.

We found that records were not completed accurately which could affect the outcome for a person with no capacity. This was a breach of Regulation 20 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2010.

We found that care plans and risk assessments did not ensure the welfare and safety of the service user. This was a breach of Regulation 9 of the health and Social Care Act 2008(Regulated Activities) Regulations 2010.

We inspected the environment and found it to be dirty in the main house. Carpets were marked and worn and we saw dirty toilet seats and commode pans. The décor was ‘tired’. This area of the service was odorous. There was no pressure in any the hot water taps on the top floor resulting in only a trickle of water been available for people to have a wash. The flooring to some toilets was in need of repair and sealing. There were no bins in bathrooms. One relative told us, “The carpet is disgusting and the décor tatty in their(relatives) room”

In the newer extension it felt fresh and clean. The fixtures and fittings were more modern and were more up to date. There was an infection control policy and procedure and contracts in place for domestic and clinical waste disposal. We spoke with cleaning staff who told us they did not follow any formal cleaning rotas and just made a note when things needed doing. This meant that there were no effective systems in operation designed to maintain the cleanliness of the service and people were not living in a clean and hygienic service.

The slings that were in use were shared between people, with the exception of one person who had their own sling but there was no regular washing schedule for these shared slings which increased the risk of cross infection.

We found that people were not always protected against the risk of infection because of the lack of effective systems in the service. This was a breach of Regulation 12 of the health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There was a fire risk assessment in place and people had personal evacuation plans in their care files. The individual moving and handling plans for service users gave them a colour coding (red, amber, green) which indicated how much support they required for their mobility. They also indicated that this colour could then be displayed on a service users door to enable staff how to prioritise them in the event of an emergency evacuation; several doors were looked at but no such colours could be found which meant that the risk assessment and plan was not consistent with current practice.

Is the service safe?

We were told by the provider that most staff had received fire safety training in November 2013 and that one of the directors had completed fire marshal training. We saw certificates in staff files verified staff were trained. The person who was fire marshal trained told us they had trained staff in the use of evacuation equipment.

When a member of staff was asked whether they had received any such training they replied that they had not. Four other staff also confirmed they had not been trained in the use of the equipment. Furthermore the first staff member spoken to did not think that they would have any role to play in the evacuation of residents in an emergency, as this had never been discussed with them. This highlighted a potential risk to service users and staff because staff roles and responsibilities had not been defined in the event of such an emergency.

Fire fighting equipment had been serviced within the preceding twelve months and regular fire alarm checks were carried out which meant that all safety precautions were in place in the event of a fire. However the staff training was not was not effective as staff were not clear about what to do in the event of a fire.

When we looked at the moving and handling equipment used within the home we saw there were only two hoists in use on the day of our inspection. This limited availability of hoisting equipment meant that hoists had to be transferred between floors. This could deter staff from following correct lifting & handling procedures and lead to staff employing

unsafe practices. Three safeguarding alerts had been made to the local authority recently by visiting professionals which specifically involved unsafe practice when people had to be moved since January 2014. These alerts related to unsafe practices used by staff and meant that people were not always moved using best practice guidelines.

There was evidence that the portable hoists and other items of equipment used for lifting people had been inspected and serviced. There was no evidence of an inventory of the slings in the home and of any regular health and safety checks for them. The director told us that they had assumed the slings were checked when the lifting equipment was serviced, but there was no evidence for this, and without a proper inventory it was difficult to see how this had been done. On one of the slings being used the Velcro hooks were extremely matted with fluff and fibres, and a member of staff commented that it could not be relied upon to be secure. This sling was taken out of service immediately by a member of staff which meant that it no longer posed a risk for people who had been transferred using a hoist.

When we looked at the electrical wiring checks we saw that recommended remedial work had not been completed. The provider arranged for this to be done on the day of our inspection. They told us they had believed it had been done. The documentation for servicing and checking of equipment was in different places and there was no system for ensuring that safety checks were carried out.

Is the service effective?

Our findings

This service was not effective. We found that the premises were not of a suitable design or layout for people. This was a breach of Regulation 15 Health and Social Care Act 2008(Regulated Activities) Regulations 2010.

People's diverse needs were not met by the layout of the service. The corridors were narrow in the main house and had many doors opening on to them as well as equipment left in the corridors. This presented a trip hazard to people trying to move safely around the building. A safety gate had been put at the top of a steep staircase leading down from the third floor which also presented a hazard to service users and staff and had the potential to cause harm.

Communal rooms were dark and full of dated furniture and all the chairs had chair pads which gave the rooms an institutionalised feel. No attempts had been made to make anywhere look homely. Some people's bedrooms were almost devoid of any personal touches and others had been personalised with the use of people's own furniture and personal items. We did visit one person whose room was a reflection of her interests and her life. This meant that not everyone had access to personalised surroundings which reflected their likes, dislikes and interests.

There was no signage to help people with a sensory or cognitive impairment find their way around the building apart from people's names on their bedroom doors. There was no sensory stimulation or use of different coloured features such as hand rails to aid those people who were living with a dementia or to act as a memory stimulant. This meant that the environment was not adapted to suit everyone.

The dining chairs had no arms or sled bases so people could safely sit at the table. (Sled bases are a means of stabilising a chair by using wooden sleds between the back and front legs so that it can be moved safely) The lack of a sled base on chairs meant that people who had mobility problems would not be able to move the chair away from the table easily. We saw that nine out of ten people were left in their wheelchairs at lunchtime. Some people could not have sat on the dining chairs available safely because they needed some support to rest their arms.

Seven people at this service were living with dementia and their specific needs around eating and drinking had not been considered. This would have a negative impact on their wellbeing. For instance there were no pictures of food or picture signage to indicate that this was a dining room.

There was nowhere for service users or their visitors to make a drink for themselves. On the day of our inspection a person asked if they could make themselves a drink. The provider told the carer to tell them "No, not with that boiler, they can just ask."

This meant that people were being prevented from carrying on their day to day lives because the service had not put arrangements in place to allow them some independence.

Service users we spoke with told us they were well cared for by people who had the skills to look after them. Comments included, "I feel cared for", "they look after me very well, I call them "my little angels"", "Yes, I think they know what to do for me - well I hope so! They're nice girls mostly."

However one relative was concerned at the lack of clinical skills, "Some of the staff haven't got the skills to recognise when (my relative) is unwell. I've come in before now to find (my relative) unwell and when I've raised it someone actually said to me "no, (my relative) is just enjoying the music." I've got that sorted out though and they do now understand when (my relative) is unwell." Another relative said "I think (my relative) is generally looked after very well. I tell them if there's a problem and it gets sorted out one way or another. Complaining doesn't always bring results"

We saw staff had received some induction training and told us that they worked with more experienced staff when they first started working at the service. We saw that there were gaps in staff training which meant that people were not kept up to date with current best practice. One trained member of staff was asked how her training and development needs had been identified, and whether this was done within the context of her supervision, she replied that 'I've never had supervision since I've worked here'. We looked at records and saw that supervision for all staff was not up to date. This meant that staff did not have the opportunity to have protected time to discuss their work and plan their development and did not benefit from having a clear training and development plan.

Is the service effective?

People who used the service felt their health needs were met "If I need the doctor they will come the same day or the day after" "Yes, if I have a problem I tell (the clinical lead) and she sorts it out, she'll get someone to come"

One of the staff told us, "Everything we know about people is by word of mouth. We started to have a handover a few weeks ago which we haven't had before but they are not regular. This morning for instance we didn't get a handover as the nurse was busy with someone else". This meant that service users were at risk because staff did not always have up to date information about people. This had been identified at our inspection in January 2014.

One person was admitted to this service in June 2014 for end of life care and the general care plans were written on 17 July 2014. There had not been any evaluation of the care plans despite a significant change in health and well-being since admission. Appropriate risk assessments had not been completed for this person. The capacity assessment was completed but had been signed by the clinical lead which is not in line with MCA 2005 guidelines

There was access to a specialist palliative care service provided by the local hospice and a specialist nurse visited the service regularly to support the service user and the staff. A staff member said "We have specialist palliative care input for people on end of life care plans but there is no protocol". The provider had told us in their information return that they were working within The Gold Standard Framework. This was not the case with this particular service user.

No one that we spoke to was able to say their individual needs were addressed. One relative said "Things are done differently depending on how the staff are paired up. They ought to be consistent because they're only doing the same things for people day in and day out. Some try to cut corners and leave work for others". Another relative said "At weekends residents are spending half their days in bed because there's no one to get them up"

We spoke to visiting health professionals on the day of our inspection and they were satisfied that the staff were providing the care that people needed appropriately and that staff followed their advice. One health professional said that the staff were, "a good bunch of carers."

People using the service had mixed experiences around meals and mealtimes: "The food is excellent and I can eat

wherever I like really. Sometimes I like to eat in my room. You get a list to choose from" "Generally there will be something I like but if not then they'll give me something else if it's feasible" "It's alright I suppose."

When asked about the availability of snacks and drinks when they wanted them people said, "They come round at regular times with tea and biscuits but you get fed up with just that". A relative said "There are no snacks between meals and no hot drinks available other than when they do rounds." Another relative said "It depends who's bringing the trolley round as to whether visitors get offered a drink. It's not very nice for the person living here not to be able to offer their visitors a drink in what's supposed to be their home. The first thing she used to do when you went to see her before she came into Ackworth was put the kettle on. Now she can't do that for herself I think it's up to them to do it for her" A person who used the service said "There's nothing between meals and I have some snack things that people have brought me but I can't reach them where they put them."

Another person appeared to have a very different experience from most people "I get a snack whenever I want because since they found out that I don't eat the sponge cake they make because I only like fruit cake, the kitchen makes me a fruit cake one week and a fruit tea loaf the next week. I keep them here in my room in that Tupperware box. It goes down to the kitchen empty every week and comes back full. I get a drink whenever I ask for one."

One person was very concerned that their relative was not getting help with meals "I often arrive to find her splattered with a large amount of food following her attempts to eat. They keep telling me she manages very well but the only thing I think she manages well is a sandwich. I'm not bothered that she makes a mess, although she would be if she realised; I am bothered about the amount of food that she's not getting. I'm going to raise this again"

We observed a lunchtime period using SOFI. One person with a dementia needed assistance with eating and drinking and the member of staff assisting them changed three times during the course of the meal because they left to do another job or were called away. This meant that the mealtime was rushed and did not feel calm for that person. One person required special cutlery because of their

Is the service effective?

medical condition but they were given normal cutlery by staff. This meant this person may not have been able to eat properly and therefore not receive the required nutritional intake.

When asked, staff told us that if a person was not eating and drinking adequately "we put them on a three day food and fluid chart and monitor them closely" When asked what they would do if the person lost any weight they said "Oh if things aren't right we will ask for nutritional advice."

We saw from peoples care plans that the service had contacted health professionals when people required additional support with nutrition. For example one person had received advice from the Speech and Language Therapist (SALT) and another person who had some weight loss had been seen by the dietician and a plan put in place to help to help maintain their weight.

Is the service caring?

Our findings

We found that this service was not caring. Nobody we spoke with felt they were involved in planning their care and no one was aware that they had a "care plan". Two of the six relatives spoken with felt they were involved in the care planning. Only one said they were fully involved and engaged in reviewing the care. We could see that care and support plans had been written and reviewed by staff. There was no indication within the plans to show that people had been involved in planning their care.

Personal life history documents were rarely completed for people and so staff did not know people's history unless they took the time to get to know them. Staff had already told us that they rarely had time to talk with people. We did, however, see examples of some staff and service users having very good trusting relationships during our inspection. This meant that there was little evidence to suggest that people received personalised care and support.

Some people felt staff were respectful and stated that they were kind to them but some didn't feel those things. "They are respectful and we have a bit of fun", "They are all very kind." A relative said "The staff are generally ok but the manager always talks down to people" Another said "All the

staff speak in a very nice and polite way, we're on first name terms but they know they can't take advantage. They always talk to (my relative) when they are doing personal care." A person using the service said "They can be harsh at times. I feel lonely, I don't like the staff, they aren't friendly" Another said "Some are very patient but some are sharp" One person said, "I love it here, I really do. They are so good to me."

We could not see any referrals to or involvement with advocates recorded in care files. We did not see any posters or information for people to access advocates. Staff spoke only of relatives advocating for people but some people told us that they did not get visitors often. Relatives and friends that we did speak to all reported that they could come and go more or less as they wished. This meant that some people may have no one to advocate for them when making decisions and choices.

We were told that two people were receiving end of life care. When we examined the documentation of a person identified as being in receipt of end of life care we found there was no care plan for end of life or for pain management. This meant the person had not been given the opportunity to choose what they wanted to happen at the end of their life and did not have a plan in place to manage their pain when it became necessary.

Is the service responsive?

Our findings

People did not always receive care when they needed it. An example of this was when we heard a call bell ringing for fifteen minutes before staff went to answer it. We saw that staff ignored the call bell despite being only yards away from the person's bedroom. They chatted for a while and then walked away in the other direction. This displayed a lack of urgency from staff and showed a lack of respect for people.

A relative said "They don't seem able to tell the difference between a bell that needs to be answered immediately and one that might be able to wait. (my relative) can't press the bell so when the call bell goes from this room you'd think they'd appreciate that I wouldn't press it unless there was a real problem. That doesn't seem to make any difference and I've had some worrying situations. It's all written down." One member of staff said, "" Much could be improved, for example the time it takes to answer bells. It's not the resident's fault that people are busy."

A relative told us that they had spoken to staff about leaving people so long when they rang the bell so that they had no choice but to "wet themselves". They said that "making people wet themselves infringed their privacy and dignity"

Another relative was concerned about the clinical skills of staff saying, "Some of the staff haven't got the skills to recognise when (my relative) is ill. They told us that staff did not always respond appropriately when their relative was taken ill. We saw staff attended when this person became ill later in the day but they did not seem to be clear about what to do and took a while to decide what they would do. This showed us that staff may not always respond to people's needs and in a timely manner.

When a service user was asked if she was comfortable when being hoisted she advised us that she did not like being hoisted and that 'I don't mind but it is uncomfortable'. When questioned as to whether she had been offered any alternative sling or means of hoisting, she replied that she had not. The records did not identify that any assessment had been carried out for this person and

did not identify the specific needs of other people. For instance which individual sling to use. There did not seem to be any system to review a person's moving and handling needs which meant that people do not have the opportunity to say when things are not right so that appropriate changes can be implemented.

There was no visible evidence of any activities taking place. People said "There are no activities" A relative said "I think there's a sing song every now and then but (my relative) doesn't join in. It's not her sort of thing". Another said "We take (my relative) out in her wheelchair for some sea air. It's lovely along the front". A staff member said "Some staff come and take the residents out in their own time, otherwise they'd never go out because there aren't enough staff." We saw some activities advertised but they seemed to happen once every two weeks.

We were told the activity organiser was working on night duty but normally they would organise activities with the help of a volunteer. When we spoke with staff about this they said this happened one day a week. There didn't appear to be any view amongst people using the service that efforts were made to help them maintain relationships with friends and family. One person said "Oh that's never been mentioned", A relative said "There are lots of people here who just need someone to come and sit with them and show some interest. You'd think the management could organise volunteers or something wouldn't you. Those people would be so much happier" This meant that there was a risk of social isolation for some people.

We looked at the complaints received by the service. There had been twelve complaints over the last twelve months. These had all been logged and the Care Quality Commission (CQC) had also been notified as is required. There was evidence of the response to the complaint and the actions taken but there was no evidence of learning from complaints.

One relative said "Yes, I'd feel that I personally could say what I wanted but you hear so much about problems for people living in homes that I'd think twice about being very contentious."

Is the service well-led?

Our findings

We found that this service was not well led. The provider did not identify, assess and manage risks relating to health, welfare and safety of service users or the quality of the service. This is a breach of Regulation 10 health and Social Care Act 2008(Regulated Activities) 2010.

We asked the provider to show us any audits that had been carried out. When we asked to look at quality assurance documents we saw clinical audits had been carried out in relation to infections, wounds, skin integrity and care plans. These were limited and some out of date with very little detail and did not reflect any evidence of analysis. We came across an audit about people who needed assistance to eat and drink. The title of this document was “Feeds”, a reference to people who required assistance to eat and drink. When we asked for the medication audits we were told that the nurse had them at home and so they were not available. The audits we saw were purely factual and there was no evidence of analysis or description of how learning or improvement had taken place.

We were not shown any environmental audits. There were no equipment audits for commodes, shower chairs, or hoist slings although we were able to see that the hoists had been checked. Accidents and incidents had been recorded but no learning had taken place or improvements made.

There had not been a registered manager at this service since December 2013. One of the directors had applied to CQC to be registered as the manager but had not met the requirements for a registered manager as defined in Regulation 6(1) and (2)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Health and Social Care Act (2008). They are acting as the manager until the provider is able to recruit a suitable manager.

The service had not got strong values and none of the staff we asked could define the company values. Leadership was inconsistent and weak. The directors took an active role within the service but this had led to some decisions being made which had raised concerns. The directors had

recognised that their involvement in clinical matters was not appropriate as they had no training and had tried to counter this by employing a clinical lead nurse who was making efforts to improve the quality of care in the service.

People told us when asked about the leadership of this service, "They could do a lot better. They could learn a lot from other places", and said, "The clinical lead is very good with residents although she can be very brusque and difficult with the staff". The clinical lead nurse was employed by the service to lead the staff team giving support and guidance on clinical matters. A relative said about the directors, "They don't show good leadership to the team, I don't think they know what people do or what they should be doing."

We found care was not always guided by best practice. For instance people were not always supported and supervised during mealtimes and medication management did not follow accepted guidelines. Staff were not adequately supervised as there was only one nurse on duty and staff and visitors told us that the directors mainly stayed in the office as a remote presence. This meant that staff were not receiving the leadership and support needed to maintain high standards.

Communication was poor and information was not shared with people using the service, staff or relatives. One relative told us, "Communication is lacking sometimes". One person said that they had asked for information regarding the use of money raised through charity events to benefit people who used the service. They had not received a response. We were told by one person that some of the money raised for people at this service had been used to buy a hot cupboard for food. When we spoke with the provider they told us that they had used some of the money raised as the money had been raised for this purpose.

The provider told us when they completed the information return that 95% of staff had a named person providing them with supervision. When we looked at records most staff had not had supervision and one staff told us they had never had supervision whilst working at this service. The information was misleading.