Hill Care Limited

The Laurels and The Limes Care Home

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 was an unannounced inspection which meant the staff and provider did not know we would be inspecting the service. The service was last inspected on 19, 20 and 27 August 2014. At the last inspection we found the service was not meeting the requirements of the following regulations: care and welfare of people who use services, supporting staff, the management of medicines and assessing and monitoring the quality of service provision. As a response to the last inspection the provider sent a report to the Care Quality Commission of the action they would take to become compliant with the regulations. The provider informed us they would be compliant by the end of December 2014.

The Laurel and Limes is a nursing home that provides care for up to 88 people. The service operates from two separate buildings on the same site in the south of Sheffield. The Limes building is purpose built. The majority of bedrooms are single and some have ensuite facilities. There are well maintained gardens and car parking is available. At the time of the inspection there

Summary of findings

were 52 people living at the service. The Laurels building is a residential unit primarily used for people living with dementia. At the time of the inspection there were 19 people living in the Laurels building. The Limes building has three floors and a lower ground floor where the service's kitchen, laundry and staff rooms are based. At the time of the inspection there were 33 people living in the Limes building.

There was not a registered manager for this service in post at the time of the inspection. The manager had left their post shortly before the inspection took place. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt "safe" and that they would speak with staff and/or a family member if they had any concerns. Relatives spoken with felt their family member was safe.

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

People gave mixed views about the staff and how they were treated by staff. We observed that the interaction and communication between staff and people was mainly focussed around completing tasks. People told us staff rarely had time to sit and talk or interact.

A pharmacist inspector from the Care Quality Commission inspected the service on 19 January 2015 to check whether improvements had been made to the management of medicines and that these improvements had been maintained. We saw that some improvements had been made, however we found that the provider had still not made enough improvements to protect people against the risks associated with the unsafe use and management of medicines.

Recruitment procedures were in place and appropriate checks were undertaken before staff started work. However, records showed that these procedures were not always being adhered to. For example, one staff member's reference from their previous employer had not been obtained before they started working at the service.

Individual risk assessments were completed for people so that identifiable risks were managed effectively. However, we found that some people's medication risk assessments had not been completed.

There was evidence in peoples care plans of involvement from other professionals such as doctors, opticians, tissue viability nurses and speech and language practitioners.

People's dietary needs were being met but we found that people were not always asked for their preference regarding the food they would like to eat. We also found the assistance provided by some staff whilst supporting people to eat could be improved.

We found that some staff had not received all their induction training suitable for their roles when they started employment at the service. We also found that staff had not completed refresher training in some areas of training relevant to their role.

Staff had not received regular supervisions and appraisals, which meant their performance was not formally monitored and areas for improvement may not have been identified.

There was a complaint's process in place in the service and people and/or their representative's concerns had been investigated and action taken to address their concerns.

Meetings had been held with people's representatives since the last inspection. We saw evidence that a catering audit had been completed with people at the service in August 2014. However, we found no evidence that the outcome of the audit or the action that was being taken had been shared with people living at the service. We found that no meetings had been held with people living at the service since the last inspection. This meant people did not have opportunities to be kept informed about information relevant to them.

Our findings demonstrated the provider had not ensured there were effective systems in place to monitor and

Summary of findings

improve the quality of the service provided. This meant they were not meeting the requirements to protect people from the risk and unsafe care by effectively assessing and monitoring the service being provided.

We saw evidence that checks were undertaken of the premises and equipment and action was taken to ensure peoples safety.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate 

The service was not safe. At the last inspection we found the service did not have appropriate arrangements in place to manage medicines to ensure people were protected from the risks associated with medicines. At this inspection we found sufficient improvements had not been made, so that people's medicines were managed safely.

We found there were not robust systems in place to ensure staffing levels were maintained when there was unexpected staff absence.

People told us they felt "safe". Staff were aware of how to raise any safeguarding issues if they were concerned.

Is the service effective?

Requires Improvement 

The service was not always effective. At the last inspection we found there was not a robust system in place to ensure staff completed all the refresher training relevant to their role and this remained the same on this inspection. We found staff had not received regular supervisions to support them to deliver care and treatment safely to an appropriate standard.

The service had policies and procedures in place in relation to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). However, we found some staff; including five nurses had not completed training in MCA 2005 and DoLS.

Is the service caring?

Requires Improvement 

The service was not always caring. During the inspection we observed the interaction between care staff and people was mainly centred around tasks. People told us that the staff rarely had time to sit and interact with them.

We saw some staff adapted their communication style to meet people's needs. However, we saw some examples where people were not treated with consideration whilst being supported by staff.

People and relatives gave mixed views about the staff.

Is the service responsive?

Inadequate 

The service was not responsive. At our last inspection we found the provider had not ensured that all the people living at the service had safe and appropriate care and support to meet their needs. At this inspection we found sufficient improvements had not been made.

We found some people did not have access to a call bell to call for assistance when they needed it. Staff had not ensured that people could access fluids easily to maintain their hydration levels.

Summary of findings

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

Is the service well-led?

Inadequate

The service was not well-led. There was not a registered manager for this service in post at the time of the inspection. The manager had left their post shortly before the inspection.

At the last inspection we found the checks completed by the provider to assess and improve the quality of the service were not effective to ensure people were protected against the risk of inappropriate or unsafe care. At this inspection we found sufficient improvements had not been made.

People's representatives views had been actively sought to improve the service. We saw evidence that a catering audit had been completed with people at the service in August 2014. However, we found no evidence that the outcome of the audit or the action that was being taken had been shared with people living at the service.

The Laurels and The Limes 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.

A scheduled inspection took place on 19 January 2015 and 2 February 2015. This was an unannounced inspection which meant the staff and the provider did not know we would be visiting. The inspection team consisted of two adult social care inspectors, a specialist advisor, a pharmacist inspector and an expert by experience. The specialist advisor was a registered nurse who was experienced in the care of older people. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience of older people's care services.

Before our inspection we reviewed the information we held about the service and the provider. For example, notifications of deaths and incidents. We also gathered information from the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We also contacted an external healthcare professional and a social worker. The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We used a number of different methods to help us understand the experiences of people who lived in the service. We spent time observing the daily life in the service including the care and support being delivered. We spoke with 20 people living at the service, three relatives, the nominated individual, a senior homes manager, the senior regional manager, deputy manager, two nurses, two care assistants, a domestic worker, an administrative manager, a maintenance worker and the cook. We looked round different areas of the service; the communal areas, the kitchen, bathroom, toilets and where people were able to give us permission, some people's rooms. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We reviewed a range of records including the following: eight people's care records, 24 people's medication administration records, three people's personal financial transaction records, three staff files and records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

People spoken with told us they felt 'safe' and had no worries or concerns. All the relatives spoken with felt their family member was in a safe place. One relative commented: "I was at the point of moving [family member] somewhere else because I wasn't happy with how things were, but there was a change in manager and things improved. I can sleep better now; I think he is safe here".

People and relatives spoken with did not express any concerns regarding the staffing levels within the service. One relative commented: "there are usually enough staff but there are often a lot of agency staff, we regularly see them".

We found that regular dependency assessments had been completed by the provider. This is a tool provider's use to calculate the number of staff they need on each shift, to identify for them the numbers of staff and the range of skills needed to ensure people receive appropriate care. For example, the number of nurses and number of care assistants for each unit. However, we found there were not robust procedures in place to ensure staff cover was obtained when there was unexpected staff absence. For example, we reviewed the staff rota for the Laurels building for week commencing 12 January 2015. The staffing level for the late shift indicated four staff should be working. On six out of seven days there had only been three staff working. We spoke with the service's administrative manager. They confirmed that only three staff had been working on these late shifts. Staff supporting people in the Laurels building told us that it was very challenging to meet people's needs when staffing levels were not maintained.

On the first day of the inspection we observed that a member of the domestic staff was supporting people to eat at lunch time in the dining/lounge area of the Limes Building. We also saw that the activities worker, who had worked previously as a care worker at the service was also supporting a person to eat. We spoke with the senior regional manager and a senior homes manager; they told us that domestic staff did not normally support people to eat. This showed that the service had not ensured there were sufficient number of care staff on duty to meet people's needs during the mealtime.

This was in breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People spoken with did not express any concerns about medicines. One person commented: "I don't take tablets every day but when I need them I can have them. I just ask the staff".

We looked at records about medication and checked people's medicines against those records and we found there were some concerns about people's medicines or the records relating to medicines for all of those people. We looked at the way medicines were stored and found concerns about the storage of medicines.

We found that medicines were not given safely. We saw that two people were sitting together at the breakfast table. One person had their tablets placed on the table but the member of staff did not supervise them taking their tablets, nor did they check the other person at the table had not taken the tablets. The member of staff signed the records stating that the tablets had been taken without checking they had been taken. Leaving medicines on the table is an unsafe method of administration as there is no assurance that the right person will take the tablets.

We saw that the arrangements to ensure people were given medicines safely, such as antibiotics to be taken with food were not in place. We saw medicines which should be taken on an empty stomach or before meals were given with meals. If the manufacturers' directions regarding food are not followed the medication may not be effective and people's health may be placed at risk.

We also saw that medicines which must be given at specific times to control symptoms of Parkinson's or give effective pain relief were not given as prescribed. If people are not given medication at the correct time they may suffer unnecessary symptoms of their illness or pain.

We saw that in the 16 people's records we looked at, people were prescribed at least one medicine which was prescribed to be given "when required". We saw that 14 of those people did not have information "a protocol" in place, for what "when required" means for each person.

Inadequate

Is the service safe?

The protocol is to guide staff on how to administer those medicines safely and consistently. We also saw that when guidance was available staff failed to follow it, which placed the person's health at risk of harm.

We saw one person was given some eye drops for a week, which were out of date. We saw that they were also prescribed a thickener to thicken their fluids so they were able to drink without the risk of choking. We spoke with the nurse who said this person no longer needed their drinks thickened. We looked at their care records and saw there was no information that the thickener had been stopped. This meant the nurse had placed this person's health at risk because they had not thickened their fluids when taking medicines.

We found appropriate arrangements in relation to obtaining medication were not in place. We saw that two people had run out of one of their medicines for up to a week. If medicines are not available to be given as prescribed people's health is placed at risk of harm.

We found that appropriate arrangements were not in place regarding records about administration of medicines. We saw medicines were signed as administered before they were given. We saw staff had signed they had given medicines when we found there was no stock to administer. We also saw that some medication had been given because of the amount in stock but no records had been made when it had been administered. We saw the records about creams were poor and did not show that creams had been applied as prescribed.

We saw that appropriate arrangements for the safe storage of medicines had not been made. We saw that creams were stored in bedrooms without any assessments being done to show it was safe to store them there. We found that a cream had gone "missing" from a bedroom and staff told us that one person has a "habit of moving things". Staff were unable to find the cream that had gone missing. We saw that eye drops were incorrectly stored in a fridge; if medication is not stored at the correct temperature then it may not work properly. We saw that waste medication was not stored safely which meant it was at risk of misuse. We also saw that when medicines were being given to people in the dining room staff left the trolley open outside the dining room. All medicines should be kept locked away unless a member of staff is in direct control of the trolley.

We found people were still not protected from the risks associated with medicines because the service did not have appropriate arrangements in place to manage medicines. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a process in place to respond to and record safeguarding vulnerable adults concerns. We saw the service had a copy of the local authority safeguarding adult's protocols to follow to report any events and safeguard people from harm. It was clear from discussions with staff that they were aware of how to raise any safeguarding issues.

We spoke with the administrative manager at the service; they showed us the system in place to manage people's spending accounts. We looked at three people's financial transaction records and saw where monies had been paid in by a relative or a representative that a receipt had been issued. We looked at the spending account records for three people. The amounts invoiced to each person showed the correct balance remained. The administrative manager told us that people at the service could choose to manage their own monies and may keep money in their room. During the inspection we noticed that one person had left a small amount of money in a pot in their room. We spoke with the senior regional manager and senior homes manager who assured us that if a person chose to keep monies in their room that a risk assessment would be completed to ensure measures were in place to protect the person from financial abuse.

We spoke with one of the service's maintenance workers. They described all the checks they completed at the service. For example, fire systems checks, emergency lighting checks, call system checks and window restricter checks. We also saw written evidence that checks were regularly undertaken of the premises. We also saw evidence that checks had been made on equipment used by people living at the service. For example, bath chair, parker bath and hoist checks. During the inspection we found a faulty electric socket in one of the communal rooms in the Laurels building. This was reported to the unit manager and one of the service's maintenance workers attended. This showed the reporting of faults by staff could be improved.

Inadequate

Is the service safe?

We reviewed the staff recruitment records for three staff members. The records contained a range of information including the following: application form, interview records, references, employment contract and Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service (DBS) provides criminal records checking and barring functions to help employers make safer recruitment decisions. We also saw evidence where applicable that the nurse's Nursing and Midwifery Council (NMC) registration had been checked. However, the monthly visit record completed by the senior regional manager in December 2014 showed that the recruitment process was not always followed. For example, the senior regional manager had identified that one staff member's references from their last employer had not been obtained prior to them starting to work at the service.

People spoken with did not express any concerns about the cleanliness of the service. There was a range of cleaning schedules for different areas within the service. However, on both days of the inspection we noticed that there were malodours in the communal areas on the ground floor in the Limes building. There were also odours emanating from the chairs in the lounge areas in the Limes building so they were not pleasant to sit in. We also found malodours in five people's rooms in the Limes Building. This told us that some areas within the Limes building were not being sufficiently cleaned. We also noted on the first day of the inspection that soiled clothing had not been removed by staff in one of the toilets on the ground floor in the Limes Building. We spoke with the senior regional manager and senior home's manager; they assured us that these concerns would be addressed.

We also noticed that staff had become accustomed to leaving equipment in the corridor outside people's room in the Limes Building. We spoke with the deputy manager regarding the importance of keeping corridors clear to enable people to exit safely if there was a fire.

Requires Improvement

Is the service effective?

Our findings

People spoken with gave us mixed views on the quality of care they had received. People's positive comments about their care included: "the staff are very helpful", "I am looked after very very well" and "I am happy here". People's negative comments about their care included: "I don't like living here, just looking at four walls and I don't like the food", "I sometimes forget to use my walker and staff should remind me to use it" and "all our activities are based here and I don't get out".

Relatives spoken with told us they were involved in their family member's care planning. One relative commented: "I had regular meetings with the manager until she left – prior to her arriving there would be no response to what I said and I had started not sleeping well. Once she was in post she co-ordinated responses things got better".

At our last inspection we found the provider had not ensured that staff were appropriately trained and supported to enable them to deliver care to people safely and to an appropriate standard. The provider submitted an action plan following our inspection, which detailed the actions they intended to take in order to achieve compliance. At this inspection we found the provider had failed to make sufficient improvements.

We received mixed messages from staff about the support they received from senior staff. One staff member commented: "I used to feel supported by the manager, I feel let down because they have left. Things have gone back to how they were". We found that some staff had not received regular supervision sessions or an annual appraisal. Supervision is the name for the regular, planned and recorded sessions between a staff member and their manager. It is an opportunity for staff to discuss their performance, training, wellbeing and raise any concerns they may have. It is important for staff to have an annual appraisal as it is an opportunity to review the staff member's performance and to identify their work objectives for the next twelve months.

The provider used a staff training spread sheet to monitor the training completed by staff. We reviewed the service's staff training spread sheet and looked at staff records. We found that the service had still not provided some staff training which was relevant to their role. For example, seven staff members moving and handling refresher training was overdue (six from 2013). Seven staff members refresher training in safeguarding vulnerable adults was overdue. We also found concerns where staff had not completed any training in areas relevant to their role. For example, five nurses had not completed training in the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS).

Our observations during the inspection showed that some staff had not been appropriately trained. For example, we found that staff were using an incorrect method to empty people's catheters. People were not being appropriately supported whilst staff were assisting people to eat. Staff were not supporting people who had behaviour that could challenge others appropriately.

We found the provider had still not ensured that staff were appropriately trained and supported to enable them to deliver care to people safely and to an appropriate standard. This was in breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act (MCA) 2005 is an act which protects and promotes the rights of people who are unable to make all or some decisions about their lives for themselves. It promotes and safeguards decision-making within a legal framework.

The service had policies and procedures in place in relation to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). The senior home's manager and senior regional manager informed us they were liaising with the local authority regarding any requirements regarding DoLS applications. During the inspection we did not observe any evidence of unlawful restriction. For example, people being restricted from leaving the premises.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

We found evidence of involvement from other health professionals such as doctors, opticians, district nurses,

Requires Improvement

Is the service effective?

tissue viability nurses and speech and language practitioners in people's records. People confirmed they saw external healthcare professionals when they needed to. For example, one person told us about an assessment completed by the Speech Assessment and Language Team to check what food they could eat. Relatives spoken with also told us that the service involved external healthcare professionals in their family members care. One relative commented: "I came to see [family member] and I thought they were not very well. I mentioned this to a member of staff. When I got home I had a phone call to say that the doctor had already been and had prescribed antibiotics".

People spoken with gave us mixed views about the quality food and the choice available. Their comments included: "you don't get a choice of food; you just get what you're given. It always suits me", "the food's alright but you get sausage and mash all the time" and "I might not have lunch if it's something I don't like, there ought to be a choice".

Relatives spoken with did not raise any concerns about the quality of the food provided at the service. One relative commented: "I have eaten here quite a few times including Christmas Day; the food is quite good" and "[family member] is often up at night and I know that he gets drinks and snacks".

We observed during lunch time in the Limes building staff asking people on several occasions what they would like for their meal. When people asked what was available they were told there was meat and potato pie. We saw that everything was plated before being brought to people, so people could not choose which vegetables were served or how much. Similarly, all the meals had gravy added to the plate, meaning that people could not choose the amount or where they would like their gravy. We observed two people express to staff that the portions sizes on the plate were too large. One person told us that the food was nice but there was just too much.

We spoke with the cook; they gave us details of the different choices available at meal times. They told us that menu choices were offered to people on the day before. We asked to see people's menu choices on the first day of the inspection. We found that the menu choices had not been offered to people on the day before. We spoke with the cook, they told us they did not always receive people's menu choices; this happened once or twice a week. The cook was aware of the people who had allergies, required a specialised diet and/or soft diet. One person who required a specialised diet told us they received the appropriate food to maintain their diet. We spoke with the senior regional manager who assured us that they would speak with staff regarding the importance of obtaining peoples menu choices for each day.

Equipment was available in different areas of the service for staff to access easily to support people who could not mobilise independently. However, we found some people's personal equipment was being stored by staff inappropriately the ensuite area of their rooms. This meant that people did not have easy access to the hand washing and toilet facilities in their room.

Requires Improvement

Is the service caring?

Our findings

People spoken with made mixed comments on how they were treated by staff. People's positive comments about staff included: "the staff do listen to me", "staff do knock on the door", and "they [staff] try to their best to help". One person identified various members of staff and used phrases such as "that person is lovely" and "that one's okay". People told us that the staff rarely had time to sit and talk to them or cheer them up if they needed it. People's comments included: "they [staff] don't bother with me much", "the staff don't really talk to me, there's only one I can really talk to" and "sometimes I sit and have a little weep to myself – they don't bother with me much".

Relatives spoken with also made mixed comments about the staff. One relative commented: "a lot of the staff here are very caring. Things had been getting so much better but they have lost a lot of very good staff. I hope things don't slip back now the manager has gone". Another relative commented about staff listening to people: "there's room for some more improvement".

Permanent staff spoken with were able to describe people's individual needs, likes and dislikes and the name people preferred to be called by. We observed staff using first names to address people and relatives. However, we did not observe any conversations, which demonstrated detailed knowledge of who people were or their wider lives and interests. We also saw in some people's care records that their social history had not been completed.

During our inspection we observed staff knocking on doors before entering people's rooms and ensuring doors were closed whilst providing personal care. We saw that staff treated people with dignity and respect. However, we saw that the interaction between staff and people was mainly centred around tasks. We observed positive and negative interactions between staff and people using the service.

The positive interactions included the following; during the lunch service in the Limes building we observed several occasions where staff asked people's permission before carrying out tasks including cutting up their food to make it easier to eat and the tones and words used were spoken in a caring way. After lunch we heard people being asked if they would like to go and sit in a comfy chair now with their responses being respected. We saw examples that staff adapted their communication style to meet the needs of the person they were supporting. For example, kneeling down and speaking with the person on their level in a chair.

The negative interactions we observed included the following: we saw that one member of staff in the large lounge area in the Limes building preferred to stand in a corner and watch people. Their interaction with people was minimal. We observed staff supporting people to transfer using a hoist. We saw some staff offered little in the way of narrative or reassurance to people, spending more time chatting to each other or not speaking rather than telling the person what was happening or checking if they were alright. We shared our observations with the nominated individual and the senior regional manager who told us they speak with staff.

There was information about the advocacy services available for people to contact in the reception area. Advocacy is a process of supporting and enabling people to express their views and concerns, access information and services, defend and promote their rights and responsibilities and explore choices and options.

Inadequate

Is the service responsive?

Our findings

At our last inspection we found the provider had not ensured that all the people living at the service had safe and appropriate care and support to meet their needs. The provider submitted an action plan following our inspection which detailed the actions they intended to take in order to achieve compliance. At this inspection we found the provider had failed to make sufficient improvements.

One of the concerns raised at the last inspection was that staff had not ensured people had a call bell in reach to call for assistance from staff. At this inspection people spoken with told us staff had responded when they used their call bell's to call for assistance; the length of time they waited depended on staff availability and which staff were working. One person commented: "normally they come quite quickly, five minutes or so; there is one person on the night staff that keeps me waiting for a long time" and "just buzz and somebody turns up".

We saw the arrangements in place for people to have access to a call bell in one of the lounge areas of the service could be improved. For example, on the first day of our inspection we noticed in the small lounge in the Limes building that the call bell was on the wall, hidden by the door that was wedged open. A hoist had been placed in front of the bell. There was a person in that room who was unable to mobilise independently and they could not be seen from the corridor. We saw that staff did not routinely check whether people in this lounge required support.

During this inspection we visited two people in their rooms; both people did not have a call bell in reach to call for assistance. For example, one person we visited in their room was lying in bed, with their call bell across the room which meant it was out of reach of the person. We also noted that they did not have access to drinks in their room; their jug of water and glass were on a bed side cabinet across the other side of the room. The person was unable to mobilise independently, they told us they knew what a call bell was for but told us that they did not usually have one left in reach. This showed the provider had not taken effective action to ensure that all the people living at the service could access assistance from staff when they needed support. We also found that the provider had not ensured all the people in their room had access to fluids to maintain their hydration levels and thereby their health.

We noticed that there were jugs of juice in the main lounge in the Limes Building. These were not positioned so that people could easily help themselves, and there were often times in the lounge in the Limes building that there were no tables where people could keep a drink beside them. This showed that that the arrangements to encourage and support people to maintain their hydration levels were not robust.

On the first day of the inspection we observed two people being assisted to eat at lunch time in the Limes Building. In both cases a member of staff asked the person if they would like to be helped. However, we observed that they were not supported appropriately and/or were not treated with consideration. For example, there were two occasions when the staff member asked the person if they were ready for more but on the majority of occasions they simply gave the person a spoonful of food without checking. The staff member did not ask the person which part of the meal they would like next or check carefully how much food was on the spoon. Most of the time there was too much on the spoon and on several occasions food was dropped onto the person's clothing. This was not always noticed and the person finished their meal with food debris on their clothes. The person was not wearing a napkin and we did not hear them being offered one.

Another person was offered help after attempting to eat without assistance. The staff member that was assisting them broke off several times to speak to other people without explaining to the person they were assisting.

During the mealtime we did not observe any staff recording what each person had eaten or drunk at the meal. We looked at three people's food and fluid intake records. They showed that the amount of food and drink people drank was not being consistently recorded. This showed that people who required accurate records of their intake and fluid recording were not being protected from the risks of inadequate nutrition and dehydration. We also noted that where people required their drinks to be thickened so they were able to drink without the risk of aspirating, that the amount of thickener being used was also not being consistently recorded on their fluid intake charts.

We reviewed eight people's care records. People's care plans contained a range of information including the following: personal hygiene, mobility, communication, eating and drinking. They also contained details of people's personal preferences. However, we found that some people

Is the service responsive?

did not have a care plan in place to meet their individual needs and ensure they received person centred care. For example, one person who required food and fluids via a percutaneous endoscopic gastrostomy (PEG), a care plan was not in place. Likewise, another person who required an oral plan did not have a plan of care in place. We spoke with a nurse regarding the omissions and they assured us that a care plan would be put in place.

In one person's care records we noted that a tissue viability nurse had recommended that one person's type of dressing to be changed on the 8 January 2015. Records showed that the new type of dressing had not been obtained by the service until 22 January 2015. It is important that the advice from healthcare professionals is responded to effectively by staff, so that people's health is not placed at risk.

In another person's care records we reviewed the notes completed by a healthcare professional when they visited on the 24 January 2015. They had found the person lying on a flat bed when they needed to be sat upright to reduce their risk of aspirating. The person required an oral care plan but there was not one in place. The healthcare professional also described that the person's sheets as dirty and that the person had not been able to reach fluids. This showed the provider had not been responsive in taking action to ensure that people were protected against the risks of receiving care or treatment that was inappropriate or unsafe.

People had individual risk assessments in place so that staff could identify and manage any risks appropriately. The purpose of a risk assessment is to identify any potential risks and then put measures in place to reduce and manage the risks to the person. However, we found that a medication risk assessment had not been completed for some people living at the service. This showed that measures to reduce and manage the potential risks to the person in relation to medicine had not been put in place.

We spoke with people and relatives about people living in the home who had behaviour that could challenge others. Most people spoken with felt that there were no such problems. One relative commented: "there are a couple [people] who can be a bit of a handful sometimes but I think that some of the staff deal with it well. Some staff ignore what's going on and it gets worse".

During our inspection we observed that people who had behaviour that could challenge were not being supported appropriately. For example, on the first day of the inspection in the Limes Building we observed two incidents. We observed two people being verbally aggressive. One person was in the dining area loudly rejecting staff's attempts to engage with them. Another person across in the lounge area remonstrated by shouting. We observed that staff did not intervene in the exchange between the two people. Other people in the lounge area did not react to the verbal altercation and seemed to be accustomed to this type of interaction. The second incident we observed was one person who was upset that another person was sitting in a chair which they felt was theirs. Two staff members and a member of the management team were involved in trying to persuade the two people to move. We noticed during the incident that the person in the wheelchair demanding the seat was moved closer to the person sitting in the seat. This enabled the person to remonstrate directly with the other person which would not have been possible if staff had not placed them there.

On the second day of the inspection we spent time in the lounge/dining area in the Limes building. We observed two people being verbally aggressive to one another whilst having breakfast in the dining room. They were sat together at one of the tables. The intervention by the kitchen assistant present in the area was inappropriate; they raised their voice and remonstrated with the two individuals. We spoke with a staff member who told us that a new staff member had inadvertently placed a person to sit with another person who did not like their personal space to be intruded upon. This showed that people who had behaviour that could challenge others were not being supported appropriately to meet their individual needs. We spoke with the senior homes manager and the senior regional manager, they assured us that they would speak with staff and provide further training.

This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People spoken with told us they did not have any concerns or complaints and if they did they would speak with staff. One person commented: "you can suggest things to the staff about changes they could make". Relatives spoken

Inadequate

Is the service responsive?

with told us they were aware of how to complain and who to speak with. One relative commented: "I don't have to [complain] as much as I used to, but at one time I had to make a lot of complaints. They know by my face when I'm not happy about something and they come and ask me what is wrong". The complaints process was on display at the service. We reviewed the service's complaints log. We found the service had responded to people's and/or their representative's concerns, investigated them and taken action to address their concerns.

The service had a former member of the care staff acting up in post as the service's activities worker; they had been in post for approximately three weeks. Some of the people spoken with commented on the lack of activities within the service. One person commented: "there's nowt all to do" and "there's not much entertainment, I just sit here". One relative spoken with also expressed their concerns regarding the lack of activities at the service. They commented: "that is something that has been lacking for a while".

On our arrival at the Limes building on the first day of the inspection the television was on in the largest lounge, but no one appeared to be watching it and no one could tell us how the programme had been chosen. We observed later in the morning an activities worker leading a session of chair exercises in the lounge area. We overheard one person say to another "I like those exercises, they loosen you up nicely". When this activity was complete the activities worker asked if people would like to watch the television or a film. It was decided that a film would be put on, although we did not observe how this decision was made by people. We saw that the decision making process had not been fully explored with people. We also noted that staff began moving people to the dining area approximately ten minutes after the film began so people did not have opportunity to engage with the film. This showed that the coordination of activities could be improved. In the afternoon we observed the activities worker encouraging people to play a variety of board games. We observed a number of people playing games either with the activities worker or against each other.

Inadequate

Is the service well-led?

Our findings

At our last inspection we found the provider had not ensured there was an effective system in place to regularly assess and monitor of the quality of the service provided. The provider submitted an action plan following our inspection which detailed the actions they intended to take in order to achieve compliance. At this inspection we found the provider had failed to make sufficient improvements.

The service did not have a registered manager in post at the time of the inspection. The last manager in post had left the service shortly before the inspection took place. One of the provider's senior homes managers and a senior regional manager was managing the service in the interim period. People were not clear about the identity of who was managing the service. Two relatives spoken with made positive comments about the manager who had recently left the service and the improvements she made whilst been in post. One relative commented: "I had been asking for [family member] to have the carpet in their room replaced. (Their personal care needs meant that the carpet regularly needed cleaning and it had started to emit a malodour). It was only when the new manager started that I got any response and the carpet was replaced with a cushioned floor".

Relatives who had attended meetings at the service told us that these meetings had been broadly productive. One relative commented: "there are always people who want to talk about a very specific issue and can't let it go but some things do get done". We reviewed the minutes of the meetings completed with relatives in August 2014 and November 2014. A range of topics were discussed including: management, laundry, mealtimes, keyworker role and activities. We saw that a catering audit had been completed with people living at the service in August 2014. However, we saw no evidence that the outcome of the audit had been shared with people. We noticed that no meetings had been held with people living at the service since the last inspection. We spoke with two members of staff who both confirmed that meetings had not been held with people. It is important that the provider regularly seek the views (including the descriptions of their experiences of care and treatment) of people using the service to enable the provider to come to an informed view in relation to the standard of care and treatment provided to people using the service.

We saw evidence that medication checks had been completed at the service since the last inspection. For example, a medication check was completed as part of the senior regional manager monthly visits in September, October, November and December 2014. Our findings during the inspection showed that the system for monitoring the management of medicines were not robust. It is essential to have robust monitoring in place in order to identify concerns, to make improvements and changes needed to ensure medicines are managed safely.

Although a dependency assessment had been completed regularly by the new manager to ensure there were sufficient numbers of staff with the right skills and knowledge working on each unit during the day and night, we found the arrangements in place to cover for unexpected staff absence was not robust. This showed that the provider had not protected service users, who may be at risk, against the risks of inappropriate or unsafe care by having effective operational systems in place to manage care provision within the service.

We found that some staff had not received training in areas relevant to their roles. We also found that some staff had not received regular supervisions or an appraisal. This showed the service had not ensured staff received appropriate training, professional development, supervision and appraisal. This meant the system for auditing and monitoring staff supervision was ineffective in practice.

We saw evidence on people's care records that care plans had been audited. However, we found examples that the action required had not been completed. For example, one person required an oral care plan putting in place and this action had not been completed. This showed that the system in place for auditing care plans in order to identify concerns and to make changes to ensure people's plans reflected their current needs was ineffective in practice.

We reviewed people's daily records. We found that there was not a robust system in place to ensure that accurate records were maintained. For example, staff were not recording the actual time people's wellbeing checks were completed. This showed that the provider had not protected service users, who may be at risk, against the risks of inappropriate or unsafe care by having effective operational systems in place to manage and record the care provision delivered within the service.

Inadequate

Is the service well-led?

Our findings during the inspection showed that the system in place to monitor the cleanliness of the home were not robust. For example, the odour coming from furniture in the communal areas in Limes lounge areas showed it was not being cleaned sufficiently. On the first day of the inspection we found two of the toilets in the Limes building had tissues on the floor and in one there was a pair of pyjama bottoms which appeared to be soaked in urine and the source of considerable odour.

Although we saw evidence that monthly checks had been carried out to assess the quality of the service by the senior regional manager since the last inspection, our findings during the inspection showed they were ineffective in practice. This meant the system to regularly assess and monitor of the quality of the service provided was ineffective in practice.

This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where 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 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: The provider had not ensured that staff were appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard. The provider had not taken appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity.

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 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Service users were not protected against the risks of inappropriate or unsafe care or treatment because the provider did not have effective systems to monitor the quality of the service provision.

The enforcement action we took:
A warning notice was issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: Service users were not protected against the risks of receiving care or treatment that is inappropriate or unsafe, because the planning and delivery of care did not meet people's needs and ensure the welfare and safety of service users.

The enforcement action we took:
A warning notice was issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Service users were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines.

The enforcement action we took:
A warning notice was issued.