Advinia Health Care Limited

Cloisters Care Home

Inspection report

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Ratings

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

Overall summary

The inspection took place over two days on 22 and 26 June 2015. The visit on 22 June 2015 was unannounced. We notified the provider we were returning on 26 June 2015 to gather more evidence and to feedback our findings.

The last inspection of the service took place on 20, 22 and 26 January 2015 when the service was rated inadequate and we identified six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and one breach of the Care Quality Commission (Registration) Regulations 2009. At the inspection on 22 June 2015 we found that the provider had taken action to meet some but not all of these breaches. There was evidence that they had focussed on improving some areas of the service. However, they had not taken enough action in other areas and we identified additional areas where people's safety and wellbeing were at risk.

Cloisters Care Home is a nursing home for up to 58 older people with nursing needs. The ground floor was also for people who were living with the experience of dementia. At the time of our inspection 55 people were living at the

Summary of findings

home. The home is managed by Advinia Healthcare Limited, a private company who manage 16 residential and nursing homes and home care services in England and Scotland.

There was a registered manager in post. 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.

The staff followed practices which put people's safety and wellbeing at risk.

Parts of the environment were not clean.

People's medicines were not managed in a safe way.

We observed and people told us that they were not always treated with kindness and respect.

People's privacy and dignity was not always respected.

People's emotional and social needs were not always met. People were not always given care in a personalised way which met their individual needs.

The provider had audits and quality checks which they carried out but these had not identified areas of concern and they had not taken action to mitigate the risks to the health, safety and welfare of people who lived at the home.

Some people felt the culture of the home was not always positive, whilst others were satisfied with this.

The provider had taken action to improve some practices. For example, they had made sure call bells were accessible, they had improved the records of risk assessments and they had taken action to minimise the risks of repeated accidents and incidents.

There were procedures for safeguarding vulnerable people and the staff, people living at the home and visitors were aware of these.

The provider had improved the systems for obtaining and recording people's consent to their care and treatment. They had assessed people's capacity to consent.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLs). DoLS provides a process to make sure that providers only deprive people of their liberty in a safe and correct way, when it is in their best interests and there is no other way to look after them. The provider was aware of their responsibilities and had acted in accordance with the legal requirements.

The staff had regular meetings with their manager to appraise and discuss their work. They had been trained to understand their roles and responsibilities.

People's nutritional needs had been assessed and recorded. They were provided with a choice and variety of freshly prepared meals.

We observed and people told us about some members of staff who were kind and caring and who took the time to listen to people.

People's needs had been assessed and these were recorded in care plans.

The provider had a complaints procedure and had investigated and responded to complaints which had been made.

We found four breaches of the Health and Social Care Act 2008 and associated Regulations. We have taken against the provider for the breach of the Regulations in relation to the safe care and treatment of people using the service (Regulation 12) and the good governance of the service (Regulation 17).

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:

• Ensure that providers found to be providing inadequate care significantly improve

• 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.

• 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 inadequate for any key question or overall, we will take

Summary of findings

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.

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 staff followed practices which put people's safety and wellbeing at risk.

Parts of the environment were not clean.

People's medicines were not managed in a safe way.

The provider had taken action to improve some practices. For example, they had made sure call bells were accessible, they had improved the records of risk assessments and they had taken action to minimise the risks of repeated accidents and incidents.

There were procedures for safeguarding vulnerable people and the staff, people living at the home and visitors were aware of these.

Is the service effective?

Good

The service was effective.

The provider had improved the systems for obtaining and recording people's consent to their care and treatment. They had assessed people's capacity to consent.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLs). DoLS provides a process to make sure that providers only deprive people of their liberty in a safe and correct way, when it is in their best interests and there is no other way to look after them. The provider was aware of their responsibilities and had acted in accordance with the legal requirements.

The staff had regular meetings with their manager to appraise and discuss their work. They had been trained to understand their roles and responsibilities.

People's nutritional needs had been assessed and recorded. They were provided with a choice and variety of freshly prepared meals.

People's healthcare needs had been assessed and recorded. Their health was monitored and they had access to healthcare services which they needed.

Is the service caring?

Requires improvement

The service was not always caring.

We observed and people told us that they were not always treated with kindness and respect. People's privacy and dignity was not always respected.

We observed and people told us about some members of staff who were kind and caring and who took the time to listen to people.

Summary of findings

Is the service responsive?

Requires improvement 

The service was not always responsive.

People's emotional and social needs were not always met. People were not always given care in a personalised way which met their individual needs.

People's needs had been assessed and these were recorded in care plans.

The provider had a complaints procedure and had investigated and responded to complaints which had been made.

Is the service well-led?

Inadequate 

The service was not well-led.

The provider had audits and quality checks which they carried out but these had not identified areas of concern and they had not taken action to mitigate the risks to the health, safety and welfare of people who lived at the home.

Some people felt the culture of the home was not always positive, whilst others were satisfied with this

Cloisters Care Home

Detailed findings

Background to this inspection

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

The inspection took place over two days, the 22 and 26 June 2015. The visit on 22 June 2015 was unannounced. We told the provider we would return on 26 June 2015 to complete our inspection and feedback our findings.

The inspection team on 22 June 2015 consisted of four inspectors 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 inspection was someone who had experience of caring for a relative and supporting other people who had dementia. On 26 June 2015 the inspection team consisted of two inspectors.

Before our inspection we looked at all the information we had about the service, including notifications of events since the last inspection and the last inspection report from January 2015. We spoke with the local authority commissioning team who had visited the service to carry out their own monitoring and we looked at the reports of these visits.

During the inspection we spoke with 15 people who lived at the home, nine visitors and 12 members of staff, including the registered manager, nursing staff, care assistants and the activity co-ordinators. We also met Advinia's chief executive officer who was visiting the home.

As some people were not able to contribute their views to this inspection, we carried out a Short Observational Framework Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

We observed how people were being cared for, including spending time with people when they had meals. We looked at the environment and equipment used at the home. We looked at the records at the home, including eight of care plans, two staff recruitment files, staff support and training records, records of accidents and incidents and the provider's own quality monitoring. We also looked at the way in which medicines were managed, including the storage and records of these.

Inadequate

Is the service safe?

Our findings

During our inspection of 20 January 2015 we found that people were not always protected against the risks of unsafe care and treatment because they did not always have access to their call bells and because risk assessments did not describe ways the staff could minimise the risks to people's safety and wellbeing.

At this inspection we saw that call bells were placed within people's reach and the manager told us checks were made by the staff twice a day to ensure call bells were within reach and were in working order. The recorded risk assessments had been improved to include clearer information about how risks to people's safety could be minimised.

During our inspection of 20 January 2015 we found that the registered person did not have systems in place to ensure people received safe care because records of accidents and incidents did not include action taken to reduce the risk of similar events.

At this inspection we saw that records of accidents and incidents had improved and included an analysis of the accident and action taken after this. We also saw that the provider reviewed all accident and incident records each month and prepared a report on the action taken and preventative measures.

At this inspection we observed practices which put people's safety and wellbeing at risk. For example, the door to the sluice room on the ground floor was unlocked and open on 22 June 2015 and the doors to the sluice rooms on both floors were unlocked and open on 26 June 2015. The room contained bottles of cleaning products. Some of these were not labelled and did not indicate what the contents were. One bottle was labelled ''urine cleaner'', one was labelled ''disinfectant'' and another bottle did not have a label. On 26 June 2015 we found an unlabelled bottle of cleaning product and another bottle with a handwritten label ''disinfectant'' in an unlocked cupboard in a kitchen used by people who lived at the home.

We noted that one person's care plan stated they required thickened fluids and a soft diet to prevent the risk of choking. Their care plan stated they should be observed whilst drinking and eating. The person was given two biscuits and a glass of squash which had not been thickened. The person was then left without any staff supervision whilst they ate and drank. In another incident a person was coughing and sounding distressed after a member of staff gave them a tablet. The member of staff continued to hold a spoon with tablets to their mouth and then a drink to the person's lips. The person had to push both the drink and tablets away to stop the member of staff. A second member of staff attempted to put a protective tabard around their neck whilst they were coughing. These practices put the person at further risk.

This was a breach of Regulation 12(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Parts of the environment were not clean. The provider had not assessed or managed the risks of the spread of infection. Throughout the morning of 22 June 2015 there was a malodour in parts of the ground floor, in some bedrooms, the linen cupboard, the corridors and bathrooms. Bathrooms and toilets on the ground floor were not cleaned sufficiently. For example, one shower room had cobwebs and the drain in the shower contained hair and other debris; one of the toilets was stained with brown drips on the outside and surround; a panel on a bath was broken and coming away from the bath, the area behind this contained dirt and debris; the area behind and to the side of one bath was dusty and stained; the tiles in one shower room were cracked and damaged presenting a risk as they could not be properly cleaned; the floor in another toilet was sticky and marked. The visitor's toilet had a malodour throughout the day. A cushion on a chair in a ground floor lounge was covered in a bin liner which had been ripped. A cushion left in a bathroom was marked with brown stains. There was a yellow lumpy spillage on the carpet in one lounge. This had been covered by a chair which was moved by a person wanting to sit down. The staff moved the chair back over the spillage. Although we saw staff cleaning the environment throughout the day, some of these smells and dirt were not attended to. Tiles in the bathrooms on the first floor were cracked or missing presenting a risk that these could not be properly cleaned.

On 26 June 2015 we found some areas of the building had a malodour. These included the large lounge and a bathroom on the ground floor.

Inadequate

Is the service safe?

The provider has told us malodours on the day of the inspection were in part related to the health conditions of some people. They told us that a survey of people living at the home in May 2015 included feedback from 19 people that there was a ''pleasant smell on the premises.''

On 22 June 2015 a member of staff handed people a hot drink and biscuits. They handled the biscuits without the use of tongs or another implement. They also attended to other tasks, for example cleaning spillages and moving furniture, and did not wash their hands between these tasks.

During our inspection the staff supported one person to change out of a dirty pair of trousers. The trousers were left on the weighing chair in a communal bathroom and were there over an hour later.

One relative told us the cups and crockery were not always clean. They showed us a drinking beaker that had been given to their relative shortly before, which was stained and marked. During lunch on the first floor we noted that one table cloth was stained with food marks before the meal was served. Cutlery was dull and had limescale marks.

One person told us, ''The housekeeping isn't very good.'' They showed us their relative's duvet cover which was damaged with missing buttons. They said, '' I've spoken to them about this on a number of occasions but it seems to make no difference.''

This was a breach of Regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the storage, recording of receipt, administration and disposal of medicines and people's records in relation to the management of their medicines. We looked at medication administration records (MAR) for 11 people on the ground floor dementia unit. We found that none of the 11 MAR we looked at were completed fully and accurately.

The quantities of some medicines received at the service had not been recorded on the MAR for ten of the people using the service. The nurses on this unit were unable to tell us if this information had been recorded on any other record. Therefore it was not possible to check whether these medicines had been administered as prescribed. This meant that appropriate arrangements were not in place for the recording of medicines received at the service.

We found that some medicines had not been signed for as being administered for four of the people we looked at. For one person we saw that the MAR recorded that they had been prescribed four tablets of a medicine to be taken weekly. We found that on week three of the medicine cycle they had refused the medicine, and in week four there was no signature as to whether the medicine had been administered or refused. We checked the disposal records for this person and found that there was no record for this medicine being disposed of. There was no explanation recorded on the back of the MAR. When we asked the nurse about this she speculated that the person could have 'spat it out'. For another person we found that an antibacterial eye drop, prescribed to be administered four times a day, was not being used as often as prescribed. The MAR showed it was being administered three times a day and on two occasions there were no signatures to say that it had been administered. This meant that this person was placed at risk of receiving inadequate treatment for their eye infection, which could have affected their health. This meant that appropriate arrangements were not in place for the safe administration of medicines.

We checked stock balances for some medicines for four people. For one person the MAR recorded that 100 tablets had been dispensed. The stock showed that there were 88 tablets. The staff could not account for the 12 tablets and the MAR for this person did not detail if this medicine had been administered. For another person the medicine balance recorded that there were 12 tablets in stock for a diuretic medicine. We checked the stock balance for this medicine and found that there were 26 tablets in stock. When we asked the nurses to locate the previous MAR for this person they were unable to find it and we were unable to confirm whether the person had been administered this medicine. Missing doses of this medicine could have affected the health and well-being of this person. This meant that appropriate arrangements were not in place for the recording and safe administration of medicines.

We found that a person had been prescribed an anticoagulant medicine. The MAR recorded that 28 tablets had been received, however the number of signatures on the MAR indicated that 46 tablets had been administered. The MAR did not record whether any medicine had been carried forward from the previous medicine cycle and when we asked the nurses on the unit for the previous months MAR they were unable to find it.

Inadequate

Is the service safe?

Medicines that were no longer being prescribed for a person were stored in the medicine fridge and in the controlled drugs cupboard. When we asked the nurses on the unit why they had not been disposed of they were unable to provide an explanation. We found two tubes of a steroid cream in the fridge, dates of dispensing were 21/2/15 and 21/4/15. No dates of opening had been recorded. We found a bottle of protein and calorie liquid, which was sticky, half full, undated and had no name of the person who it was prescribed for. When we asked one of the nurses who it was for they took the bottle, wrote the name of a person and the date previous to our inspection and handed it back to us.

We asked the nurses how they monitored the medicines on the unit. They told us that weekly audits were carried out and that the manager and deputy manager also carried out monthly audits. We looked at the weekly audits carried out for the ground floor dementia unit. We checked the audits for 13 and 25 May 2015 and 3, 10 and 18 June 2015. The audit carried out on 18 June 2015 indicated that there were no issues with the medicines identified. Where issues had been identified in the other audits these did not always detail which person they related to. For example, the 3 June audit stated that two signatures were missing but did not detail the people this related to, the 10 June audit found that codes were not correctly recorded, again the audit did not identify which people this related to. The last manager's monthly audit was dated 21 April 2015. This had been given a score of 98% which was a 'good' rating. This meant that these checks had not been effective in identifying and addressing issues with the management of medicines that we found at the inspection and that people using the service were not protected from the risks associated with the unsafe management of medicines as the quality assurance checks for medicines were not effective.

This was a breach of Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some of the people who lived at the home and their visitors thought that there were not enough staff to meet their needs. Some of the things they said were, ''You can wait up to twenty minutes before they come and answer the call bell" ,''There is a lack of continuity and consistency the staff do not have time to meet people's needs'', ''you have to wait a long time if you want someone to help you'', "I don't think that there are enough staff, if there were enough staff they would have the time to listen to what [relative] is saying. Because they don't this increases the level of frustration" and ''they leave us alone and forget about us'' Staffing rotas indicated that the provider employed sufficient staff, however some of these staff were temporary and they did not know people's individual needs.

The service followed safe recruitment practices. We viewed two staff recruitment files which detailed that the relevant checks had been completed before staff began work. These included two references, one from their previous employer, a check conducted by the Disclosure and Barring Service (DBS) to show they were not barred from working in adult social care and proof of the person's identity and right to work in the UK.

The provider had a procedure for safeguarding vulnerable adults. Copies of the procedure and information about recognising and reporting abuse were shared with people who lived at the home and their relatives. Information was included in the service user guide which was placed in all bedrooms. The staff had been trained in this area and regular refresher training with the local authority had been organised. The staff were able to tell us about different types of abuse and what they would do if they felt someone was being abused. They knew about the local authority procedures and that they should report any concerns. There was evidence the provider had worked with the local authority to help investigate and act on concerns which had been raised. These had been recorded, along with the investigation and action taken by the provider to help protect people.

There were recorded risk assessments in people's care plan files. These included assessments of nutritional risk, risk of moving around and the use of equipment. The staff had updated these assessments each month and there were clear actions to state what the staff needed to do to minimise risks.

Good

Is the service effective?

Our findings

During our inspection on 20 January 2015 we found people had been deprived of their liberty in an unsafe and unlawful way because the provider had not acted in accordance with their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

At this inspection we found the provider had acted in accordance with their legal responsibilities. The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLs). DoLS provides a process to make sure that providers only deprive people of their liberty in a safe and correct way, when it is in their best interests and there is no other way to look after them. The provider had identified where people lacked capacity to consent to their care and treatment. They had carried out assessments for each person and these were recorded. Where a decision had been made to deprive someone of their freedom or liberty, for example restricting their ability to leave the building and the use of bed rails to prevent them getting out of bed without support, there was a record to show that this decision had been made by a group of people in their best interest. The person's next of kin had been involved in making these decisions. The provider had made applications to the local authority for them to authorise these decisions. We saw records of the assessments, decisions and applications under DoLS.

Where possible people's consent to their care had been obtained and they had signed their care plan. Where people did not have capacity, assessments clearly indicated this and relatives had signed on behalf of the person.

We viewed Do Not Attempt Resuscitation (DNAR)' documents for five people. These documents indicated an agreement not to attempt to sustain or prolong life should the person stop breathing. In one case the document did not contain evidence that the person had been consulted about this. Their care plan indicated they had capacity to make this decision. The other DNAR forms had been correctly completed and included information about the person's wishes and consent.

There was a nutritional assessment for each person and this had been updated monthly. These included information about people's allergies, assistance required and any specific nutritional needs. People were weighed monthly. There were nutritional need care plans for each person.

In the majority of cases the assessments and care plans contained the required information. However the information in two of the care plans we viewed was incomplete. For example, one person had an assessment which indicated they were at high risk of malnutrition. There was no evidence the person had been referred to a dietitian for additional support and guidance about how these risks could be managed. The person had been assessed by a speech and language therapist for swallowing difficulties but the details of this assessment and recommendations for the person's care plan had not been recorded. The care plan stated that the person should be weighed weekly, however the records of their weight were monthly. In another case a person had been referred to the dietitian in April 2015. There was no record of this or any outcome from the referral. The information in the person's care plan was limited and did not clearly indicate how their nutritional risks could be managed.

People's opinion of the food varied. One person told us, ''The vegetarian food is very poor, even though we have provided the chef with simple recipes that would be easy and cheap to deliver. It's disappointing." Another person said that the food served on the day of our visit tasted ''burnt''. Other people told us the food was ''alright'', ''nice, hot and varied'', ''the food's not bad'' and ''quite nice.''

Menus were printed and available on the dining tables each day for people to see. People told us they were able to make choices about what they ate. They also said they met with the chef and activities coordinator to discuss the menus. They said that changes to menus had been made as a result of their feedback and comments.

We observed people being offered breakfast and lunch during our inspection. During breakfast on the first floor people were offered a choice of fruit alongside their cereal, porridge and toast. People on the first floor were offered a choice of different meals for lunch and the staff took note of their individual choices and preferences. At lunch time people were served the meal of their choice in varying portion sizes. However, people were not offered sauces or condiments and these were not available on the tables. One meal choice at lunch time was spaghetti bolognese, but people were not offered cheese with this.

Good

Is the service effective?

The chef told us they were given information about people's food preferences and any special dietary requirements. Records of food storage and hot food temperatures were maintained and indicated these were appropriate. The kitchen was stocked with fresh vegetables and food and the catering staff freshly prepared rather than reheated meals.

People told us they were able to see their GP when needed. They told us communication between the staff, GPs and other health professionals was good and they felt their needs were met. The home employed nursing staff to meet people's nursing needs. Assessments of their health and wellbeing were made each month and we saw records of these. Where people had wounds there were appropriate care plans to state how these should be treated. Information was regularly updated.

Some staff told us they felt supported. They said they had regular individual and team meetings. One member of staff told us they were able to raise concerns with the manager. Some staff said, ''we are fairly well supported.'' However, other staff told us they did not always feel supported although they said they had regular meetings. They were not able to tell us how they felt unsupported although they told us there were not enough staff and they had too much to do. The staff told us they had regular training and had received an induction when they started work. They were able to tell us about training in safeguarding adults, moving people safely and health and safety. They told us training was regularly updated. The provider had a training plan which included information about when staff were due to participate in specific training courses and where there was an identified training need.

Requires improvement

Is the service caring?

Our findings

During our inspection of 20 January 2015 we found that people's privacy and dignity was not always maintained because the provider had displayed photographs showing the staff how to support someone and these photographs did not protect the person's privacy and dignity.

At this inspection we found these photographs had been removed.

However, people's privacy and dignity were not always respected.

We saw that one person was lying flat on their back with their eyes open looking directly at an overhead light which was on. There was no other entertainment in their room. We saw another person lying in bed with their eyes closed whilst a member of staff vacuumed their bedroom floor. We observed a nurse putting on disposable rubber gloves before entering a person's bedroom. This practice suggested they were about to perform some intrusive or personal procedure, as they entered the room they did not greet the person. The member of staff did not knock on the person's door. In another incident we observed a member of staff enter someone's bedroom, they took their clothes and toiletries (in preparation for a shower) without speaking with the person. There was no conversation and the staff did not ask the person what clothes they wanted to wear.

In another incident on 26 June 2015 a person called out to us that they needed help. We alerted a member of staff to this. The member of staff told us, ''he always does that'' and ignored the person. Half an hour later the person was continuing to call out for help. We did not see any staff approach them or try to comfort them.

Some people looked unkempt and their hair was not brushed or was washed. Some people were wearing dirty or stained clothes. For example we saw one person with food stains on the sleeve of their cardigan and another with food stains on their jumper early in the morning. Some people had dirty finger nails. We saw one person wearing pop socks which had been labelled with a black marker with their name, the person was wearing a knee length skirt so the name could be clearly seen.

This was a breach of Regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed people lying on their beds (including some people who were asleep) with their doors wide open. On 26 June 2015 11 people on the ground floor and 14 people on the first floor were lying in bed with the doors wide open. Some people were asleep. Curtains were drawn back and in some cases the overhead lights were on. Following our inspection visit the provider consulted people about this practice and had recorded their views about whether they wanted their bedroom doors left open whilst they were in bed. They told us they would also consider people's views on a daily basis in case they changed their minds.

Some people and the relatives of other people told us the staff were not always kind or caring. One relative spoke about an incident at the home and then told us, '' I was so worried about (my relative) that I stayed here all night - it was as though they were being punished.'' Another relative said, '' (my relative) has told me that people hardly ring their bells at night but if they ever do, when a carer comes they are brusque with them. (My relative) doesn't want to make a fuss.'' Another relative said, ''I don't feel I can leave (my relative) because I can't trust them to look after her properly.''

One relative told us ''There is a cultural divide, with language a constant problem –(my relative) often can't understand what the staff say to her and they don't seem to understand her.''

People were not always offered choices or given enough information to make choices. Throughout the day we saw the staff pouring people drinks. A small number of staff offered people the choice between blackcurrant or orange squash. No other cold drinks were offered. However, the majority of the time the staff handed people a drink without offering them a choice. During lunch time on the ground floor we observed the staff bringing one person a plate of food. The person asked the member of staff what the food was but they had walked away as soon as they put the plate down and did not answer the person. We saw two people leaving their chairs in the lounge to be escorted immediately back to the chair, or another chair in the lounge, by the staff on four different occasions. The staff asked people, ''why don't you sit down here?'' and ''sit here'' without any acknowledgement that the person just made a choice not to sit there. The staff did not wait for an

Requires improvement

Is the service caring?

answer or have any other conversation with people. On one occasion a person was positioned in a chair which faced the wall, they moved the chair to face into the room. A staff member moved the position of the chair (whilst the person was still sitting in it) back to face the wall without any interaction with the person. At lunch time the staff moved people's wheelchairs, sometimes from behind, without first approaching the person or telling them what they were doing.

We saw a staff member bring three people who were seated in a lounge a hot drink at 11.30am. The staff member offered one person a choice of drink, but the only other communication with the person was that they repeated their name twice and said ''here'' as they handed them a biscuit. They did not speak with one person and their only interaction with the other person was to say, ''slowly, (the person's name) coffee for you.'' One person dropped broken pieces of biscuit on their clothing. A staff member entered the room, handed them one of the pieces of biscuit but left the other on their clothing, they did not speak with the person and then they left the room again. One person later spilled their entire cup of coffee on their lap. The staff member who witnessed this, firstly called for another member of staff and then told the person, ''she is coming to change you.'' They did not reassure or comfort the person or check on their wellbeing. The person was not offered a replacement drink when they returned after changing their clothes.

We saw one person sitting next to a member of staff for almost half an hour. The member of staff did not speak with the person. The person had a runny nose, throughout this time and we observed they were not offered any support to address this by the member of staff. We noted that the person still had a runny nose which needed attention two hours later.

At the beginning of lunchtime on the ground floor a person who had presented as very confused throughout the morning walked into the dining room and said to a member of staff, ''tell me what you want me to do?'' the person looked anxious. The member of staff laughed, did not answer and then turned to smile at another person. The person was then seated at a table on their own facing a wall. The person's care plan stated that they had dementia and they had only recently moved to the home.

At one point we overheard a person in their bedroom crying out for staff to help. We alerted a member of staff to this. The member of staff responded by saying ''yes'' and then walked in the opposite direction.

We read in one person's initial assessment and a document entitled, ''this is me'' that their religion was very important to them. The person's care plan, including their activity care plan did not mention their religion or any importance with this. Daily logs recording the activities they had taken part in did not include information to suggest the person had been supported to pursue their religion.

There were instances where the staff appeared rushed and did not show an interest in what people were saying or asking them. For example, we overheard a person tell a member of staff, ''I used to run a restaurant once.'' Instead of engaging in a conversation or showing an interest in this the staff member said, ''fab'' and walked away. People we spoke with confirmed this, telling us the staff did not have the time to engage with them. For example one visitor said, ''there's no time for the staff to do what they need to do. It needs time to talk to (my relative) but they don't have that so they don't wait and then (my relative) feels ignored and gets agitated.'' Another person told us, '' They don't even have time to be nice to people.'' One person told us, "I have no company unless one of my daughters comes in. Sometimes I'm lonely. The nurses pass by but don't respond and sometimes you call them and they ignore you for a bit. I need more communication." One person seated in a communal room told us, ''They dump us in here all the time and then forget about us.''

One person told us they were concerned about the support people received at night time. They said there were often temporary staff employed who did not know people's needs. They said, '' It is chaotic at night.'' Another person told us, ''the staff are generally kind'' but that they were nervous of using their call bell as they ''got into trouble'' if they used this especially at night.

This was a breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people told us the staff were kind and caring. One relative said, ''they are a great crowd'' and ''they really look after (my relative).'' Another relative told us, ''we are very happy, they look after him.'' One person who lived at the home said, ''they are nice and kind.'' A relative said, '' The

Requires improvement

Is the service caring?

staff are obliging and want to make the residents happy, they are like jewels in a crown.'' Another person said, ''The staff are very good.'' And another person said, ''I am happy with the home and the staff are nice.''

We observed some kind and caring interactions. In particular the activity coordinators were patient and kind with people. They offered people choices and listened to their answers. They involved people in preparing activities and thanked them for their help. We saw some other care staff being gentle and caring. They bent down to listen to what people had to say and offered them comfort when they were distressed. Some staff showed an interest in what people were doing or the things that interested them. For example, one member of staff talked about someone's magazine with them discussing articles. We also heard some care staff complimenting people on their hair and clothes.

We overheard a person asking the staff if their partner (a visitor) could join them for breakfast and this was organised. The staff listened to one person's concerns about getting to a hospital appointment on time. They reassured them and agreed to make sure their breakfast and care were arranged earlier so they would make the appointment. We witnessed an incident where one person was becoming upset and agitated. A member of staff reassured them and comforted them.

We saw families and other visitors throughout our inspection. They told us they were made welcome and were able to visit whenever they wanted. They told us they could be involved in the person's care and were informed about their wellbeing or if anything was wrong.

The provider carried out a survey of people who lived at the home in May 2015. Almost 50% of people responded and said that they were happy with the care they received and that they were treated with dignity and respect. Ten relatives also responded and said they were happy with the care and treatment their relatives received at the home. The provider showed us examples of compliments and thank you letters from relatives.

Requires improvement

Is the service responsive?

Our findings

During our inspection of 20 January 2015 we found the registered person did not provide meaningful and entertaining activities.

At this inspection we found some improvements had been made but the majority of people's social and emotional needs were not met.

People told us they did not have enough to do, they said were bored and they wanted more interaction with others. One relative said, '' The brochure for the home says that they care for people who have had strokes but what they mean by that is just the physical aspects of care. There is no recognition of people's other needs – which are just as important." Another relative said, ''activities have started to improve and there have been some fun things like flower arranging, but (my relative) is not always offered the chance to join in.'' Another relative told us, ''many of the activities don't engage people and there is no stimulation for anyone.''

Some of the things people living at the home told us were, ''Some primary school children did come in and sing carols last Christmas which was lovely, but we've never seen any of them since'', ''people are just crying out for some conversation and interaction'', ''it is ok here, but there is nothing to do and I would like to go home'', ''There's just no time for us'', ''there's no point in asking for help, because I wouldn't get it'', ''There are never enough staff, although those that are here do their best. And I miss going outdoors. We ate nearly all our meals in the garden when I lived at home'', ''I can't move around unless I'm helped – so if I want to go and do anything, I have to wait to be taken. And then all I hear is, 'In a minute, in a minute…' and then that turns into a long time'', ''There's not enough to do here and no one to talk to'', ''The staff are wonderful, but there's nothing to do and no one to do it with. We play Bingo on Mondays, which I enjoy'', ''I'd like more company'' and ''the staff told me I need to regard this room as my home now. But then sometimes I'm in here for hours with no one coming in, no one to talk to.''

Some people told us about events in their past, the careers they had or past interests. They told us they did not think the staff knew about these and they never asked them about these or talked to them about their interests.

During our visit we were approached by one person who told us they could not operate the remote control for the TV in their bedroom. The TV was on a station they had not chosen and was too loud for them. The staff told us the remote control was broken and there was not another way to turn the TV off. They took the remote control away for repair but did not return it to the person for over an hour. In the meantime they were left in their room with the TV on a station they did not want to watch.

Throughout the ground floor on 22 June 2015 the TVs in the communal rooms were turned to a radio station at a high volume. When the staff entered these rooms they did not offer people an alternative television or radio station. Some rooms had a selection of books, toys and games. However, no one was offered an opportunity to use these, encouraged to look at them or to make choices about using them.

This was a breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On 26 June 2015, some people were watching a music DVD of their choice in one of the lounges on the ground floor.

There was a schedule of weekly activities including core activities such as bingo, exercise sessions, cookery, discussion, quizzes and games as well as additional special events during the year and outings to local attractions such as pub lunches, parks. The timetable of activities were provided for each person's room and displayed on noticeboards in the corridor and dining room with notices of forthcoming events.

The activities coordinator told us that she also held regular one to one sessions in individual bedrooms with those who were unable or unwilling to participate in group activities. She said she always had a 'meet and greet' session with all new people to get to know them and understand their needs, personalities and preferences. In addition she told us people could book individual escorted trips outside the home, for example to go shopping. However outside these planned activities provided by the activities coordinators people did not have support from the staff to participate in other activities.

Bedrooms had been personalised and people were able to bring their own ornaments and belongings. One relative told us she had arranged for specific channels for her partner's bedroom television. People had photographs and

Requires improvement

Is the service responsive?

other important items in their rooms. The bedroom doors had been painted to look like front doors with a door knocker. Each person had a memory box with items which were important or personal to them outside their bedroom door. People liked these, although one relative said, ''I do not know why they have put some of those things in there'' (pointing to the memory box), they told us about their relative's interests which were not represented in the box.

The day of our inspection was the home's open day. They had arranged for a 1950's themed party, with the staff dressing up and putting on a show. People were encouraged to watch this in the afternoon.

There had been improvement to the care planning system. People's care plans were up to date and included information on how staff should meet a range of their needs. In most cases we found information was consistently recorded and clear. However, in two cases we found that information about a specific need in one part of the person's care plan had not been included in another relevant part. For example, one person's care plan stated they should be checked hourly each night. However, there was no information to indicate why this was needed and other areas of their care plan suggested they slept soundly and did not require additional support at night. In another care plan information about wound care had not been included in a care plan about the person's skin. The staff recorded interventions and care given to people each day. However, many of these records were hard to read because of the handwriting. Records included basic information about care and nursing needs but did not contain information about the person's emotional wellbeing or how they had responded to their care.

Most people we spoke with told us their physical needs were met. However, one visitor told us they were concerned their relative did not always get the support they needed, for example turning to prevent pressure areas developing. They told us they had discussed their concerns with the staff.

The provider had a complaints procedure and copies of this were given to people who lived at the home and their representatives. People told us they knew how to make a complaint and who they would speak with if they had any concerns. Most people said they felt complaints and concerns were investigated and acted upon but some people told us they had made complaints and had not been satisfied with the outcome. We looked at the provider's records of complaints. These showed that complaints had been investigated. The provider had responded to the complainants with their findings and had apologised where they had found mistakes had happened. They had also recorded an action plan to state what improvements needed to be made following complaints.

Inadequate

Is the service well-led?

Our findings

During our inspection of 20 January 2015 we found the provider had failed to notify us of the deaths of people who used the service.

Since January 2015 the provider had made appropriate notifications of deaths, serious injury and other significant events at the service.

During our inspection of 20 January 2015 we found the provider did not have effective systems in place to monitor the quality of the service and audits did not identify risks to people's safety and wellbeing.

At this inspection we found the provider had not taken appropriate action to assess, monitor and mitigate against the risks to people's health, safety and welfare. There were a number of audits and checks, however the provider had not identified serious risks or taken action to mitigate against these. For example, the provider's infection control audits for the previous three months did not identify any concerns with cleanliness or infection control. Following our inspection the provider told us the registered manager, chief executive officer and quality manager had not noticed any significant mal odours during the days of our inspection. However, malodours were noted by all five members of the inspection team.

The provider had undertaken an audit they called, ''KLOE audit: is the service caring?'' on 22 June 2015, the same day as our inspection. The provider rated themselves GOOD in this area. The audits looked at policies and procedures related to care and also care planning. The audit also included observations. The audit did not identify where there were risks of people not receiving appropriate care and treatment. For example one observation from the provider's audit on 22 June 2015 was, ''Do staff take practical action to relieve resident's distress or discomfort i.e. do they recognise and action if a resident is in pain or becoming agitated?'' The provider had rated this as ''good''. However on the same day we overheard a person calling for help, which the staff ignored, saw a person with a runny nose which the staff did not attend to, witnessed someone pour a hot drink on their trousers and they were not comforted by staff.

The operations manager sent us a document which was created on 24 June 2015 based on the Care Quality Commission's (CQC) provider information return (PIR) which was designed to allow providers to tell CQC how well they felt their service was meeting Regulations and any areas they had identified for improvement. In this document the provider stated '' The home is clean and odour free'', we found that the environment was not clean and people were at risk of acquiring infections. The provider also stated, '' There is a culture here of an open door policy'', comments we received from people living at the home, visitors and staff indicated that this view was not shared by all stakeholders. The provider identified two areas for improvement regarding medicines management but did not identify errors in record keeping, storage or administration. We found medicines were managed in a way which put people living at the home at risk, as there were problems with storage, record keeping and administration. The provider's audit had not identified these. The provider stated, '' Activities are planned to help support many areas of life including emotional and physical well-being.'' The evidence of our inspection through observations and from the things people living at the home and their visitors told us was this was not the case.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some of the staff, visitors and people who lived at the home told us they did not think there was a positive or inclusive culture at the home. Some of the staff told us there was a ''blame culture'' and they were afraid to speak up. One person told us, '' I hear arguments going on between the staff in the corridor about money and rotas and how the Nurse Sisters don't do any caring.'' A member of staff started crying when they spoke to us, they said they felt unsupported and frightened to speak up. A relative said, '' There is a blame culture here, so there is no openness.'' Another relative told us, '' it takes a lot to change the culture of a place such as this and many staff have entrenched behaviours and attitudes from the previous culture. The manager has been embracing and addressing the issues like responding to call bells and bringing in new staff, but she isn't supported from those above her and the home runs on hierarchical lines with nurses doing nothing to support the carers.'' One relative who had raised a concern about their relatives care told us they thought, ''staff all cover for each other and the concern

Inadequate

Is the service well-led?

was not investigated properly.'' One relative told us, ''the staff see me and my family as a nuisance and they make that clear to us.'' One person told us, ''there is something not right about this place.''

We spoke with some of the staff on duty about events which had happened during the day. In one example a visitor had told the staff they thought their relative was unwell. They requested an ambulance was called. When we spoke with the nursing staff about this they told us they had already identified the person was ill themselves and they did not know why the relative had raised concerns. They then told us they thought the person was ill because their relative had taken them in the garden a few days before and they had caught a chill because of this. At another point we asked a member of staff about someone who had been coughing violently for several minutes whilst they had been administering medicines. The staff told us they thought the person was ''putting this on'' and said they regularly did this when the staff were administering medicines. They did not demonstrate an understanding that this may have been distressing for the person or that there may have been an underlying cause to this. We asked another member of staff about a person who appeared anxious and had expressed concern. The member of staff told us the person was '' rather difficult with negative family dynamics.''

One member of staff told us, ''Staff morale is low. We would like to have more interaction with the residents but can't. There aren't enough of us and too many agency staff. We are not appreciated.''

Some people living at the home and visitors told us they did not feel the service was well managed. One person said, ''I hardly ever see the manager up here – she only comes up when she's showing people around.'' Another person told us about their concerns. They said ''no one here listens to me.'' One relative said, ''the managers do not listen to us and are hostile.''

This was a breach of Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The provider has systems to monitor the service. These included analysis of accidents and incidents, monitoring people's weight changes and fluid intake.

The provider has introduced a number of new audits and systems to monitor the quality of the service. They told us they were trialling some of these and working towards continuous improvement of their quality monitoring systems. They also made use of peer reviewing by asking managers from other services to carry out audits at the home.

Following the inspection visit the provider took action to address some of the concerns we identified. They started to investigate some of the incidents relating to safety. A new manager started work at the service and was in the process of applying to be registered with the Care Quality Commission.

The registered manager had been in post at the home since 2012. Before that she worked as a deputy manager in another care home. She was qualified to NVQ Level 3 and was working towards a management in care qualification at the time of our inspection. The registered manager left the organisation in July 2015.

Advinia Healthcare Limited was a privately run organisation managing 16 nursing and residential homes and a home care service in England and Scotland.

The authorities who commissioned care from the service had carried out their own monitoring to make sure the service was meeting their required standards. They had shared their findings with the manager and had discussed any actions they wanted the provider to take.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The care and treatment of service users did not meet their needs or reflect their preferences.** **Regulation 9(1)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Service users were not treated with dignity and respect.** **Regulation 10 (1)**

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person did not operate effective systems to assess, monitor and improve the quality of the services provided. They did not assess, monitor and mitigate the risks relating to health, safety and welfare of service users. Regulation 17(1) and (2)(a) and (b)

The enforcement action we took:
We have issued a Warning Notice telling the provider they must take action to meet this Regulation by the 10 August 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for service users because the registered person had not mitigated against risks, did not manage medicines in a safe and proper way and did not assess the risk of, prevent, detect or control the spread of infections. Regulation 12(1) and (2)(b), (g) and (h)

The enforcement action we took:
We have issued a Warning Notice telling the provider they must take action to meet this Regulation by the 10 August 2015.