Warren Park (Chapeltown) Limited

Warren Park

Inspection report

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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?	**Inadequate**
Is the service well-led?	**Inadequate**

Overall summary

This inspection took place over two days on 21 and 25 September 2015. Both days were unannounced, which meant no-one at the service knew we would be visiting.

This service was registered under this registered provider on 10 April 2015 and this was their first inspection.

Warren Park is a care home registered to provide accommodation with nursing and/or personal care for up to sixty older people, including people living with dementia. At the time of our inspection 28 people were living at the home.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. This registered manager was not managing the service at the time of our inspection. The service was being covered by

Summary of findings

another manager who is referred to in the report as covering manager. The service manager is the member of staff who has line manager responsibility for the manager of the care home.

Relatives and staff reported the registered manager did not demonstrate good management and leadership of the home saying they felt she did not listen to worries or concerns they had, providing an appropriate response or taking action where needed. One set of relatives told us they observed her being unkind to staff, in public. This was also reported by staff.

People told us they were well cared for by staff, and relatives reported they felt their family members were safe now, but we found systems and processes in place to protect people from harm had not always been followed.

People and most relatives felt staff were visible, but we found times staff were not available to support people in accordance with their plan of care.

Staff recruitment procedures needed improving to evidence staff employed from overseas were eligible to work in the United Kingdom and that the service could be assured that agency workers had undergone the necessary recruitment checks and had the appropriate training relevant to the role they were to perform.

We found systems were in place to make sure people received the medication they needed, however, the recording of the receipt of controlled drugs, which are prescription medicines under the Misuse of Drugs legislation were not always recorded as required.

We found some staff who had not received all the appropriate training relevant for their role and responsibilities and some who had not received any supervision.

Written records were not always available to support that decisions about people's care and treatment were taken in their best interests in line with legislation and guidance.

People had access to a range of health care professionals to help maintain their health.

Whilst the unit of the home for people living with dementia had been refurbished, it was not in a way that assisted orientating those people to different parts of the environment to maintain their independence.

People and all relatives we spoke with told us staff were caring and compassionate in their approach. We observed this when staff were interacting with them. However, we found staff actions had not always shown respect for people, for example, making beds where sheets were stained and not knocking on closed doors to elicit a response before entering.

The majority of relatives spoken with had no concerns regarding their family members care, however, when we looked at people's care records we found people had not always received the care that was planned and the risks surrounding their care had not been reviewed when there had been a potential for increased risk in that area.

In general, communal areas of the home were clean, but we found bedrooms where bedding was dirty and the rooms untidy or hadn't been cleaned. The bedding we saw needed replacing as some had become thin with use and one pillow case was torn.

Staff confirmed in the last month the food provided for people had improved. People and relatives confirmed they were satisfied with the food provided. This meant people were receiving a varied and nutritious diet that took into account their dietary needs and preferences, so that their health was promoted and choices could be respected.

People and relatives reported the activity co-ordinator had left and this had resulted in a lack of stimulation for people. People told us they missed those activities. This was evident during the inspection, with many people asleep.

There was an inadequate system in place to monitor and improve the quality of the service provided. Regular checks and audits had not been undertaken to make sure full and safe procedures were adhered to.

Meetings for people and relatives were undertaken to obtain their opinion of the service to identify any areas for improvement, but we found actions to measure any improvements were not recorded.

The overall rating for this service is inadequate and the service is therefore in special measures.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, the service will be inspected again in six months.

Summary of findings

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of 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 this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated up to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People told us they felt 'safe' and relatives now supported this view, but we found systems and processes in place to protect people from harm had not always been followed.

People and most relatives felt staff were visible, but we found times staff were not visible, supporting people in accordance with their plan of care.

The systems and processes for recruiting staff needed improvement to ensure all pre-employment documentation was in place.

We found systems were in place to make sure people received the medication they needed, but the recording the receipt of controlled drugs, which are prescription medicines under the Misuse of Drugs legislation were not always recorded as required. In addition, there was a risk that people went more than 12 hours between their evening and morning medication.

Is the service effective?

Requires improvement

The service was not always effective.

We found some staff who had not received all the appropriate training relevant for their role and responsibilities and no supervision.

Written records were not always available to support that decisions about people's care and treatment were taken in their best interests in line with legislation and guidance.

The mealtime experience had improved recently with more choice available for people and people told us they enjoyed their meals.

We saw information in people's care files that health professionals were contacted in relation to people's health care needs such as doctors and the community health team. This was confirmed by the people who used the service and staff.

More comfortable chairs were needed for people to sit on in their rooms and the unit for people living with dementia needed improving with pictorial and written information available to assist people in orientating them to different parts of the environment to maintain their independence.

Is the service caring?

Requires improvement

The service was not always caring.

People and relatives made positive comments about the staff and people told us staff treated them with dignity and respect. This was supported by relatives, although we found occasions when this did not always happen.

Summary of findings

Although interactions between people and staff were mainly prompted by and based around tasks, we found staff interactions were patient and caring in tone and language.

Is the service responsive?

Inadequate

The service was not responsive.

People had assessments, care plans and risk assessments in place, but this was not always reflected in the care provided and risk assessments reviewed when needed as a consequence of any increased risk.

In the last four weeks there had been a lack of stimulating activities available for people to participate in or opportunities to maintain hobbies and interests.

There was a complaints procedure in place, but until recently relatives had not felt the registered manager had listened to their concerns.

Is the service well-led?

Inadequate

The service was not well led.

Relatives and staff reported the registered manager did not demonstrate good management and leadership of the home. They told us that she did not listen to worries or concerns they had, providing an appropriate response or taking action where needed.

There was an inadequate system in place to monitor and improve the quality of the service provided. Regular checks and audits had not been undertaken to make sure full and safe procedures were adhered to.

Warren Park

Detailed findings

Background to this inspection

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

This inspection took place over two days on 21 and 25 September 2015 and was unannounced.

On 21 and 25 September 2015, the inspection was carried out by an adult social care inspector. On 21 September 2015 a specialist advisor and an expert by experience assisted the inspector. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. This expert by experience was a full-time advocate for a relative and visited them daily in two different care homes, co-ordinating their care for four years. A specialist advisor is someone with specialist knowledge about aspects of the service delivered at the location. This specialist advisor had personal and professional experience over many years in the care of older people living with dementia.

The inspection included reviewing information we held about the service. This included correspondence we had received about the service and notifications required to be submitted by the service. We also gathered information from the local authority. This information was used to assist with the planning of our inspection and inform our judgements about the service.

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. This information was also used to assist with the planning of our inspection and inform our judgements about the service.

We used a number of different methods to help us understand the experiences of people who lived in the home. We spent time observing the daily life in the home including the care and support being delivered. We spoke with five people who used the service, 10 relatives or visitors, two healthcare professionals, 11 staff, a manager covering the service and a service manager. We looked round different areas of the home such as the communal areas and with their permission, some people's rooms. We reviewed a range of records including five people's care records, people's medication administration records, three people's personal financial transaction records, resident fund records, four staff files, maintenance records and quality assurance records such as audits related to the management of the regulated activity.

Inadequate

Is the service safe?

Our findings

People we spoke with told us that they felt safe and their relatives or friends supported this. One relative told us, "There were times earlier in the year when I didn't feel [relative] was safe because there were people from upstairs living down here and there were some people who would just walk into bedrooms or start hitting people, and I wasn't happy about that. But it's not like that now."

Staff we spoke with were familiar with what might constitute abuse and how they would report any concerns. We discussed with them their concerns about incidents they had reported to the registered manager, that they felt had not been appropriately dealt with, including incidents like those reported by a relative. This meant they had to escalate their concerns to Head Office.

We saw that people were relaxed in the company of care staff and that there were friendly and respectful interactions between them.

We looked at notifications received from the service and looked at care records to see how people were protected from bullying, harassment, avoidable harm and abuse that may have breached their human rights. We found notifications had not been received about some incidents relatives and staff had described. This meant the registered manager had not met their responsibilities in line with the Health and Social Care Act 2008.

We asked the manager covering the service for the review of accidents and incidents at the service. She was unable to provide an overview of any monitoring that was carried out of such incidents, but provided a number of accident/ incident files. We could not be assured that all accidents and incidents were in the file provided, as no records could be found after June 2015. Information to be recorded on the accident/incident form included the date of the incident, the name of the person involved, what the incident was, actions taken, investigation and follow up and sign off by the home manager. However, there was incomplete information in the majority of the forms to demonstrate that accidents or incidents had been fully addressed and resolved. For example, one record stated one person had punched another person on the head, but declined the nurse to check vital signs. There was no further record of any action taken, investigation or follow up and the record had not been signed by the home manager. This incident was a reportable incident to the Commission and to the safeguarding team. A review of our records did not reveal the incident had been reported as required. This meant systems and processes were not operating effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse.

Prior to the inspection we had received a notification of alleged financial harm.

During the inspection staff raised concerns that they had been told there were some people who used the service who did not have money to buy toiletries and clothes, and that they never knew what happened with money they raised for people who used the service.

One set of relatives told us they received receipts when they paid monies for fees, but there was no consistency about the form the receipt took, sometimes it would be a receipt book and other times on an invoice. Another relative also told us they had bought slippers for one person's birthday, because they didn't seem to get anything new.

We spoke with the covering manager and checked the finance records of three people and the residents fund.

There was no financial policy/procedure to identify the system and process to be used when dealing with people's finances. Individual records were in place, with a running balance of the money people had available. However, monies were not held separately for those people and the covering manager told us there was insufficient funds available to cover the running balance of the total of all the people who used the service. There was no system in place to tally receipts with payments paid and there were no signatories on the record to confirm the transactions. Likewise, for the resident funds. In addition, the resident fund record did not tally with the bank account for the fund. There were also handwritten entries with no explanation and entries that had been tippexed out. This information has been passed to the local safeguarding authority.

The service manager stated monies had tallied when they exchanged contracts as service provider, but no audits had been carried out since that time.

This meant effective systems and processes were not in place to safeguard people from financial harm.

Inadequate

Is the service safe?

The information above demonstrated a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Safeguarding service users from abuse and improper treatment.

We checked how the service managed risks at the service so that people were protected.

Subsequent to the inspection the covering manager provided a service record log to confirm servicing and checks of the environment to ensure it's safety, in addition to what we had seen during the inspection. These included equipment used for moving people, legionella, lift, fixed electrical wiring, fire safety and gas.

We checked that sufficient numbers of suitable staff were on duty to keep people safe and meet their needs.

People and all but one set of relatives we spoke with told us they thought there were enough staff on duty to support with their own, or their relative's care needs. One relative said, "When I come there's always carers around. They are busy, though." Another relative said, "I think the carers do a good job at making sure everyone's well cared for, but if there were more staff, they'd be able to chat a bit more, or do something a bit different with the residents." However, one relative told us of an occasion when they had been asked to escort their relative to hospital, because there had only been two members of staff on the unit caring for people with nursing and personal care needs.

Relatives we spoke with told us they did not see agency care workers at the home, but they did see a lot of agency nurses, although they were usually familiar agency nurses. One relative said "I know they do have a lot of agency nurses here, but at least they're regular agency nurses and you get to know them and they get to know the residents."

We spoke with the manager covering the home, checked staffing rotas at the home and carried out observations throughout the day to assess whether staffing levels were adequate.

On the day of our visits we saw that care workers were very busy with care tasks and at times care staff were not visible on the unit caring for people living with dementia as they were dealing with care needs in people's bedrooms, particularly after lunch. On the unit downstairs caring for people with nursing and personal care needs we observed care staff were not in lounge areas for more than an hour after lunch.

The registered manager had identified in the PIR the "Rhys Hern dependency tool" was used to identify the staffing levels required. However, the acting manager covering the service during the inspection was unable to provide us with a copy of this dependency tool. Therefore, we were not shown evidence of how the service made sure staffing levels were appropriate to meet people's needs. The covering manager told us there were currently 28 people who used the service, the same number the registered manager had identified in the PIR submitted in August 2015.

We inspected staff rotas from 17 August to 13 September 2015. We found consistency in the staffing arrangements at night, with the majority of nights identifying three care staff were on duty at night, plus a nurse. We found three agency care staff covered five of the 28 shifts. However, the rota identified on two night shifts there were two members of care staff on duty, plus a nurse. The nursing staff rota identified eight nursing shifts (day and night) were covered by agency staff, but the rota showed two shifts did not have a nurse on duty. The numbers of care staff covering the day shifts varied between four members of staff on seven day shifts, five members of staff on 31 shifts and six members of staff on 18 shifts. This meant there had been occasions when there had been only two members of care staff on the nursing and residential unit, which may impact on care staff escorting people to hospital.

The information above demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Staffing.

We looked at staff records of three staff members who worked at the home, including two nurses and a night care assistant. We found information and documents of pre-employment checks, including identification, references of their suitability to work with vulnerable adults and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups, by disclosing information about any previous convictions a person may have. There was no information or documents in two of the staff files to confirm the staff members right to work in the United Kingdom.

On the first day of the inspection two agency nurses were working at the service. The manager covering the service was unable to provide a contract from the agency to identify what checks had been undertaken on those staff

Inadequate

Is the service safe?

and verification those checks had been made. This meant staff were working at the service whose suitability to do so had not been verified with the employment agency. This meant the home had not demonstrated safe recruitment practices to ensure the safety of people who lived at the home and that they were appropriately trained to carry out their role and responsibilities.

The information above demonstrated a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Fit and proper persons employed.

We saw that medicines were securely stored in medication trolleys secured to the wall within the Nurses Station and Controlled Drugs within an appropriately locked cupboard within a locked room within the Nurses Station. We saw the medicine's trolley was locked between the administration of one person to another and the nurses approached people in a friendly professional manner.

We observed on both mornings of the inspection, the morning medication started at 9.30am and was completed approximately one and a quarter hours later. This meant there was a risk that people were not given sufficient time between their medicines and potentially longer than 12 hours between their night and morning medicines.

We checked Medication Administration Records (MAR). Each person had a photograph of themselves to identify them on individual MAR charts, so that they were identifiable to staff. This was particularly important given the use of agency staff. We found where prescriptions had been hand written onto the MAR, because of medicines prescribed mid cycle, the prescription had been confirmed by another member of staff, minimising the risk of medicines being administered incorrectly. We observed that when nurses administered medicines the MAR chart was signed by the administering staff member after the person had been given their medicines. This meant accurate records were in place for medicines that had been administered to the person. Where medicines were unused or a person had refused to take them, this was identified on the MAR.

We found some people were administered controlled medicines under the Misuse of Drugs legislation. The legislation impacts on care homes as they require special arrangements for storage, administration, records and disposal. The legislation states controlled drugs must be entered into the controlled drugs register as soon as they are received into the home. We found that this did not always happen. We brought this to the attention of the covering and service manager who said they would address the issue.

Requires improvement

Is the service effective?

Our findings

People we spoke with told us they thought staff were well trained and competent. We saw care staff carrying out care tasks competently, including turning people in bed and assisting people with limited mobility. We saw care staff distract one person who displayed behaviour that dominated other people away from them to minimise the risk of both parties becoming distressed.

One person using the service was receiving end of life care and the home were funded to provide nursing care. It had been arranged for district nurses to provide this care as nursing staff were not adequately trained to provide that aspect of their care.

The covering manager and service manager could not be confident in confirming the training staff had undertaken. They provided a staff training matrix used to check that staff received suitable and on-going training, but didn't know whether it was up to date. The training matrix identified 33% of staff had completed care planning guidance, 97% dementia awareness, 29% dignity, personal care, 21% equality and diversity, 90% safeguarding, 87% Mental Capacity Act and Deprivation of Liberty Safeguards and 64% challenging behaviour. Some staff had also received training in other topics relevant to the needs of people who used the service, for example, customer care, diabetes and falls. This meant records did not support staff had received all the training relevant for their roles and responsibilities, for example, health and safety, Control Of Substances Hazardous to Health (COSHH), tissue viability, moving and handling and infection control.

When we spoke with staff they described a range of training they had undertaken relevant to their roles and responsibilities, including, safeguarding, moving and handling, first aid, challenging behaviour and nutrition. We found the training three new staff had undertaken was insufficient for their role. Two staff had undertaken the companies induction programme, but felt it was insufficient to prepare them for their role. This was confirmed when we spoke with them about some of the training they had received. Both staff could not recall their competency being checked to confirm they were competent in the tasks that would be required of them. For the other member of staff, they had not worked in care previously and had only undertaken formal training in moving and handling. They had undertaken an informal induction with the registered manager for one day discussing topics associated with their role and responsibilities.

In one person's file a range of certificates were available to confirm the training they had undertaken that was relevant to their roles and responsibilities.

Supervisions are accountable, two-way meetings that support, motivate and enable the development of good practice for individual staff members. Appraisals are meetings involving the review of a staff member's performance, goals and objectives over a period of time, usually annually. These are important in order to ensure staff are adequately supported in their roles.

Discussions with staff told us supervisions were not undertaken on a regular basis.

The supervision policy/procedure we looked at did not identify a frequency for staff to take part in supervisions.

We looked at one staff file where the last supervision record was from May 2014 and the last appraisal December 2013.

The covering manager provided a supervision/appraisal file that contained an appraisal planner. We sampled four records and found that appraisals had been undertaken in accordance with the plan. We also found evidence that some supervisions had taken place, but none since December 2014. There was no evidence of supervisions since this registered provider had registered.

The above demonstrates a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Staffing.

The MCA (Mental Capacity Act 2005) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and in place so that where someone is deprived of their liberty they are not subject to excessive restrictions. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes and services.

We found records that told us for some decisions the home had acted within MCA 2005 legislation, so that people who were deprived of their liberty had appropriate DoLS

Is the service effective?

authorisations in place or had DoLS applications submitted to the local authority for authorisation. However, on the first day of our visit we saw nurses attending the home to give people their flu jabs. The nurses told us they had a list of people who had given consent for the jabs, although they did not know how the consent had been obtained. When we spoke with relatives they told us they had been asked for their permission to give the flu jabs. We looked at both those people's care files and found they lacked capacity to make the decision themselves. There was no information in the care file to confirm the care home had acted within MCA 2005 legislation and the outcome of any best interest decision that had been taken. Best interest meetings are held to ensure that any decisions made about the care, treatment and support of a person are done so in their best interests.

Staff we spoke with were able to explain the main principles behind the MCA 2005 and DoLS and what this meant for people who lived at the home, although understanding of this was limited.

The above demonstrates a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Need for consent.

We checked the systems in place to ensure people were supported to have sufficient to eat, drink and maintain a balanced diet.

In care records we looked at, we saw nutritional assessments were completed to assess whether the person was at risk of becoming nutritionally compromised.

People we spoke with told us they enjoyed their meals. We also spoke with relatives about the meals provided. One relative told us they were particularly happy that recently people had been allowed to have cooked breakfasts every morning if they wished. Their relative really enjoyed this meal. The relative said, "It's the best meal of the day for [relative]."

We saw there was a choice of two hot lunches one of the days of our visit. We saw that people who needed support with their meals were served first and only after they had finished their meals, were the remaining people who were served their meals in the dining area, lounges or in their bedrooms. The lunches were large portions and looked appetising.

In the unit for people living with dementia, some people left some of their meal. A member of care staff told us that several people had, had a large breakfast and were not very hungry. We saw a member of care staff take hot meals to two people receiving care in their bedrooms and left their meals with them. Both people were awake. We went back to the bedrooms at 3.15 pm and one person still had their meal untouched by their bedside. This person was still awake. We brought this to the attention of the covering manager who said she would speak with staff. People told us they had plenty to drink throughout the day. We saw warm drinks served mid morning and mid afternoon.

Care staff confirmed what relatives had told us and that meals for people had improved recently when the covering manager had commenced, for example, the provision of a cooked breakfast in a morning. Staff told us that people with mental capacity were asked for their choice of meal the day before. For people without the mental capacity to choose a meal, care staff would choose an appropriate meal, using their knowledge of the person's likes and dislikes.

We checked that people were supported to maintain good health, had access to healthcare services and received on-going healthcare support.

Relatives told us that care staff would call a GP if their relative became ill. One relative told us that recently a GP had been called to their family member because staff suspected a urine infection.

We also spoke with a GP who was attending the home. They told us they attended each week to provide support to staff and ensure people who used the service had access to healthcare services and receive on-going healthcare support.

We saw care records contained details of visiting healthcare professionals that the person had seen and details of those visits. This meant staff involved professionals, so that people received intervention for their healthcare needs to support them to maintain good health and have access to relevant healthcare services.

We checked that people's needs were being met by the adaptation, design and decoration of the service.

Requires improvement

Is the service effective?

Overall the home was appeared clean, but despite having new carpets there remained and unpleasant odour in some parts of the building, which the covering manager was trying to address.

We saw in a number of bedrooms that the chair provided for the person to sit and relax in was not a comfortable armchair, but more of a dining chair. We spoke to one relative who told us they thought the armchair supplied for their family member 'was not great for sitting in all day' and was of the dining room type. This person spent all of their time in their room, either in bed or in their chair. We raised this with the covering manager who said they would look into this and put an action plan together to address the issue.

The communal areas were bright and well decorated, with new carpets throughout. However, the environment on the first floor was not dementia friendly. There was no colour coding for doors on the corridor, with sufficient signs around both pictorial and written to aid people to different areas of the home and what might be behind closed doors. There were no reminiscence displays and no memory boxes by bedroom doors to assist people living with dementia to independently find their own bedroom. There were some attractive, tactile, woollen tapestries on the corridor, but originally these were placed too high to be used as a sensory experience. The covering manager had addressed this by the second day of our visit.

We discussed the environment for people living with dementia with the covering manager. She was aware of the need to improve the area, but had identified other priorities, such as the care of people to address first.

Requires improvement

Is the service caring?

Our findings

People and all relatives we spoke with told us staff were caring and compassionate in their approach. We observed this when staff were interacting with them. Their comments about care staff were complimentary and included, "They're brilliant, so caring and thoughtful," "I can't fault these carers, they work like stink and still manage to smile," "I think the carers have a lovely way with [relative]. She's not always easy to help, but they just seem to know how to get the best out of her," "I'm happy here. The carers are all my friends and I love them all" and "The carers are just wonderful. They have the patience of saints."

We saw that staff interactions with people and relatives were warm and friendly. Care staff knew the preferences of individuals, such as where they liked to sit and how to make them comfortable. Care staff knew relatives by name and greeted them warmly. Relatives we spoke with told us that care staff were always friendly and approachable.

One relative told us they were particularly pleased with the supportive attitude of the care staff towards their family as their family member was receiving end of life care. They said, "As a family, we're all very grateful for the way the carers are supporting us. It's a difficult time and they're really helping us cope."

However, we saw examples of care provided that did not demonstrate a caring approach towards people. For example, we found one person's room untidy and unclean, with bedding not made up and food remnants on the floor. We saw that a visitor was picking up some of the food remnants on the floor of this person's room and they said, "Her room is always such a mess." When we asked a member of care staff why the room was so untidy and unclean, they explained the person refused personal care and would not allow people to clean their room whilst they were in their room, which they were most of the day. However, we had seen this person spend the morning in the lounge, which gave staff plenty of opportunity to clean the person's room. We checked the cleaning schedules for this person's room and it identified the room had been cleaned. This was identified to the covering manager who said she would address with staff.

We saw in some rooms that some bedding was of poor quality, for instance a torn pillow slip and thin sheets.

We also saw another person's room where the bed had been made. The sheets and one pillow case had stains on them that looked like blood, with a toilet roll under the two pillows. One of the pillows did not have a pillow case on them. The top sheet was covered with a fleece blanket. When we spoke with the relatives of the person they said the room wasn't usually like that and their relative usually had a duvet. We spoke with a member of staff who showed us where linen was stored. There was ample clean sheets, pillow cases and duvets. We raised this with the covering manager who arranged for clean bedding and duvet, so that the person's dignity was maintained.

People we saw looked clean and well groomed, apart from the people who, we were told, often refused personal care. We saw one person with a stained top on during the morning, which was not changed.

When we observed staff interaction with people, they were familiar with them and their life histories and knew their likes and dislikes and they approached discussions with people in an informed manner. Our observations identified a respectful relationship between the staff and people.

It was clear from our discussions with care staff that they enjoyed caring for people living at the service, because they spoke of people in a caring and thoughtful way. Care staff demonstrated familiarity and knowledge of people's individual needs, life history, their likes and dislikes and particular routines.

Throughout our inspection, we observed staff giving care and assistance to people. At those times we found staff were respectful and treated people in a caring and supportive way. We also saw signs on people's doors to inform people when personal care was taking place and to maintain people's privacy. However, whilst we were speaking with relatives in a person's room, two members of staff entered the room without knocking. This does not show respect for people's personal space.

Inadequate

Is the service responsive?

Our findings

On both days of the inspection we did not observe any activities taking place. People we spoke with told us there had been no activities since the activities co-ordinator left several weeks ago. All of the people we spoke with told us they missed the activities as they used to do activities such as play bingo, bake cakes, make cards, go on trips, watch films and enjoy sing songs.

We saw that care staff did not engage people in meaningful activities. On the first day of the inspection we saw two care staff sitting in the ground floor lounge with people in the afternoon, but they were writing their notes and did not engage with people in the lounge. We saw that most people spent almost the whole day asleep. We spoke to one person who told us they liked knitting. We saw there was a knitting bag next to their chair, but we did not see any care staff prompting them to do their knitting.

We saw that the televisions were switched on in all the lounges, but no-one was watching them. One relative said, "I don't know why they always have the television on because no-one ever watches it. Sometimes I just change the television to Smooth Radio because music is much better than television. I think they could put more music on. At least people can sing along or tap their feet then."

We saw there were very few resources to engage people living with dementia in meaningful activity, for example, visible rummage boxes, apart from one person who was enjoying cradling a doll. A rummage box is a means of tapping into memories from the past and helps people living with dementia to feel empowered and secure in familiarity. It is about reminiscence. The rummage box can be used as an activity, as a distraction technique and therapeutically as a reminiscence tool.

The covering manager told us a new activity co-ordinator had been appointed and they were just awaiting all the information and documents as part of their pre-employment checks before they commenced duties.

Relatives we spoke with told us they were involved in regular care plan reviews for their family members. One relative said, "We've got a review coming up soon and I always find it useful, because we can tweak things if necessary."

One relative whose family member was receiving end of life care was pleased with the way care staff responded to their family member's changing needs. The relative said, "The staff organised a syringe driver last week. They explained everything to [relative] and she's been so much more comfortable. Also, [relative] said the duvet was too heavy and hot, so the carers swapped the duvet for a lighter fleece straight away and she's been much more comfortable since." A syringe driver helps to control pain, sickness, agitation or fits by reducing symptoms through delivering a steady flow of injected medication continuously under the skin.

Care records we looked at did contain personalised information and information about whether the person or their advocate wished to be involved in their plan of care. However, we found that the service had not always responded to people's needs in accordance with their plan of care. For example, for one person the plan of care stated the person was to be taken to bed each day after lunch to relieve pressure areas and moved two hourly. In addition, that to prevent falls for the person a staff member was to be present in the lounge at all times. We observed the person was not moved two hourly, taken to bed after lunch or that there was a staff member in the lounge at all times.

One relative said, "The carers are lovely, but I'm not sure if they're looking after [relative's] legs properly. She needs lots of cream and plasters replacing regularly and I'm just not sure that always happens, so when I come I always put cream on her legs and keep a supply of plasters in the room so I can change them." We looked at this person's care file and medication administration record (MAR). The MAR identified the person was prescribed creams prescribed to be administered as often as needed, but there was no record it had been administered. The person's care plan recorded that cream was to be applied. We spoke with three members of staff working on the unit where the person resided and none knew of the cream to be applied. The cream was found in the person's wardrobe and had been used.

We spoke with a visitor of another person who said, "I think [person] has only had one bath in two months. I know she can be difficult, but that's a long time without a bath". We asked two members of staff how we might find out when

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Is the service responsive?

people had, had a bath. They didn't know, because they said the recording system for how they did this was in the process of changing, so since September 2015 they had not recorded when people had, had baths.

We saw one person tried to use a knife at first to eat their meal, which was chicken curry and then used either their fingers or a spoon. Care staff gave this person various utensils during the meal, but when left on their own the person often resorted to using their fingers. This person did not eat much of their meal. We looked at the person's care plan where it was identified the person ate independently and used cutlery appropriately.

The above demonstrates a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Person-centred care.

Relatives we spoke with told us that if they wanted to make a complaint they would see the manager. Relatives we spoke with told us that they thought the new manager was much more approachable than the previous manager and would sort out any problems they had. One relative said "There was no point going to see the previous manager. She just dismissed everything you said. I think she also ripped out pages in the comments book when there was a complaint in there. But the new manager does listen to you."

One relative had contacted the provider by telephone when they were concerned about people living with dementia moving downstairs during some refurbishment. This relative was pleased with the helpful response as the member of staff from the provider company explained that the people living with dementia would move back to the first floor when the refurbishment upstairs was complete. The relative said "I felt much better hearing it from the horse's mouth."

We noted that the complaints procedure was displayed prominently in the corridor areas.

The covering manager provided the complaints file held at the home. We saw that two complaints were recorded, each showing some response to the complainant.

When we spoke with staff they did not feel that their concerns were listened to by the registered manager and had felt the need to escalate their concerns to Head Office.

The service manager provided complaints that had been received by Head Office. These evidenced the complaints had been forwarded to the registered manager to investigate. There was no record of these in the home's complaint file.

This meant an effective, accessible system was not in place to identify, receive, record, handle and respond to complaints made by people and others.

The above demonstrates a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Receiving and acting on complaints.

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Is the service well-led?

Our findings

It is a condition of registration with the Care Quality Commission (CQC) that the home have a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run. On the day of our inspection, the person managing the home was not the registered manager.

We asked people, their relatives and staff if they felt there was openness and transparency at the home.

Most people we spoke with knew who the acting manager was and they were all very complimentary about her.

Relatives said, "At last we've got a manager who listens and sorts things out. I was thinking of moving [relative] a few months back, but she's turned things round and I know things are only going to get better. It's such a relief," "We're going in the right direction now and the staff are all happier. So we're happier too" and "You see [acting manager] walking around the home and she speaks to you, which is more than the old manager ever did. And that makes you feel she cares."

Two relatives told us that they thought some staff had left the home due to not getting on with the previous manager, but now "the staff are a lot happier with the new manager, so that makes us feel that the home is a better place for [relative] to live."

Staff told us they felt communication with the registered manager was not effective as they felt she did not listen or act on their concerns.

We asked the acting manager for minutes of staff meetings. The home manager brought us a file that they said contained minutes of meetings that had taken place. There was evidence of flash meetings that staff had told us about, but it did not identify the roles of staff who attended the meetings. The last meetings that had taken place were in April 2015. The content was dictatorial in nature with topics showing no evidence of discussion, just statements to be adhered to. We found a staff meeting planner that identified when staff meetings were to take place. There was no record for the one identified for April 2015, and the record for May 2015 stated no staff attended. A qualified meeting had taken place with one nurse and the registered manager and one head of department meeting.

We saw the resident meeting schedule displayed for people, together with minutes of the last meeting. These had been held with the previous activity co-ordinator. No action points were identified in regard to outcomes of discussions that had been held. This meant there was no effective monitoring of actions as a result of the meetings, to measure any improvements in people's experiences of the service.

When we spoke with relatives, they knew of some meetings that had taken place, because they had attended them, but the records we saw stated no-one attended.

We spoke with the service manager. She confirmed no external auditing of the service had taken place. This meant there had been no oversight by the registered provider, that the registered manager was complying with regulations in accordance with their roles and responsibilities as registered manager.

We were provided with various files by the acting manager, including a green audit file that included audits for the kitchen, daily charts, care documents, medicines, personnel, financial, environment, domestic, infection control, dignity, meals and nutrition, maintenance, health and safety and reports. We found records for the audits ceased in March 2015 and no other audits were available. We spoke with the acting manager who explained if they were not in the files provided, she couldn't confirm any had taken place. We found another one in a separate medication audit file, but this was from months previous and the acting manager found another in the office. We found the evidence did not support our findings from the inspection, for example, the recording of the receipt of controlled drugs meaning the audit had not been effective in improving practice to maintain legal compliance with legislation.

We spoke with the acting manager about accident/incident monitoring that had taken place. She was unable to explain where these might be or of any monitoring of accidents and incidents that had taken place, to assess if systems and process in place were satisfactory and that any investigations needed took place, but provided various files, with different headings. One was accident/incident

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folder, another safeguarding/contracts. Both contained accident/incidents from various months in the year. The forms identified safeguarding incidents that had not been reported to CQC. There was no record of some incidents that we knew had taken place since that time, from people's daily records and from what staff had told us.

Three of those identified notifications to CQC should have been made, but there was no record of these. This meant safeguarding concerns and alerts had not been regularly reviewed to identify any themes or trends.

The above information demonstrates a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints An effective system was not in place to identify, receive, record, handle and respond to complaints by service users and other persons in relation to the carrying on of the regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed appropriately to meet people's needs. Persons employed had not received such support, training and supervision as is necessary to enable them to carry out the duties they are employed to perform.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed All information specified in Schedule 3 was not available for all person's employed.

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 9 HSCA (RA) Regulations 2014 Person-centred care The care and treatment of service users did not meet their needs.

The enforcement action we took:
Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Effective systems and processes were not in place to prevent abuse of service users and to investigate immediately upon becoming aware of, any allegation or evidence of such abuse.

The enforcement action we took:
Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes were not established to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk arising from the carrying on of the regulated activity.

The enforcement action we took:
Warning Notice