Leopold Nursing Home Limited

Saint Mary's Nursing Home

Inspection report

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Ratings

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

Overall summary

We inspected this service on 19 January 2015 and this was an unannounced inspection. Saint Mary's Nursing Home provides accommodation and personal and nursing care for up to 40 older people. Some people are living with dementia. There were 27 people living in the service when we inspected.

At our last inspection on 3 September 2014, we asked the provider to take action to make improvements in care and welfare of people who use the service, cleanliness and infection control, staff recruitment, training and supervision and assessing and monitoring the quality of the service provision. The provider wrote to us to tell us how they had implemented these improvements. During this inspection we checked on their improvement plan and found that some actions had been completed, but there was need for further improvement and we had identified further issues which needed action.

There was not 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

Summary of findings

the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service was being managed by a registered manager from another of the provider's services. We refer to this manager in this report as the acting manager.

We found multiple breaches of regulation that affected the wellbeing of people using the service. People were not protected against the risks of receiving care or treatment that is inappropriate or unsafe. Risks to their welfare were recognised but assessments for people were not up to date or in some cases completed. People's nutritional needs were not being consistently assessed and met.

There were not sufficient numbers of staff to meet people's needs. Staff were not always available when people needed assistance, care and support.

The service was not clean and hygienic enough to protect people from the risks of poor hygiene.

People who used the service were supported by staff who were not trained and had the necessary skills to meet their needs effectively.

The acting manager told us that the service was up to date with recent changes to the law regarding the Deprivation of Liberty Safeguards (DoLS), however, appropriate referrals had not been made to ensure that people were not unlawfully deprived of their freedom to make their own decisions. Despite staff having training in MCA and DoLS not all understood them and how they impacted on the care provided to people.

People's privacy and dignity was respected and staff interacted with people in a caring manner.

There were procedures in place which safeguarded the people who used the service from the potential risk of abuse. Staff understood the various types of abuse and knew who to report any concerns to.

People were supported to see, when needed, health and social care professionals to make sure they received appropriate care and treatment.

Where concerns were identified about a person's food intake referrals had been made for specialist advice and support. However, improvements were needed in how the service monitored people's dietary and fluid intake.

People were provided with their medicines when they needed them.

A complaints procedure was in place. People's concerns and complaints were listened to and addressed in a timely manner. Improvements were needed in the ways that the service obtained people's views and used these to improve the service.

We found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

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 consistently safe.

Systems to keep people safe were not robust and effective. There were enough not enough staff to meet people's needs.

The service was not clean and hygienic.

People were provided with their medicines when they needed them.

Is the service effective?

Inadequate

The service was not consistently effective.

Staff were not trained to meet the needs of the people who used the service.

The Deprivation of Liberty Safeguards (DoLS) were not implemented when required. Despite receiving training in DoLS and the Mental Capacity Act (MCA) 2005, not all staff understood the DoLS.

People had access to appropriate services which ensured they received ongoing healthcare support. Improvements were needed in the way that people's fluid and nutritional intake was monitored.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff interacted with people in a caring manner. People's privacy and dignity was promoted and respected.

People and their relatives were involved in making some decisions about their care, but these were not regularly revisited to ensure people's changing preferences and needs were met.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's wellbeing and social inclusion was not assessed, planned and delivered to ensure their social needs were being met.

People's concerns and complaints were investigated and responded to.

Is the service well-led?

Inadequate

The service was not consistently well-led.

The service did not provide an open culture which was empowering.

The service had a quality assurance system, but this was not robust enough to identify shortfalls. As a result the quality of the service was not continually improving to ensure that people received a good quality service at all times.

Saint Mary's Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. This inspection took place on 19 January 2015 and was unannounced.

The inspection team consisted of two Inspectors and an Expert by Experience. An Expert by Experience is a person who has experience of using or caring for someone who uses this type of service. The Expert by Experience had experience of older people and people living with dementia.

We reviewed the previous inspection reports to help us plan what areas we were going to focus on during our inspection. We looked at other information we held about the service including notifications they had made to us about important events. We also reviewed all other information sent to us from other stakeholders for example the local authority and members of the public.

We spoke with 11 people who were able to verbally express their views about the service and four people's relatives. We used the Short Observational Framework for Inspectors (SOFI). This is a specific way of observing care to help us understand the experiences of people. We also observed the care and support provided to people and the interaction between staff and people throughout our inspection.

We looked at records in relation to five people's care. We spoke with seven members of staff, including the acting manager, the nurse on duty, care staff, catering, maintenance and domestic staff. We looked at records relating to the management of the service, staff recruitment and training, and systems for monitoring the quality of the service. We also spoke with stakeholders, including a staff member from the local authority and one health care professional.

Prior to our inspection we had received concerns about the service provided, these had been reported to and were in the process of being investigated by the local authority and other professionals. The local authority were keeping us updated with the support that they were providing to the service to assist them to improve the care and support provided to people and the outcomes to their investigations.

Inadequate

Is the service safe?

Our findings

Our previous inspection of 3 September 2014 found people were not provided with a clean and hygienic environment to live in. The provider wrote to us and told us about how they had addressed this. We found some improvements were made but the provider had not ensured that the lessons learned were sustained and applied to other areas of the service. We therefore found some areas which were still not clean and other areas, where poor infection control put people at risk.

People and relatives told us they felt the service was clean, however we found that many areas were not safe, clean or hygienic for people to use. For example a communal toilet was dirty, the seat raiser needed cleaning at the bottom and the paint had peeled leaving a rusty surface which meant it was hard to clean effectively. There was dark coloured mould at the back of the toilet. We also found air freshener and disinfectant on the window ledge, which, given the needs of people, had a potential risk, of being used incorrectly or being ingested. The floors in the sluice room and the laundry room were dirty. We saw that there was a basket of clean laundry on the dirty floor and there was a bucket with dirty clothing in it nearby. This was a risk to cross infection.

Systems were not in place to provide people with a clean and hygienic environment to live in and to prevent the risks of cross infection. The soap dispenser in the staff toilet was empty at 9am. This had not been refilled by 12.05pm, we then told the acting manager about this and it was immediately addressed. The acting manager said that no one had reported this prior to us raising it with them. This was the designated staff toilet and we were concerned that there was no soap to allow staff to wash their hands appropriately after they used the toilet. There were other areas in the service where staff could wash their hands but this would mean having to move between areas. A plastic table cloth and the chairs in the dining room were stained, for example there was dried food debris and writing on the cloths. Without regular cleaning of the areas where people eat their meals from we could not be assured that the risks of cross infection were managed appropriately. Carpets on the top floor hallways and the back stairs were old and stained, showing that they were not cleaned effectively. In the shower room on the top floor, the grouting around the tiles were stained and therefore not cleaned appropriately, and there was exposed plaster where a new shower had been installed, this was a risk because bacteria could develop. The flooring in a toilet on the second floor was not of a style which allowed effective cleaning. A bathroom on the first floor was dirty and there was hair in the plug hole of the bath. In this room was a steam cleaner, this had an unidentified liquid substance in it and there was a mop bucket with dirty cold water in it with the mop in the dirty water. The room was not locked and was therefore accessible to the people who used the service. Other toilets and shower rooms had tile sealant coming away from the tiles and the overflow in sinks needed cleaning. These issues provided opportunities for the risk of cross contamination because they were unclean, had not or could not be cleaned effectively. This placed people at risk.

There were cleaning schedules in place which showed when the service was cleaned, but there were no systems in place to identify if this cleaning was effective. Records showed that the last infection control audit had been completed in 2013. Therefore there were no effective systems in place to monitor and address infection control shortfalls and the acting manager was unable to tell us how this was managed. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There were not enough staff numbers to meet people's needs. People's comments about if there were enough staff in the service varied. One person told us, "The last two weeks we had staff from [provider's other service] and the Christmas period this was noticeable." Another person commented, "They need more at night, more between 6pm and midnight." Another person said, "There are rather fewer staff than there ought to be but they are friendly and obliging."

Two people explained how the staffing levels in the service affected the care that they received. One person commented there were, "Not so many staff now so we have a wash down but I did have a shower several weeks ago, they have to be done before 12.00 noon. There is not enough staff to do showers." Another person said, "Showers are a bit awkward here… with the time factor, waking up and getting dressed, they are a bit rushed to get things done." Care records confirmed what people told us, that they were not having showers as often as they had asked to.

Inadequate

Is the service safe?

People had varied experiences of how quick staff responded to their needs. One person said. “They come within 10 minutes.” However, another person commented, “Mornings they are stretched as they have a lot of people to look after but in the middle of the night they are quick.” Another person said, “Usually they are quite quick.” Further comments included, “I press the bell and they come quickly, they are very good, the longest 20 minutes,” and, “Five minutes usually, the worst is at 8pm and I wait 15 minutes.” People said they were able to wait for some things but that if they needed the toilet, this was a problem. We were concerned because people may need urgent support, for example if they fell and the times that they told us it took to respond to call bells meant that people were not provided with the support that they needed, when they needed it.

One person’s relative told us, “The only negative is they are short staffed and weekends are the worst.”

Staff comments also varied relating to the staffing levels. One staff member said that there were always enough staff to meet people’s needs. Comments from another two staff members were, “Sometimes there is not enough staff, in the mornings they need more,” and, “We are pretty well covered, it is worse when people got sick, we have not pulled any one in from [provider’s other service] recently but a couple of times the medication nurse comes on the floor and helps out.”

We looked at the staffing rota and found that there was a nurse on each shift. We also noted that the acting manager’s name was on the rota but there was no day or time recorded when they had worked in the service, when we raised this they told us that this would be included. Care staffing levels varied from between five and six in the morning and afternoon shifts and four and five on the evening shifts. There was no pattern or documentary evidence to show why these differences happened and there was no system in place to calculate people’s dependency levels to assess how many staff were needed. Without this information we could not be assured that there were enough staff to meet people’s needs. This is a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People’s care records did not include detailed risk assessments which identified how the risks in their daily living, including the use of mobility equipment, accidents and falls, nutrition and pressure area care and prevention were minimised. Where incidents had happened there were no systems in place to show how the staff had responded to them and reduced the risks of them happening again.

There were ineffective systems in place to show how people were supported to reduce the risks of pressure ulcers developing. For example, one person’s records stated that they needed to be repositioned every two hours to reduce the risks of pressure ulcers. Repositioning charts in their bedroom did not show that they were always turned as directed. Another person was assessed at risk of developing pressure ulcers, we checked this person throughout our inspection visit and found that they were lying on their back at all times. Their records stated that they required to be repositioned in bed every four hours. Therefore this person had not been supported as guided to reduce the risks of pressure sores developing. We told the acting manager about our concerns regarding how people were supported to reduce the risks of pressure ulcers developing and they told us that they would look into it. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Our previous inspection of 3 September 2014 found that the provider’s recruitment procedures and processes were not robust enough to ensure that the people who used the service were cared for and supported by staff who were able to care for people in a safe manner. During this inspection we found that improvements had been made.

Appropriate checks had been made on staff to make sure that they were suitable to work in care and were of good character. The application form had been reviewed and now included requests for information about the reasons for leaving previous employment and the reasons for any periods of unemployment. These improvements meant that there were processes in place to safeguard the people who used the service from being cared for and supported by staff who were not suitable and safe to work in care.

People told us that they felt safe living in the service. One person said, “Yes I do feel safe and the people are kind and good tempered.” One person’s relative said, “Yes [person] is safe and [person] is being looked after and [person] only has to press [person’s] buzzer.”

Staff understood their responsibilities to ensure that people were protected from abuse. They were able to explain the different types of abuse and if they had any

Inadequate

Is the service safe?

concerns how they would report them. However, not all staff who worked in the service had received training in safeguarding. Two staff members were able to explain what they understood by whistleblowing and said that they would have no hesitation is reporting concerns if they saw colleagues treating people in a manner that was abusive or not caring.

Risks to people injuring themselves or others were limited because equipment, including the passenger lift, fire safety equipment and hoists had been serviced so they were fit for purpose and safe to use. Regular fire safety checks were undertaken to reduce the risks to people if there was a fire.

There was guidance in place to advise staff of the actions that they should take to minimise the risks to people in the case of an emergency. The service had a business continuity plan. This covered what the procedure was in case of fire or the need to evacuate people. The provider had a mutual agreement with another of the provider's services where people could be moved to.

People told us that they were happy with the arrangements for how they were provided with their medicines. One person said that they got, "A tiny pot of pills when you wake or with our breakfast and they stay with you when you take them, then again lunchtime and at the evening meal and then when I am in bed. Never missed any." Another person commented that they got their medicines, "Once a day first thing." One person's relative said, "I am told [by the person] that [person's] drugs are on time."

People's medicines were stored securely so they were kept safe but available to people when they were needed. We saw that medicines were managed safely and people were provided with their medicines in a safe and caring manner by staff. Medicines administration records were appropriately completed which identified staff had signed to show that people had been given their medicines at the right time.

Inadequate

Is the service effective?

Our findings

Our previous inspection of 3 September 2014 found that staff were not provided with the training and support that they needed to meet people's needs effectively. During this inspection we found that some improvements had been made in the provision of one to one supervision meetings to staff and training, but further improvements were needed.

Since our last inspection staff had been provided with one to one supervision meetings. However, there was no detailed information about how staff had been provided with the opportunity to discuss issues they had and to receive feedback on their work practice to help improve the quality of the service.

People's comments regarding the staff's competence varied. One person told us, "The staff's level of training is good." Another person commented, "They need fully trained staff on adequate pay."

Staff were not provided with the training that they needed to meet the needs of the people who used the service effectively. The provider had not taken action to improve the ways that they managed and planned their training. Their action plan identified the improvements that they were making and would be completed by the end of November 2014. They told us that training in specific subjects would be provided. We found that training in continence care, falls prevention, pressure sore and other risk assessments had not been completed, despite the provider telling us that this training would be delivered. Some staff had received training in the malnutrition universal screening tool (MUST) in July 2014. The acting manager advised that some staff had attended dignity training in the provider's other service which had been delivered by the local authority, but there was no record of this in Saint Mary's Nursing Home. There was no record to show that any staff had received training in infection control, food hygiene, behaviours that challenge or training in people's diverse needs, such as diabetes, dementia and mental health conditions specific to the people using the service in 2014 or 2015. Without this training or regular best practice updates we could not be assured that people's needs were met effectively.

The local authority were supporting the service in developing moving and handling risk assessments and had held workshops to support the staff to meet people's mobility needs safely. However, other professionals reported that there were still some areas of poor practice relating to moving and handling which put people at risk of injury.

There was an induction in place which included new staff shadowing experienced staff and being shown how to perform care tasks, but this did not incorporate a recognised induction programme during which new staff were provided with core training. The acting manager was able to show us some plans for future training but was unable to evidence that this covered all the gaps in staff's skills or explain why this had not been completed as their action plan stated in November 2014. They also could not explain how they were ensuring staff knew how to meet the assessed needs of people without reflected training and updates. This is a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The service did not properly ensure that people's consent was sought in relation to care and treatment provided to them. There was a notice in the service's office which stated that all staff must have completed on-line training for the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) by 27 January 2015. Some staff had received this training previously in 2013. We found that not all staff we spoke with had an understanding of what MCA or DoLS meant for those they cared for. The subject was also not part of regular discussions and planning of people's care with the staff team.

The acting manager told us that they had an understanding of the deprivation of Liberty Safeguards (DoLS) legislation and had completed referrals to the local authority in accordance with new guidance to ensure that any restrictions on people, for their safety, were lawful. Despite this we found they were not acting in accordance with DoLS. For example, two people were provided with their medication which was hidden because they refused to take it. The provider's policy on administering medicines stated that this should only be done when a multidisciplinary team had assessed the person as lacking capacity to make decisions. Staff in the service were not following their own policy. The acting manager and nurse both stated that the decision had been reached by speaking with the person's doctor and family members. Both of these people's records said that the people had capacity to make their own

decisions. There was no further information available which showed that the person had consented or that a DoLS referral had been made to the appropriate professionals to ensure that these people were not deprived unlawfully of their liberty to make their own decisions.

There was some confusion about the capacity of another person who had recently been discharged from hospital and had returned to the service. We discussed the case with the acting manager because it was not clear if the service had reassessed if the person's ability to make decisions independently had changed. There was no documentation in place to show that this had been revisited since returning to the service. Therefore we could not be assured that this person's decisions were appropriately sought and the service had consulted with appropriate professionals about their ongoing care.

People's care plans identified if people had the capacity or not to make decisions. However, these lacked detail to guide staff on actions they should take if a person lacked capacity to make specific decisions. There was no documentation in place to show that people had consented to their care, treatment and support other than for the use of bed rails. There was no explanation in people's records as to why this consent had not been sought. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The ways that the staff planned for, provided and recorded people's diet and fluid intake were not robust. People's daily records identified the percentage of the meals that they had eaten, but there was no indication of the size of the portions to allow staff to accurately identify the amounts people had eaten. One person who was at risk of malnutrition was sometimes supported to eat by their relatives with food they had brought in for them. This person's records did not consistently show if the person had received a balanced and healthy diet to minimise the risks. Some entries to the records showed the percentage eaten and others just said, "Family." We discussed this with the acting manager, because they could not monitor what the person had eaten because they did not have the detail of the amount of food their relatives had brought in. The acting manager told us that they would look into this. None of the records included the amounts that people should eat and how this was monitored.

We looked at records which were intended to show how people's fluid intake was monitored for those who had been assessed as at risk of dehydration. However, none of these showed the amounts that people should drink. The records were not consistent, some were recorded in sips and some the amount in, "mls." There was no calculation to show the total amounts people had each day. Therefore the systems in place to assess people's fluid consumption were inadequate to ensure the risks of dehydration were minimised effectively. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People's views about the food that they were provided with varied. One person said, "The food is very good and I never go hungry, they always give you a choice if you do not like it." Another person commented, "Generally the food is pretty good, I am on a soft diet and they ask me what I want and mostly I get it. Snacks are OK but dinners leave a bit to be desired." Another person said, "They need more flexibility in food like a better substitute meal, the fish portion is quite meagre but we don't go hungry we have got biscuits and toffees." Another commented, "I give it (the service) five or six out of 10 but the food lets it down." One person told us about how their comments were listened to and acted upon regarding the provision of food, they said, "We have complained about the supper menus as being unimaginative and inadequate and now the supper menus are under review. They rely heavily on soup and sandwiches and this does not cut it with people of my age and now they ask me what I want. Myself and [other person] have beans on toast, egg on toast or an omelette rather than spam or ham sandwiches."

People's relatives were positive about the food in the service. One said, "Food looks good and I have tasted the lunch on four or more occasions and it was always tasty."

We saw that where people required assistance to eat and drink, this was done at their own pace and in a calm way. Staff took appropriate action when they saw that people had not eaten their meal, for example, one person was provided soup as an alternative when staff saw that they had eaten a small amount of lunch. Lunch was well presented and we saw that people were offered choices of drinks and snacks throughout the day of our visit. Records showed that people were weighed regularly and that when there had been issues, such as weight loss, the staff had sought support and guidance from a dietician.

Inadequate

Is the service effective?

We spoke with the chef who knew about the specific dietary requirements of people and people's likes and dislikes. They told us how they always provided alternatives to the menu when people did not like the two choices on offer for meals.

People said that their health needs were met and where they required the support of healthcare professionals, this was provided. One person said, "If you are not well you can request a doctor." One person's relative commented, "They [staff] will get a doctor or the practice nurse if [person] needs one."

People had access to healthcare services and received ongoing healthcare support. Staff took action to seek support and guidance when issues with people's wellbeing were identified.

Requires Improvement

Is the service caring?

Our findings

People told us that the staff were caring and treated them with respect. One person said, "Care is adequate, the carers are very good here." Another person commented, "I know all of the staff and the staff are nice and friendly, they have a good working atmosphere." Another told us, "Staff are very approachable and very good. I cannot fault any of them."

This was confirmed by people's relatives, one told us, "The staff are excellent and make me welcome." Other comments from people's relatives included, "The patients here are happy and the carers are very chatty," and, "I am quite satisfied, everyone is so kind and they are patient."

Our observations and discussions with staff confirmed what people and their relatives had told us. Staff spoke about people in a caring way and interacted with people and their relatives in a compassionate, respectful and professional manner. For example staff made eye contact and listened to what people were saying, and responded accordingly. There was laughter and light hearted chatter between staff and people. One person and a staff member talked with us about the person's hobbies and the type of music that they enjoyed. Another staff member engaged in discussion with a person about a book they were reading. Both people responded in a positive way to staff, such as smiling when they were chatting.

People told us that their privacy was respected and that the staff knocked on their bedroom doors before entering. One person said, "They always tap on the door before entering." This was confirmed in our observations.

We saw, from one person's records that the staff used a communication board to communicate with one person who used the service. This meant that their diverse communication needs had been identified and they were taking action to try to meet this. However, there was no information to show that the service's staff had used interpreting services to seek the person's decisions about their care, this was done with the assistance of relatives.

People's records included information to tell staff about people's life experiences and diverse needs. This included how they communicated, mobilised and their spiritual needs. However, the care records did not appropriately identify how people's diverse needs were met, including those with mental health needs. Where people could not verbally express their experiences to staff there was a 'this is me' booklet in place which identified what was important to the person, their family, their work history and any hobbies and interests they had.

People told us that the staff listened to what they said and their views were taken into account when their care was planned and reviewed. However, none of the people we spoke with said that they had seen their care plans. One person said, "I have lunch and dinner downstairs and breakfast in my room, my choice." Another person said, "I get up and go to bed when I want."

People's relatives told us that they were consulted about their relative's care and that they were kept updated about their wellbeing.

People's preferences including their likes and dislikes and their decisions about end of life care were included in records. However, there was limited information to show that people's preferences were regularly revisited to ensure that staff were provided with the most up to date information about people's needs and choices.

One person told us about how the staff respected their independence when they were provided with their personal care support. Staff were made aware of the areas of care that people could attend to independently. We saw staff encourage people's independence throughout our inspection visit, for example when people were eating their meal.

The service had placed CCTV cameras in the communal lounge of the service, this was to enable the manager to observe the activities of the staff. There was no documentation in the service to show that people or their relatives had consented to show they had been consulted about the risks to their privacy being compromised. The acting manager told us that people's consent had been sought and would send us the documentation. This was sent to us, which showed that people had been consulted about issues which could affect their rights to privacy. However, there was no signed consent from people and their representatives.

Requires Improvement

Is the service responsive?

Our findings

Our previous inspection of 3 September 2014 found that care and treatment was not planned and delivered in a way that was intended to ensure people's safety and welfare. During this inspection we found that some improvements had been made, but there were further improvements needed.

There had been improvements made in the way that people's changing needs were recorded in 'continuation sheets', which were monthly reviews. However, the main care plans had not been updated to reflect these changes to show how they had affected the care that people needed. Therefore the provider had not made the necessary improvements to ensure that records were fit for purpose and up to date to ensure that staff were consistent in how their care was provided. For example, one person's records stated that they did not like accepting assistance with oral hygiene, but there was nothing in the records to guide staff on how this person was supported to ensure that they received care which met their needs.

There had been no improvements made since our last inspection to show how staff responded to people's individual care needs and how the care was planned for and provided to meet these specific needs. For example, one person's records stated that they required a diabetic diet but there was no indication of what this diet was, for example what was not appropriate for the person to eat and why. There was also no information provided about signs and indicators of the person becoming unwell associated with their condition and the actions that staff should take. This could lead to the person receiving unsafe and inappropriate care.

Three people's care records identified that they had mental health conditions, some including dementia. There was no specific information in these records to show how people's conditions affected the person's wellbeing and the signs and indicators of them becoming ill or distressed. For example, one person's care records stated that their mood was unpredictable and they needed encouragement and reassurance. However, there was no specific information about what unpredictable behaviours this person displayed and the tried and tested ways that they were supported to reduce their anxiety. One person's relative told us, "They [staff] have rung me when they have found [person] distressed in the mornings and I have come and managed to calm [person]." Whilst it was positive that the staff had took action to seek additional support for this person, staff were not provided with the information they needed to support this person directly. There was no guidance in their records about if information had been sought from their relatives about how to support them when they became anxious which could lead to them being supported in an inconsistent manner.

The acting manager told us that if care staff had concerns about people's wellbeing they were to report them to nursing staff who would make assessments and take action. However, the care plans did not adequately identify the signs and indicators that care staff should be aware of to identify concerns. There was also an assumption that nursing staff had the knowledge to address issues appropriately. Without the detail in care plans and the lack of staff training we could not be assured that people's needs were assessed, planned for and met in a safe and consistent manner.

People were not supported to undertake stimulating activities that interested them. People told us that there were limited social activities that they could participate in. One person said, "We sat in the garden in the summer about six times. We used to have a monthly keyboard singer session but that stopped before Christmas. They [staff] don't tell us if anything is happening or may be it is on a notice board downstairs. They have a library cupboard with second hand books." Another person said, "There should be more things to do but most of them (other people) have dementia." One person told us that they attended a day centre in the community twice a week.

The acting manager told us that they had arranged for an activities staff member to provide arts and crafts activities for people. They showed us the plan for 2015, which identified that there would be two sessions each month. There was a notice in the lounge which stated that there was an exercise session each Wednesday, bingo Thursday and Flix night (watching a film) on Fridays. In addition there were afternoon activities, such as 'getting to know each other'. However one person told us, "Sometimes we do quizzes but activities are not good. Bingo used to be weekly, it ended a month ago as they did not have the staff. Flix Night on Fridays petered out, they did not have the staff to do it." We did not see any activities happening on the day of our visit. There were no sensory items in the service which people could handle and use to stimulate their

Requires Improvement

Is the service responsive?

senses, particularly those people who were living with dementia. There was no evidence of people being assisted to maintain their interests and hobbies on a one to one basis or for those people who chose to stay in their bedrooms. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us that they had access to call bells. One person said, "There are ample bell stations plus an emergency alarm in my room [bedroom]." Another person commented, "I have the buzzer on my knee as I have to make sure I have it to hand." One person's relative told us how the staff cared for their relative, "They are patient and they watch [person] carefully as [person] is unsafe on [person's] feet." However, during the morning we saw that two people who were in their bedrooms did not have their call bells within their reach, which we pointed out to staff. Which meant that if they needed assistance they could not call for it. We checked on these people and others later in the afternoon and saw that all people in their bedrooms had the call bells to hand.

We saw a notice in the service which stated that visiting times were from 10am to 7pm. This did not promote and respect people's rights to maintain relationships with people who were important to them, particularly if people's relatives could not get to the service during these times. We spoke with the acting manager about this restriction and they told us that the notice would be removed because it was in place due to late visits from a relative of someone who had previously lived in the service. We asked people's relatives if this restriction affected them when they wanted to visit people. One said, "I visit between 10am and 7pm and I have come earlier and it has not been a problem." Another commented, "I can visit any time between 10am and 7pm but they don't say anything if you are still here at 7.30pm."

People told us that they were supported to maintain their relationships. One person told us that their relative had visited regularly and, "At Christmas [relative] came here for dinner and had the Christmas dinner, it was a fantastic meal." Another person regularly visited a friend.

People told us that they knew who to speak with if they needed to make a complaint. Complaints were documented and acted upon in a timely manner. Records showed that staff were advised of the outcomes to complaints. There was a complaints procedure in place which was displayed in the service, and explained how people could raise a complaint.

Inadequate

Is the service well-led?

Our findings

Our previous inspection of 3 September 2014 found the provider did not have an effective system to regularly assess and monitor the quality of the service that people received. During this inspection we found that some improvements had been made, but there were further improvements needed.

One person's relative commented, "I don't know where the manger is and I am not sure who is in charge but the staff are excellent and make me welcome." There were no meetings held in the service to which people and their relatives were invited. Therefore people were not kept up to date with changes in the service and they could not contribute to the running of the service. The provider's action plan told us, "Meeting of residents, relatives and friends will be held at least once every quarter." There was no information provided that confirmed these were taking place.

Records showed that people were asked for their comments about the service. Some recorded the outcomes of these discussions, for example providing a specific drink during mealtimes and changing the range of food available for evening meals. This was confirmed by one person we spoke with. However, without the opportunity to express their views anonymously and in regular meetings we could not be assured that people were provided with the opportunity to contribute to the running of the service they were provided with.

There was no registered manager in post since September 2014. The registered manager from another of the provider's services was splitting their time between this service and the other on an interim basis. During our inspection we were told a new manager had been appointed and was due to start the day after our visit. This would allow the staff to receive consistent leadership.

The acting manager told us that the provider had recently employed the services of a person who was assisting the service with their quality assurance. This was confirmed in the provider's action plan, which stated, "As part of an ongoing quality monitoring, an independent agency has been asked to visit the service and conduct an in depth survey of satisfaction amongst the users of the service and their relatives. Records of such surveys will be maintained." The acting manager was unable to show us what impact this had or what improvements had been made as a result of this work. Staff were also unaware of how the service was planning to improve. They were unable to tell us what the vision and values were for the service. This led to the culture of the service being task orientated.

One staff member told us that they felt supported by their colleagues but there had been changes in management which did not make them feel secure in their role. Another staff member told us that there had not been much change since the previous registered manager left, there had been another manager in the service during our last inspection but they said, "I don't know where they went." This told us that the staff were not kept updated with changes in the service.

The service's quality assurance systems were not effective in driving continuous improvement. We saw that the provider visited the service and they reviewed what they found producing a report. However, there were no action plans following the visits to address areas of the service that were identified as requiring improvement. This was also the case following safeguarding concerns and incidents where the outcomes had not been used to learn from to reduce the risks of reoccurrence and train staff. Actions were not monitored to demonstrate that improvements had or had not been made and sustained.

We found that the provider had not taken appropriate and swift action to improve the service as a whole. They had only taken action in some of the specific areas identified by us and other professionals but had not independently looked at where the lessons learned may apply elsewhere. For example best practice and provision of good quality care, staff training and infection control. Not all of the improvements identified in the provider's action plan had been completed, such as with staff training. No reasons were given for this despite it meaning that potential risks to people's health and welfare continued.

There were no systems in place to assess the levels of staff against people's needs. We had found that staff were not following the provider's own policies and procedures regarding the provision of medicines that were hidden. There were no systems to monitor that the policies and procedures were effective and staff were aware of them. The lack of improvements in people's care planning meant that we were not assured that people were provided with safe and consistent care.

Inadequate

Is the service well-led?

The service's quality assurance systems did not identify, assess and manage risks to the people who used the service. The provider had not identified or taken any action to ensure that there were systems in place to identify risks in the environment of the service. We found that there were areas in the service that were a risk to people who used the service and did not provide a pleasant and well maintained environment to increase people's wellbeing. For example there was a room on the first floor which was used for storage, this was not secured and was accessible to people who used the service. Access to the back stairs was not secured and provided a risk to people whose mobility was impaired who might use them unnoticed. The door to the drying machine in the laundry was broken and was propped closed with a broom or mop handle. The acting manager had said that they were aware of this and would check when it had been broken. Although people who used the service could not easily access this room, there was no further investigation taken to check that the machine was safe to use by having the door shut by another method than its design intended. We picked up a chair in the dining room to move it and it fell apart, this was immediately removed by staff. However, this had not been noted until we had pointed it out. This was a risk because the chair was clearly not secure and could have fallen apart when a person sat on it.

There was not an effective system in place to monitor the wear and tear and safety of the environment and drive improvement. The environment was tired and in need of refurbishment. Skirting boards and walls were marked and chipped where, for example wheelchairs, had scraped along. On the top floor there was a hole in the corner of one skirting board. One the first floor there was no trim between the carpet in the hall and the carpet in a bedroom, which was a trip hazard. The radiator near to the office door was leaking and left a wet area on the carpet. We saw that the metal grating on one radiator cover in the dining room had bent leaving an exposed sharp edge. We pointed this out to staff by telling them that a person could cut their hands, the staff took immediate action to address it. This is a breach of Regulation 10 of the Social Care Act 2008 (Regulated Activities) Regulations 2010.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **Systems were not in place to provide people with a clean and hygienic environment to live in and to prevent the risks of cross infection. Regulation 12 (1) (b) (c) (2) (c) (i) (iii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **Systems were not in place to ensure that there were sufficient numbers of staff to safeguard the health, safety and welfare of people who use the service. Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **People who used the service were supported by staff who were not trained and had the necessary skills to meet their needs effectively. Regulation 23 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.**

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 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment

This section is primarily information for the provider

Action we have told the provider to take

The systems in place to obtain and act in accordance with, the consent of service users in relation to care and treatment provided to them, was not effective. Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations 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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The service's quality assurance systems did not identify, assess and manage risks to the people who used the service. Regulation 10 (1) (a) (b) (2) (b) (i) (iii) (c) (i) (e) of the Social Care Act 2008 (Regulated Activities) Regulations 2010.**

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 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **The service's quality assurance systems did not identify, assess and manage risks to the people who used the service. Regulation 10 (1) (a) (b) (2) (b) (i) (iii) (c) (i) (e) of the Social Care Act 2008 (Regulated Activities) Regulations 2010.**