Mr Steven William Saltmer & Mrs Penelope Alison Saltmer

Pennyghael Residential Home

Inspection report

Westbourne Grove, Selby, YO8 9DG
Tel: 01757 210204

Date of inspection visit: 28 & 29 April 2015
Date of publication: 24/06/2015

Ratings

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

Overall summary

This inspection was unannounced and took place over two days on 28 and 29 April 2015.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

1. Ensure that providers found to be providing inadequate care significantly improve

2. Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

3. Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of

Summary of findings

inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

At the last inspection, which took place in January 2014, we found the provider was in breach of regulations in relation to the safety and suitability of the premises. At this inspection we found that problems with the safety and suitability of the premises continued. We also found the service was breaching five other regulations; person centred care, the need for consent, safe care and treatment, good governance, and ensuring staff are suitably trained and supported to care for people.

Pennyghael Residential Home is a care home which provides residential, personal and social care for up to 16 people who are living with dementia. The home is on two floors with one staircase, two bedrooms are shared occupancy, although only one person was living in them at the time of our inspection. None of the bedrooms have en suite facilities. The home is in Selby.

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

The environment was not safe or suitable for people living with dementia. There was limited communal space, which meant the only quiet areas for people were their own bedrooms, this impacted on people's distress and agitation. We toured the premises and found that some people had broken bedroom furniture in their rooms; people did not have comfortable chairs in their rooms unless they bought their own, and none of the beds had headboards. A number of rooms were due to have new flooring fitted and one bedroom had a sunken floor which was awaiting repair, this bedroom was in use and therefore, this was a trip hazard.

The communal areas were due to be refurbished, in the main lounge area we were told a new carpet would be fitted the week after our inspection. This was because the current carpet was torn and had been stuck down with tape; it was uneven and posed a trip hazard.

Some work had recently been undertaken in the garden to make it safer for people to use, however, the paving was still uneven in parts and meant people could trip and fall. CQC were aware of an incident which involved someone who used the service getting out of a gap in the fence, we confirmed during this visit that this had been fixed. This incident was referred to the local authority safeguarding team to investigate and CQC will monitor the outcome of this.

The registered manager and provider were aware of the issues in relation to the environment and the registered manager had developed an action plan. However, at the inspection we were not given any timescales telling us when the work would be carried out.

Parts of the service were not clean. The dining table in the main lounge was dirty as were coffee tables, which were in use. Door handles were sticky throughout the home and each bathroom we went in had sticky flooring. In the communal bathrooms we saw dirty grouting, one bathroom had just had a new bath fitted and was awaiting re-grouting.

Staffing levels were not assessed robustly by the registered manager against the dependency levels of people using the service. We were told "they were as they had always had been." We observed periods of time when staff were trying to support people with a variety of tasks, this meant staff were rushed, and people did not experience good care.

Care staff were aware of the procedures around abuse and explained to us what they would do if they observed or suspected abuse. CQC are aware of four safeguarding incidents which are currently being investigated by the local authority. We will continue to monitor these and liaise with the local authority as needed.

Summary of findings

People received their medicines safely and in line with the prescribing instructions.

Care staff had not received the training and support they needed to be able to deliver effective dementia friendly care for people who used the service. Supervision was not being held on a regular basis, although we did see staff had received an annual appraisal.

Mental capacity act assessments were not detailed. We saw evidence of care being delivered without staff seeking permission or explaining what they were doing. Where people were unable to give consent we did not see any best interest decisions were recorded, this meant care staff were not following the principles of the mental capacity act when planning and delivering care to people.

People had regular drinks and snacks; however, the main meal could have been a more pleasurable experience. The menu was repetitive. Some people were on food and fluid charts, we saw evidence of people being weighed on a regular basis and did not see people losing significant amounts of weight.

People did not receive warm and compassionate care. We saw examples of care being "done" to people, without explanation or reassurance being given. We saw people were distressed and agitated and not all care staff knew how to respond to this.

Care plans were not always being followed, and were not up to date. Care plans were not person centred and contained minimal information about the person's life history and their preferences about care and daily life. This meant care and support might not be provided in line with a person's previous wishes and lifestyle choices.

A number of people had behaviour which placed them or others at risk of harm. Risk assessments were not detailed and did not contain the information required for care staff to know how best to support the person and alleviate their distress.

Health professionals were consulted but we did not see effective records of these interventions and could not see whether they had suggested any changes to the treatment or care of people. This meant there was a risk people might not be getting the appropriate care and treatment, based on their current needs.

People did not have access to meaningful stimulation or regular activity based on their choices and life experiences.

Record keeping was poor and audits were not effective. There was no evidence of good practice being used to support people who were living with dementia.

Relatives were given the opportunity to comment on the service by completing a questionnaire and the responses were good overall. We were told staff meetings took place but there were no minutes or records available for us to see.

Staff told us they felt well supported by the registered manager and the deputy manager.

We found multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The environment was not safe or suitable for people living with dementia. People did not have access to quiet and calm communal areas, bedrooms were not homely or easily identifiable for people, in some cases they were unsafe.

Not all areas of the service were clean and hygienic, and this meant there was a risk of infection developing and spreading.

There were periods of time when members of care staff had to do other tasks such as cooking and cleaning and this meant there were less care staff available for people who needed support or supervision. Staff were safely recruited and people had their medication provided in a safe way.

Is the service effective?

Inadequate

The service was not effective.

Staff were not provided with the appropriate training and supervision to help them deliver good care to people living with dementia. Care staff received an annual appraisal.

Members of care staff were not applying the principles of the mental capacity act; we saw evidence of care being delivered without consent being obtained or adequate explanations being given. Where people did not have the ability to give consent, we did not see records of best interest decisions.

We had no concerns people who lived at the service had lost weight, however, the experience of meal times was not as positive as it could have been for people. The menu was repetitive.

Is the service caring?

Inadequate

The service was not caring.

We observed care was task focused and did not see a consistently kind or warm approach from all care staff.

People's basic care needs were not being maintained to a high standard. We saw some people looked unkempt in their personal appearance.

Is the service responsive?

Inadequate

The service was not responsive.

Care was not assessed, planned or delivered in a person centred way. We saw some care plans were not being followed, and staff told us they had not been updated.

Where people were at risk of harming themselves or others because of their dementia condition, we did not see detailed risk assessments which would enable care staff to support people well. We did not see evidence of guidance being sought from relevant health professionals to support staff.

Summary of findings

There was no stimulation for people who lived at the service; we found no meaningful activity took place during our inspection. We were told the service had access to weekly armchair exercises and monthly entertainment. However, this was planned on an adhoc basis, meaning there were periods of time when people were sat without additional recreational support.

Is the service well-led?

Inadequate

The service was not well-led.

Record keeping was an area of significant concern. We found gaps in records and incomplete documents which meant it was difficult to see what plan had been put in place to support individuals. Audits were completed by the registered manager but these were not effective in highlighting issues.

We saw people's relatives had been given the opportunity to complete a survey and comment on the service. Overall people gave positive feedback.

Care staff told us they felt well supported by the registered manager and the deputy manager. They told us the care and support people received was good but the environment made it difficult to support people.

Pennyghael Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 28 and 29 April 2015, the first day was unannounced, but we told the registered manager we would return the following day to complete the process. At the time of our inspection there were 14 people living at the service, all of whom were all living with dementia.

On the first day the inspection team consisted of two inspectors, a specialist advisor (who was a nurse with experience of working with older people and dementia care) and an expert by experience. 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 on this visit had experience with older people and people living with dementia. The second day of the inspection was completed by one inspector.

Before our inspection we reviewed all the information we held about the home. The provider had not been asked to complete a provider information return (PIR). This is a document that provides relevant and up to date information about the home that is provided by the manager or owner of the home to the Care Quality Commission. We were aware of concerns that the local authority had regarding Pennyghael Residential Home, and that they had taken a decision to suspend new placements. We contacted Healthwatch, which is an independent consumer champion that gathers and represents the views of the public about health and social care services in England; they did not have any feedback to share regarding the inspection.

We spoke to the registered manager, deputy manager and six members of staff including; care staff, the cleaner and the chef. We also spoke with two visiting health professionals. We spent long periods of time observing care as we were unable to get people's views verbally due to their complex needs and communication difficulties. We also observed the medications round and care being provided in the communal areas of the home. We looked in people's bedrooms, and communal bathrooms. We also observed breakfast and lunch being provided.

We looked at documents and records that related to people's care, and the management of the home such as training records, policies and procedures. We looked at six care plan records.

Inadequate

Is the service safe?

Our findings

The service was not safe.

At the last inspection in January 2014 we found the service was in breach of regulation 15 of the HSCA 2008 regulated activities 2010, safety and suitability of premises. The provider had sent the Care Quality Commission an action plan and confirmed they felt they were now meeting this regulation. We saw the provider had carried out some structural work; they had a new roof fitted, as this had been leaking into people's bedrooms at the time of the last inspection, and the wooden fire escape had been replaced with a metal external stairwell. However, there were still significant concerns in relation to the safety, cleanliness and suitability of the environment for people living with dementia.

The service had a small entrance area, this lead into the communal dining area which had sufficient seating for eight. There was a desk in this area, which was used by the registered manager on a day to day basis. Confidential information about people who use the service was kept here, for example the handover book and diary. The main lounge was through a doorway to the left, which also had a dining table at the back with seating for eight. There were no other communal areas for people who used the service.

Throughout our inspection we observed the majority of people who used the service sat in a semi-circle in the lounge. Space was limited and meant when people were distressed or becoming agitated, there were no other communal quiet spaces for them to access and this resulted in people's behaviour escalating. Staff dealt with this by taking people to their bedrooms, this meant people were then unsupervised and it did not feel like a dignified way to support people living with dementia.

There was a conservatory which had a sign attached to the patio doors, saying, 'crafts and games area.' We were told this room was not in use as it was not a safe area; it was being used to store equipment such as hoists and wheelchairs, it also stored four fridges and freezers. The conservatory had no blinds or curtains which meant on a sunny day it would have been too hot for people to use. In order for people to access the garden area they would need to go through the conservatory this meant that people could be at risk, and would be need staff support to access this.

Some work had recently been done in the garden to make it safer for people to use and the fence had been fixed. This work had been carried out after a person who used the service had been able to get through the gap in the fence. This incident is currently being investigated by the local authority safeguarding team. CQC will monitor the outcome of this.

Two wooden sheds had been demolished as they were unsafe. However, the paving was still uneven in parts and posed a trip hazard for people. There was little to stimulate people who used the service, we saw three large planters had dried soil and dead plants in them. We saw empty tubs, which contained cigarette ends and we saw some staff smoked in this area throughout the first day of our inspection. This was a large secure area and work could be done to ensure it was safe for people who lived there to enjoy it.

People's bedrooms were sparse, none of the beds had headboards, and in one bedroom the edge of the top of the bed was positioned next to a boxed radiator, we pointed this out to the registered manager as we were concerned the person could bang their head, they agreed to rectify this. One bedroom had bare walls, and contained just a wardrobe and the bed. We asked the registered manager about this and were told they were waiting for the person's family to bring some things in to make it more personal, they explained the person moved into the service December 2014, but the decision they would stay had only recently been made. However, we thought the provider should make people's bedrooms more comfortable. In one bedroom the floor had sunk and this area was covered by a wardrobe. The registered manager told us this was due to be fixed as a matter of urgency as they were aware it was a hazard. Throughout the service we saw broken bedroom furniture and no comfortable bedroom chairs were provided unless people bought their own.

On the outside of people's bedroom doors the service had put up a pictorial sign indicating this was a bedroom. However, only one bedroom had anything to identify whose bedroom it was. No other bedroom had any name, photograph or object the person could associate as being familiar to them to enable them to recognise the room as their bedroom, so that they could access it independently.

Inadequate

Is the service safe?

The general décor throughout the home was poor and needed refurbishment; wallpaper was coming away and the registered manager told us they had suggested to the provider that the whole service needed to be redecorated; we confirmed this was in the action plan.

We saw some people spent time walking up and down the corridors but there was nothing on the walls to encourage reminiscence or interaction. We saw some reproductions of old advertisements but these were minimal in number.

The floor was uneven in various areas on the ground floor. We saw carpet had been stuck down with tape, which was coming away, and this posed a trip hazard for people who used the service, staff and visitors. The registered manager explained the carpet in the main communal area was due to be replaced the week after our inspection.

The service has one main staircase. People using the stairs had to negotiate three steps and then a turn in the stairs, before reaching the main staircase. A stair lift operated on the main staircase. One three occasions we saw the stair lift was left at the top of the stairs, which were very narrow. This made it difficult to get past the stair lift and meant it was a hazard due to the risk of people falling. We discussed this with the registered manager and later the provider who told us staff knew this needed to be kept at the bottom of the stairs, where it was wider, and they would remind staff of the importance of this.

These issues meant people did not have access to quiet and calm communal areas which might help the service to support people living with dementia and to reduce incidents of agitation and distress for people. People did not have bedrooms that were easily identifiable or homely and in some cases they were unsafe, and the outside space was not safe for people to access independently due to the risks of tripping on uneven flooring. This was a breach of Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2014.

The registered manager told us they were aware of the issues and had developed an action plan and presented this to the provider; we confirmed this to be the case. The registered manager and provider were due to meet with a builder to look at a major programme of refurbishment for the home. At the time of our inspection there were no timescales for this work to be completed and no action plan of how people would be supported to be safe whilst the work took place. However, we did see some works had been undertaken such as window restrictors fitted to upstairs bedroom windows, this followed a visit by the local authority contracts team.

The service was not clean. In every bathroom we entered the floor covering was sticky to the extent our shoes stuck to it. We pointed this out to the registered manager who told us they could not understand it, and thought it may be an issue with the cleaning product. In the main shower room the grouting on the floor was black with dirt, and the wooden boxing behind the sink was coming away, in another bathroom we saw a new bath had been fitted and the tiling was about to be grouted.

These issues put people who used the service, staff and other people at risk of acquiring or transferring infections. This was a breach of Regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the registered manager how they worked out the number of staff needed to provide appropriate care and support for people who used the service. We were told that the staffing levels had been the same since the registered manager started at the service and they felt this was sufficient. The registered manager told us she did not use a staffing tool to calculate the amount of hours of support people needed or to take into account individual's dependency levels. The registered manager told us two members of care staff worked a 12 hour shift and then a further member of care staff worked from 7am until either 1pm or 3pm. This meant from either 1pm or 3pm there were two members of care staff available to support 14 people living with dementia, some of whom needed assistance with their personal care from two care staff. Some people had behaviours which could place themselves or other people at risk of harm.

In addition to this, the chef does not start work until 8.00 or 9.00 am and finished in the early afternoon. This meant a member of care staff was providing people's breakfasts until the chef arrives and then preparing and serving the teatime meal for people later in the day. We observed the period between 7 am and either 8.00 or 9.00 am, (before the chef arrived) to be chaotic, people had to wait for their breakfasts and the member of care staff making food was trying to accommodate the needs of people getting up and provide the breakfast meal.

Inadequate

Is the service safe?

We recommend the provider review the current staffing levels, in order to assure themselves there is sufficient staff available to support people, particularly when kitchen and cleaning staff are not available.

Staff were able to explain the safeguarding adults procedures. They described to us the immediate action they would take if they witnessed abuse and were aware of how to report it. We were aware of recent safeguarding incidents which had been referred to the local authority safeguarding team. CQC will continue to monitor the outcome of these investigations.

The service had effective recruitment and selection processes in place. We saw appropriate checks were undertaken before staff began work, this included records of Disclosure and Barring Service (DBS) checks. The DBS checks assist employers in making safer recruitment decisions by checking prospective staff members are not barred from working with vulnerable people.

People had personal emergency evacuation plans to ensure staff were aware of the level of support people living at the service required should the building need to be evacuated in an emergency.

We looked at the storage and handling of medicines as well as a sample of medication administration records (MARs), stocks and other records for six people. We found the arrangements for handling medicines were safe. All medicines were administered by senior care staff. Medication was stored securely in a locked cabinet in a locked medication room.

We saw MARs contained a photograph of each person to ensure care staff could identify them. The system for ordering stock was easy to follow and effective as was the recording of returned medication. The service had a controlled drugs cabinet and register in place, at the time of our inspection no one who used the service was in need of controlled drugs. There was a designated drugs fridge.

Inadequate

Is the service effective?

Our findings

The service was not effective.

We asked the registered manager about the training provided to staff. We saw that staff had received little training; the local authority had recently raised this concern with the registered manager and they had purchased an on line learning tool. At the time of our inspection, out of 14 staff none had completed Mental Capacity Act training, only one had completed fire training, nine had completed dementia training and two had completed safeguarding training. We spoke to the registered manager who told us their priority was ensuring staff had completed the online training. We asked what they did to ensure the online learning was effective and they told us this is something they needed to consider for the future but their current priority was ensuring all staff had received mandatory training. The manager did not have a system in place which meant they could easily see what training staff had attended. This meant it would have been difficult to keep track of the training staff needed.

People were placed at risk of harm because the service had not taken steps which ensured staff had been trained to support people living with dementia, especially those who could become agitated and distressed. During our inspection we saw care staff struggling to respond to people who were distressed. One person went from being tearful and distressed to quickly being agitated. Staff appeared unsure how to respond to the person, who was in a wheelchair. The registered manager told a member of care staff to take the person to their bedroom. However, this caused the person to become more agitated and the registered manager then suggested the person be wheeled backwards because they were putting their arms out to stop themselves being moved. We did not see staff offering reassurance to the person during this interaction.

We asked the registered manager how often staff had supervision. Supervision should be an opportunity for staff to discuss any training and development needs, any concerns they have about the people they support, and for their manager to give feedback on their practice. The registered manager told us supervision was held every two to three months, and that they supervised all staff. We checked four staff records and saw gaps in supervision, the deputy manager had not had supervision since August 2014, another member of care staff last had supervision in October 2014. We saw two members of care staff had received regular monthly supervision, however, on checking the records we found supervision records were about shift patterns or personal issues, instead of matters relating to their training needs or practice; the needs of people who used the service or the staff member's development. We asked whether the registered manager had supervision, and they told us they had regular discussions and meetings with the provider but did not have formal supervision. Out of the four records we checked we saw staff had received an annual appraisal.

This meant that people were not being cared for and supported by a staff team who the provider could be confident were using current good practice and people were at risk of receiving unsafe and inappropriate care. This was a breach of Regulation 18 (2) HSCA 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act (MCA) 2005 provides a legal framework for acting and making decisions on behalf of people who lack the mental capacity to make specific decisions for themselves. The Care Quality Commission monitors the operation of the Deprivation of Liberty

Safeguards (DoLS) which applies to care homes. These safeguards are in place to protect the rights of people who use services, by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. We found staff and the registered manager did not understand what they needed to do to comply with the MCA.

None of the staff we spoke with were able to tell us about the principles of the Mental Capacity Act or about the need to seek consent from people before they delivered care or treatment. We saw examples of care staff giving people who used the service instructions; they did not seek the person's consent and did not discuss what was happening with the person. One member of care staff approached a person, took hold of their hand and instructed them to get up out of the chair saying, "Come on [person's name]", we did not see the member of care staff offer any explanation as to what was happening.

We looked at six care plan records and saw mental capacity assessments were completed but these involved a tick box with no information about how the decision was reached that the person lacked capacity to make their own

decision. One assessment we looked at had contradictory information so it was unclear whether the person had the ability to make their own decision. When we asked the registered manager they told us the person would be unable to make their own decisions due to their mental health.

Where people were assessed as being unable to make their own decisions we did not see any evidence of best interest decisions being made. A best interest decision is a decision made on behalf of a person who is unable to make their own decision and should involve the person's family or friends and other health and social care professionals. This meant that staff were not always following the principles of the Mental Capacity Act 2005 when planning peoples care.

At the time of our inspection the registered manager had applied for DoLS for all of the people who lived at the home, some of these had been authorised and the others were being assessed or awaiting assessment from the local authority. We asked the registered manager about why they had applied for the DoLS and were told this was something the local authority had advised them to do.

This meant care and treatment was bring delivered without consent being obtained, or where people were unable to give consent there was no record of staff following the principles of the MCA when planning and delivering care. This was a breach of Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2014.

We observed breakfast and lunch on the first day of our inspection and lunch on the second day.

Breakfast was being prepared and served by the deputy manager. We saw people were offered tea, toast and cereal. We asked whether people were given the option of a cooked breakfast, and were told people could have anything they wanted. The chef started between 8am and 9am and arrived at 8.30am on the day of our inspection. As people had been getting up since 7am it was unclear how their preferences were catered for, whether people had a light breakfast to start with and were then given a cooked breakfast. We saw one person had poached eggs on toast, we did not see anyone else being offered hot food.

We checked the store cupboards and fridge freezers and found the tinned and frozen food to be a supermarket 'value' range. We looked at the menu choices available for people and found them to be limited. Out of ten days, 18 April to 27 April there had been a choice of sausage on five days, mince, cottage pie, liver and onions and a roast dinner on Sundays. This meant that although we found no evidence of people losing weight, we did not see people were given a good range and choice of food.

During our inspection we saw drinks were being provided throughout the day. We saw a member of care staff hand out chocolate biscuits in the morning and afternoon, with a hot drink. This was into people's hands, some of whom were struggling to hold a drink at the same time, onto their laps or onto unwiped coffee tables.

We observed a member of care staff setting the table with people sat at it, the table had not been wiped clean and there was no table cloth. No condiments were on the table so people could not season their food. People did not have napkins or place mats. We thought the lack of these basic standards meant staff did not view this as important and showed a lack of respect and dignity for people who used the service; it meant the experience of eating their main meal was less pleasurable for people than it could have been.

We spoke to the chef who told us they worked four days a week, on the other three days a member of the care team provided the meals. We checked the rota and saw this was in addition to the shifts already covered by care staff. The registered manager told us the weekly budget for food was £250, and that the food was ordered online from a supermarket. They were unable to tell us what this amounted to per person per day. The chef told us they hadn't planned to be in work on the day of our inspection and that they hadn't planned a meal; people were given chicken burgers, chips and beans or eggs, chips and beans for their main meal. The chef made some buns in the morning, which we saw people enjoyed.

We saw one person was offered a sandwich when they didn't eat their main meal. Members of care staff gave verbal encouragement to people to eat, but they did not stay to see that the person had eaten. One person had their meal on their lap, resting on a tea towel. The following day their meal was on a small table next to them. It was unclear what their preference would be.

We noted a number of people declined to eat, we asked the manager how they kept track of how much food people had eaten and were told they would try and encourage people to eat later in the day or offer alternatives. The registered manager told us they kept food and fluid charts

Inadequate

Is the service effective?

for people at risk of losing weight, we checked this and the information completed was minimal. However, we saw people were weighed regularly and did not see evidence of people losing weight.

Inadequate

Is the service caring?

Our findings

The service was not caring.

People who lived at the service had complex needs because of their dementia and were unable to tell us about their experiences of the service. So we spent long periods of time observing the interactions between care staff and the people who lived at the service.

On the first day of our inspection we arrived before 7am as we had received concerns about people being got out of bed early, against their wishes. On arrival we saw two people were in the main lounge, both were sleeping. We were told by the night care staff one person had got up at 5am. This person was sat in a reclining chair with their feet raised.

We looked at their care plan and could see the person was at risk of developing pressure ulcers, the care plan clearly stated the person was an early riser but should be supported to have a cup of tea in their bedroom and not brought into the lounge until the day staff arrived at 7am. We asked the registered manager why the person was up in the lounge so early and the care plan instructions were not followed. They were unable to provide an answer. A member of staff from the night team advised they had got the person up to prevent their skin becoming sore. Despite the risk of developing pressure ulcers, we saw the person was not assisted to use the toilet or moved until approximately 12.15pm, meaning they had been sat in one position for over five hours.

This person needed to use a wheelchair to get around, and needed a member of staff to assist them. We noticed in their bedroom a foot plate from the wheelchair; this was on the floor next to their wardrobe. We raised this with the registered manager as we were concerned the person may have been moved into the lounge with only one footplate on their wheelchair. This meant there foot or leg could have been at risk of injury. It also posed a trip hazard in the room which was on the ground floor and accessible to other people with dementia who were walking around the home. The registered manager agreed to investigate this.

The registered manager had not taken steps to ensure the person had their care needs met and there was a risk of the person being uncomfortable and developing pressure ulcers. This was a breach of Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014.

We observed one person was asking for support from a member of care staff to go to the toilet. They said, “I wanted to go to the toilet, I’m sorry.” The member of care staff provided support to assist the person to the bathroom but did not give any verbal response to their request. The member of care staff could have spoken to the person and told them not to worry.

We found members of care staff to be task focused and we did not always see a warm approach from staff towards the people who used the service. For example we did not consistently see care staff getting down to people’s eye level or offering reassurance.

We did not think people’s care needs and personal hygiene was being maintained to a good standard. We noted that a number of people who used the service were unkempt and dishevelled in terms of their personal appearance. For example, two people were seen to have long fingernails with dirt underneath, one person had chipped nail varnish, people’s hair was not groomed, men were unshaven and three people were wearing foot wear but they had no socks or stockings on.

One person was distressed on and off throughout the first day of the inspection, they were tearful at times and when we spoke to them they were confused. Staff did not appear confident in how to respond to this person. However, we did observe the registered manager notice this, they went to the person and helped them out of the arm chair and took them through to a different area, where it was quieter. They sat and talked to the person, gave them a tissue and spent time reassuring them.

Inadequate

Is the service responsive?

Our findings

The service was not responsive.

Care was not assessed, planned or delivered in a person centred way. Care plans were difficult to follow and did not contain detailed information to enable members of care staff to know how the person should be supported. We found limited information about people's preferences, and life histories.

Care plans were not being followed by care staff. We looked at the care plan record for another person who was up early on the first day of our inspection. The care plan stated, "[name of person] is known to twitch in a morning. Put sensor mat at side of bed to alert when [person] is awake. [person's name] gets up at 6.30am. Staff are to, before this time, take a cup of tea up to offer [person], so they are not on their own when waking up." We checked this with the deputy manager who told us; "It's [movement sensor mat] no longer in place, [person] was stepping over it and we didn't know if they were up and about, [person's name] was at risk of falling." This had not been changed in the care plan, and there was no assessment of the current risk of falling. We asked what other things had been tried to minimise the risk and were told, "nothing," this was confirmed by the registered manager.

All of the people who lived at the service had dementia and as a result, some people had behaviours which could place them, other people or staff and visitors at risk of harm. We did not see good quality risk assessments recorded within people's care plans which could assist care staff to support people and reduce the risk of harm.

We observed one person was agitated and distressed on both days of our inspection, we saw care staff appear unsure what to do to support the person and heard them being told, by the registered manager, to take the person to their room. Later the person walked back towards the main lounge and two care staff had to intervene to prevent a frailer person being caught up in the person's agitation. The interaction was chaotic and staff appeared to be responding to the escalating situation rather than working to prevent the person becoming more upset and to minimise the risk of harm.

We looked at the person's care plan and specifically the risk assessment related to their behaviour. The summary of needs had no information relating to the person's behaviour, the risk assessment recorded in the care plan stated, 'Falls Risk Assessment', however it contained a section which read, "[person's name] can hit out at staff. Staff to be aware. [Person] will stop if you request [person] to stop. Behaviour chart in place." The risk was recorded as high. There was a record in the care plan which said, 'community psychiatric nurse aware.' However, there was no guidance from the mental health nurse recorded as to how best care staff should support the person.

We looked at the record of incidents on a separate behaviour chart, and saw there was a significant number involving the person being distressed, shouting and lashing out at other people who used the service, and hitting staff. Staff had recorded in the actions taken box the following statements; 'Removed [name of person] from lounge and explained behaviour was unacceptable', 'ignored behaviour', and 'left [name of person] to calm down.'

We checked with the registered manager that there was no information anywhere else which would assist staff in supporting this person and the registered manager confirmed all of the information was in the care plan record we reviewed. As the person was becoming more distressed the inspector asked the registered manager to contact the GP and request an urgent visit and also to make contact with the community mental health nurse. The registered manager did both of these things whilst we were there.

This was a breach of Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014.

We did not see any evidence of people or their families being involved in the development of people's care plans or reviews. The evidence of reviews we saw was minimal, and contained repeated reference to, 'No change in needs. Care plan remains in place.' We would expect to see involvement of the person, and or their families in reviews of their care, as this would enable people's previous choices and wishes to be taken into account when staff were providing care.

The majority of people who lived at the home spent all day in the main lounge area, in a semi-circle. People who were able to walk without assistance moved about the home on the ground floor. Because of the size and layout of the home there were no quiet areas for people to spend time.

Inadequate

Is the service responsive?

There was no structured activity for people who used the service, on both days we were there a DVD film was played in the afternoon. This was at the request of one person who lived there and watched by everyone else.

We asked a relative about their views on the service and they said, “They [members of care staff] could do with talking more with people. There aren’t many activities going on, an organ player visits once per month and a gentleman comes one hour per week. The residents could do with more games, like bingo and dominoes to keep them occupied. Carers could do more with residents instead of them watching television all day.” Another relative contacted us after the inspection and echoed these comments, they told us care staff spent time in the dining area and did not spend time with people in the main lounge.

We asked the registered manager what activities were available for people and were told somebody comes in each week to do armchair exercises and once a month there is a singer or entertainer. It did not appear that any thought had been given to engaging with people on a one to one basis or how to ensure people’s hobbies and interests before they moved into the service could be maintained.

We saw one person had been involved in a local place of interest all of their life, we asked staff whether the person was supported to visit the area which was approximately 10 minutes away from the home. We were told they did not have enough staff to do this. Another person had worked as a farmer and we asked whether any outdoor activities had been considered to support their previous lifestyle, we were told by the registered manager this had been considered but not yet implemented. The registered manager told us staff spent time in the garden with one person who did not communicate verbally, they said it was evident they enjoyed this time.

People were not supported to be involved in meaningful activity which was person centred and based on their previous lifestyle choices. This was a breach of Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

The service was not well led.

The service had a registered manager who was supported by a deputy manager, and a team of care and ancillary staff.

At the last inspection in January 2014 we highlighted a breach which related to the safety and suitability of premises. Although some work had been undertaken to address this, we concluded the service was still in breach of this regulation. We also found the service was breaching five other regulations; person centred care, the need for consent, safe care and treatment, good governance, and ensuring staff are suitably trained and supported to care for people.

We found record keeping an area of concern throughout the inspection; this was in relation to individual records for people who used the service and wider service records.

We saw in one person's care plan members of care staff had completed a behaviour chart and noted incidents of concern in the person's daily record sheet. However, there was no other documented evidence detailing what the service had done regarding the increased agitation and distress this person appeared to be displaying. We saw a log of a call to a doctor but there was no evidence of the content or outcome of this conversation. The registered manager informed us the doctor had been contacted on more than one occasion and tests had been undertaken to rule out any type of infection. We asked the registered manager to show us the records of these contacts; they were unable to do so. Later in the inspection the doctor visited the person and we confirmed with them that the home had been in contact on several occasions. We concluded that although the home was seeking appropriate medical advice this was not being documented. This meant that care staff did not know what the doctor had advised or if any changes to the care and treatment was required for the person.

We saw examples of documents in care plans without dates or names of the member of care staff who had completed the form. We saw a body map had been completed for one person which showed they had an injury. However, there was no date on the body map to establish when this occurred or explanation as to how this happened, and no record of the action taken or what was required as a result of this. We showed the registered manager this as we were concerned this practice needed to be addressed immediately. The registered manager accepted we had significant concerns about record keeping and acknowledged the lack of clear recording.

Another example of inaccurate recording was about the frequency of people being bathed or showered. The records from January 2015 to present day showed that people were being provided with body washes every day except for the very occasional bath or shower. This was recorded on a daily basis. We were concerned people were not having a bath or shower. We discussed this with the registered manager who showed us another file which contained information about people's bathing regimes. This record contradicted the daily record, it showed a weekly bath or shower for those able to use the facilities. We asked the registered manager why the records were not being kept accurately. She could not provide an explanation but agreed to discuss this staff..

We asked the registered manager what they did to assure themselves they were running a good service. The registered manager told us they completed a number of audits. However, we found these were not effective. One example of this was the infection control audit which had been completed in April 2015. Issues were cross referenced to the previous audit, but the registered manager had rated this as good. The audit had not highlighted the issues we found regarding cleanliness within the service such as sticky floors, unclean door handles, dirty coffee and dining room tables which appeared to be longstanding rather than overnight dirt.

There was no evidence of consistent good practice at this service particularly in relation to the care of people living with dementia. There was no evidence to suggest that the service was using NICE guidelines or other relevant guidance in their care of people with dementia.

During our inspection we noted people did not have access to call bells. We asked the registered manager whether people were able to use call bells to request help and they told us people were not able to do this due to their dementia. We asked the registered manager whether they had recorded this anywhere or taken steps to minimise the risk of people being unsafe if they were unable to call for assistance and we were told they had not.

Inadequate

Is the service well-led?

We concluded the registered manager was not ensuring records were up to date or completing effective audits. This meant they could not assure themselves they were running a good service. This was a breach of Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014.

We asked the registered manager how they sought the views of people who used the service and their relatives. They told us they had tried to hold meetings but these had not worked so they no longer offered them. However, we saw the service asked for feedback from relatives and visitors via a questionnaire. 12 relatives had completed a survey in February 2015. Nine of the questionnaires rated the service from quite good to very good, one had highlighted concerns about the cleanliness of the home. The data from this had not been analysed, and we could not see whether people's views had been acted upon.

We were told by the registered manager they held regular staff meetings, however, they were unable to provide us with any minutes or record of the meetings. On the second day of our inspection we saw the registered manager had booked a staff meeting for May 2015, there was a note with the details on a whiteboard to ensure staff attended.

Staff told us they felt well supported by the registered manager and the deputy manager. They described the on call system at the weekend. One member of staff told us the management team were, "Always there to go to for advice and support." They talked to us about their frustration regarding the lack of progress around the required improvements to the environment, and felt that and the lack of stimulation for people was the main problem. Staff told us if it was about the care provided to people they would be happy for their family member to live there, however all staff told us the environment let the service down. A visiting health professional told us they felt the care was 'adequate', and the manager and care staff were very caring but the fabric of the building caused constraints.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent We concluded the provider was not assessing people's ability to make their own decisions. When people were unable to give consent to decisions we did not see records of Best Interest decisions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We concluded the service was not clean and hygienic this could place people who used the service and others at risk of acquiring and transferring infections. Regulation 12 (2) (h) HSCA (Regulated Activities) Regulations 2014 Safe care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance We concluded the service was not completing effective audits to ensure they were delivering a good service, in addition to this record keeping, in relation to people who used the service was poor. Regulation 17 (2) (d) HSCA (Regulated Activities) Regulations 2014 Good governance.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Action we have told the provider to take

We concluded staff were not supported to have effective training, supervision to ensure the use of good practice when supporting people living with dementia.

Regulation 18 (2) HSCA 2008 (Regulated Activities) Regulations 2014 Staffing.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment We concluded the environment was not suitable to provide good dementia care. People who use services and others were not protected against the risks associated with unsafe or unsuitable premises.

The enforcement action we took:
We have served the provider with a warning notice. The date for compliance is 2 September 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care We concluded care was not assessed, planned or delivered in a person centred way. Care plans were difficult to follow and did not contain detailed information to enable members of care staff to know how the person should be supported. We found limited information about people's preferences, and life histories.

The enforcement action we took:
We have served the provider and registered manager with a warning notice. The date for compliance is 2 August 2015.