Britannia Care Homes Limited

The Limes Nursing Home

Inspection report

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Date of inspection visit: 2 & 9 December 2014
Date of publication: 30/04/2015

Ratings

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

Overall summary

We carried out an unannounced inspection of this service on 2 and 9 December 2014. When we last inspected the service in June 2014 we found that the registered manager had not taken proper steps to give written guidance to inform care staff on how to support people in line with their care plan, provide adequate staffing levels to support people with their meals or maintain their mobility, provide training for staff in dementia care, ensure there was a clean and safe environment for people using the service or conduct quality audits across all service areas to ensure people using the service were happy with their care.

Following that inspection the registered manager sent us an action plan to tell us the improvements they were going to make. They said their improvements would be completed within two months of 16 July 2014.

During this inspection we found that improvements had not been made to protect people who used the service and there were still significant breaches which the registered manager had failed to address. Some people

Summary of findings

living at the home were being unlawfully deprived of their liberty and had unnecessary restrictions on their choices and personal freedom. The quality of life for people who lived at the home was poor.

The Limes Nursing Home is a care home providing residential and nursing care for up to 42 people. At the time of our inspection 38 people resided at the home. The Limes Nursing Home is separated into two units. The main part of the home, The Limes unit, and a smaller part, The Pines unit. Some people who reside in the Limes unit spend their day in the Pines lounge.

There was a registered manager in post at the time of this inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The staff we spoke with were not confident in describing the different kinds of abuse and the signs and symptoms that would suggest a person they supported might be at risk of abuse. They did not know what action to take to safeguard people from harm.

People told us contradictory things about the service they received. While some people were happy, others were not. In addition, our own observations, the opinions of visiting professionals and the records we looked at did not always match the positive descriptions some people had given us.

People's safety was being compromised in a number of areas. This included how well equipment was cleaned and maintained and the lack of support for people who could mobilise if they wanted to.

Staff were not always following the Mental Capacity Act 2005 for people who lacked capacity to make a decision. For example, the registered manager had not made an application under the Mental Capacity Act Deprivation of Liberty Safeguards for two people, even though their liberty may have been restricted.

We found that people's care was not planned or delivered consistently. In some cases, this either put people at risk or meant they were not having their individual care needs met. People were not always supported to eat and drink enough to meet their nutrition and hydration needs and this was not monitored effectively.

We were concerned that some people living at the home were isolated because they did not leave their rooms. There were not enough opportunities for people to engage in hobbies, social interests or activities either as a group or on an individual basis.

People were not involved in the decisions about their care. We also found that staff did not always respond appropriately to people if they became agitated or distressed.

Staff working in the home did not understand the needs of the people they supported. There were no person centred plans in use and staff did not access the nursing care plans which were being used by the nurses. Person centred plans are designed to capture the needs of a person on an individual basis. Person centred plans are crucial to guide staff in how to support individuals in the way they want to be supported. They also help staff understand the different ways people communicate if they are unable to communicate verbally. Without them staff cannot provide effective care and support. We had addressed this with the registered manager at the last inspection in June 2014 who assured us this would be looked as a priority. There was little or no interaction between staff and people living at the home and people were not encouraged to make their own choices or be involved in decisions about them.

People who used this service did not receive safe care and support from a trained and skilled team of staff. There had been six new staff recruited to replace those who had left. Some had not received an induction, were new to care and did not know what they were expected to do. They did not understand their caring responsibilities and they received little or no support from the registered manager of the home.

There were not enough staff to respect the rights and promote the dignity for all people living at the home. We found people were got up early by the night staff as there were not enough day staff available to support a flexible morning routine. We did not see evidence that the care

Summary of findings

and support afforded to people living at the home was based on best practice guidance, and nurses did not receive adequate training or clinical supervision to keep their skills and knowledge up to date.

At the last inspection in June 2014 we had raised the issue with the registered manager about the need for staff to be clear about their roles and responsibilities. We asked that job descriptions be made available for staff so they fully understood what they were expected to do. We found this had not happened and there was still ambiguity between the team about who did what. There were no clear lines of accountability and there was friction between different members of the team and the registered manager.

The provider had no effective systems of quality assurance which measured the outcomes of service provision. Leadership within the service was weak and there was a lack of communication and involvement between the registered manager, the staff and people living at the home, regarding the day to day things which affected their lives or work.

Inspectors found that improvements required as a result of a previous inspection had not been made, and we also identified further concerns. As a result CQC is considering all options available to them in relation to protecting people who use the service.

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.

Staff we spoke with did not know how to keep people safe from abuse. Staff were not aware of any procedures and supporting documents to guide them on taking the correct action if they suspected a person they supported was at risk of harm.

People who used the service had unnecessary restrictions on their choices and personal freedom. There were not enough staff to promote independence or respect choice.

Appropriate support was offered to ensure people received their medicines safely.

Is the service effective?

Inadequate

The service was not effective.

People using this service were not involved in decisions about how their care and support would be provided.

People who used this service were not supported by trained staff who understood their individual needs well.

There were systems in place to monitor people's health and the nurses made referrals to health and social care professionals when necessary.

Is the service caring?

Inadequate

The service was not caring.

People who used this service were not always treated with kindness and compassion and their rights to privacy, dignity and respect were not upheld.

Care staff did not engage on a personal level with the people they were supporting or listen to the views and preferences of the people they cared for. There was no person centred approach to the provision of care.

Care staff did not understand the specific care needs of the people they supported.

Is the service responsive?

Inadequate

The service was not responsive.

People were not encouraged to express their views on how their care and support would be provided.

People did not receive support to utilise the equipment they needed to maintain their independence.

People using this service told us they were not confident that their concerns would be listened to and dealt with appropriately.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well-led.

Staff received very little support from the registered manager and the team did not work cohesively together. There was ill feeling between staff at all levels which was not being managed effectively.

Staff had little understanding of their responsibilities or the responsibility of others and there was no clear management structure or lines of accountability in place.

There were no quality assurance systems in place to drive continuous improvement which was reflective of what was in the best interests of people who used the service.

The Limes 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place over 2 days, 2 and 9 December 2014. The inspection was unannounced.

The inspection team consisted of two inspectors, a specialist nurse advisor and an expert by experience, who had experience of older people's care services. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we sent the provider 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 had not received the PIR back from the provider at the time of our inspection.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Before our inspection, we reviewed the information we held about the home, and spoke with commissioning officers from Manchester City Council. During our visit we spoke with 21 people who used the service, three relatives and 10 members of staff including the registered manager, the cook, an administrator, the housekeeper, care assistants and registered nurses. We observed care and support in the lounge and dining room and also looked at the kitchen, the laundry and several people's bedrooms.

We reviewed a range of records about people's care and how the home was managed. These included eight care plans, four of which we looked at in detail, to ensure the correct support was being delivered in line with the care plan. We looked at food diaries, continence logs, daily incident logs and medication records for all people residing in the main part of the home. We looked at two records reviewing dressings management and information relating to capacity assessments and best interest decisions for three people. We looked at staff training and supervision records as well as staff files, and maintenance audits the housekeeper had completed.

Following our visit we spoke with the community nursing home team and the safeguarding team and received feedback on the quality of the service from the local authority contracts officer and a healthcare professional who visits the home on a regular basis.

Inadequate

Is the service safe?

Our findings

At the last inspection in June 2014 we identified that there were not enough staff available to ensure people were protected from having their freedom restricted or to meet their needs.

The registered manager told us "Since CQC's last inspection we have recruited approximately six new staff. One role was recruited as an additional post to work seven days a week from 7am to 2pm." And "We are currently advertising for care staff. Our intention is to improve support in our Pines unit particularly at lunch time. We are currently aiming to recruit 2 care staff, adverts have been placed."

We identified that six staff had been recruited to replace six staff that had left and by looking at the rota and speaking with the registered manager we found no additional staff had been recruited. The senior carer told us there were no additional hours worked since the last inspection and where it seemed a 7-2 shift was a new addition to the rota, hours had been cut elsewhere to accommodate it.

We looked at the rota which outlined there were not enough staff to support people safely. We spoke with five care workers and two registered nurses who confirmed this. They told us, "it is only a matter of time before something serious happens. Other comments included, 'We want to spend time with the residents but we have no time for them," and "'We want to have time to talk and do the little things like paint their nails".

We checked the files of the six new staff that had been recruited since the last inspection in June 2014. We found the information contained in some of the files was inadequate. References did not correspond with the information on the application form, the references in place were unsuitable and some staff members had one reference when the provider told us they required two. One referee had described the person's suitability for the role as "average/poor" and this had not been followed up. The registered manager did not send out job descriptions or person specifications to potential applicants and there was no formal structure to the recruitment process.

One staff member told us they had not supplied a reference from their last employer but had been asked to commence work the day after the appropriate checks had come back from the Disclosure and Barring Service (DBS). A DBS disclosure is a legislative requirement which employers must have to check for criminal records of potential employees.

We found the provider to be in breach Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This is because The registered person did not operate effective recruitment procedures.

On the first day of the inspection we arrived at the home at 6.00am as we had received information of concern from an anonymous source that people were being woken up early by the night staff so they were up and dressed when the day staff arrived. On arrival we noted there were three people up and dressed in the Limes unit. We spoke with the staff member on duty who told us they were instructed by the nurses to get people up from 5.30am. The nurse we spoke with confirmed they got people up early as there were not enough staff on during the day to support people with their morning routine. We spoke with the registered manager who said he had told staff to only support people who wanted to get up or were already awake. This was supported by a notice on the wall prompting staff to get those people up who were awake. However there was nothing recorded in the care plans about people's preferences for retiring to bed or waking up and nothing to direct staff about people's individual preferences and choices.

The registered manager did not do any dependency assessments to determine if there were enough staff on duty at any one time. We observed unsafe practice occurred where one member of staff moved a person when, according to their care records, two were needed. We spoke with the nursing home team who told us this was a concern. They told us there were not enough staff on duty to move people safely and in line with their mobility assessments.

We found the provider to be in breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because the provider had not taken sufficient steps to protect people from the risk of insufficient numbers of suitable staff needed to keep them safe and meet their needs.

Inadequate

Is the service safe?

We spoke with three members of staff about their understanding of safeguarding. Two did not know what safeguarding meant. This meant people were at risk of not receiving the correct support and protection if a safeguarding incident were to occur.

We observed the medicines round in the Limes unit was carried out safely.

The tablets were received monthly, from the pharmacist, in blister packs as prescribed. Medicines in liquid form were stored in individual named baskets. The drug prescription was checked prior to giving the prescribed medicines. Attached to the prescription was a photograph of the resident as well as their room number. For those residents receiving medicine patches a body map was in use to ensure site rotation. All were up to date and showed evidence of site rotation.

All medicines were given to the residents by the nurse with one exception. We saw one person was refusing to take the tablets, the nurse asked the carer to persuade the person. The nurse stood next to the carer and the person took the medicine from the carer with no complaints. This was an appropriate and effective way to enable the individual to take the prescribed medicine.

The nurses were not aware of a policy for reporting drug errors, but were able to talk through what they would do, as they had been involved in an incident a few months prior to the visit.

There were no plans in place for responding to emergencies or untoward events, such as outbreaks of infection, fire, flood and the failure of equipment used in the home. Risks of system and equipment failure had not been assessed although we did see routine checks were being done by the housekeeper in relation to electrical equipment checks.

At the last inspection we found there were breaches in relation to infection control. The provider told us they "have already implemented a cleaning programme with the intention of thoroughly cleaning the whole premises."

During our inspection on 2 and 9 December we noted a strong malodorous smell was present throughout the day on the Pines unit. We asked the care staff who was responsible for cleaning and maintaining the premises and they told us they were not sure. We noted the hoists and slings were dirty with many having human waste present.

At the last inspection we noted clinical waste was not being disposed of appropriately increasing the risk of cross contamination and infection. The provider told us, "The clinical waste bins have been replaced with new bins". When we looked around the building we saw a number of bins in communal bathrooms were not clinical waste bins. They did not have pedals or the yellow clinical waste bags in them. The bins contained clinical waste. When we asked the registered manager about this we were told staff were not following procedure.

When walking around the home we noted the floors in two of the bathrooms were painted and the paint was chipped and worn. People's cream medicines were in the bathroom as were a number of hairbrushes, toothpaste, shampoo, a pair of glasses and a razor. Each person living in the home was required to have their own toiletries and personal effects including hairbrushes and glasses if required. These items should not be left in communal bathrooms and should remain with the person to whom they belong. Using toiletries for more than one person increases the risk of infection and cross contamination. None of the bathrooms we looked at had a dignity lock. These locks are used when people are using the bathroom to stop other people walking in.

We found the registered manager had not taken sufficient steps to protect people from the risk of infection and cross contamination. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At the last inspection in June 2014 we had spoken with the registered manager about the safety of people who used the service in relation to fire evacuation. We were concerned staff did not know what to do in the event of a fire and how people could be evacuated safely. We spoke with registered manager about developing Personal Emergency Evacuation Plans (PEEPS). They told us they would do this as a matter of urgency. At the inspection 2 and 9 December 2014 we found this had not been done.

We found this to be a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because the registered manager did not have procedures in place for dealing with emergencies, in order to mitigate the risks arising from such emergencies to service users.

Inadequate

Is the service effective?

Our findings

We spoke with a number of staff about their training and development needs. Two staff told us the induction programme was limited to watching several modules on a DVD followed by the completion of a questionnaire to assess the learning. Once they had completed the questionnaire they were signed off as competent. The two members of staff did not see this as real training but more of a formality to be completed, without recognising the importance of it and seeing it as a learning opportunity. Staff told us they had no opportunity for discussion, or clarification of any queries from the DVD or questionnaire.

The DVD was completed by staff in their own time and did not have a time frame attached to it. This meant staff may be working without having the appropriate knowledge to deliver effective care.

One member of staff who had worked in the home for one month had no knowledge of what to do in the case of a fire as they had not completed that part of the training and had received no instruction. Fire protocols should be discussed with new starters on day one of employment. At our last inspection in June 2014 we saw the Fire Procedure was located on the walls around the home. We found it was out of date and instructed staff to "proceed to the fire". We found this had not been corrected which meant people using the service, visitors and staff were at risk as there was no clear instruction as what to do in the event of a fire.

We asked two staff what they would do if a person was unresponsive or unconscious, they both stated they would check the person to see whether they were able to wake them and then go for help, neither stated that they would stay with the person and use the call bell, though on discussion they agreed that would be better than leaving the person alone. Neither had any knowledge of basic life support.

We found the training to be a 'tick box' process which staff did not see as training and did not find useful to support them within their role.

We were told all new staff had an identified buddy who they should meet with on a weekly basis. Existing staff told us this was not protected time, did not always happen and lacked structure. We spoke with the registered manager who told us "it should be happening".

There was no structured on going training for support staff although they had a dietician booked to deliver an update session in January 2015. We were told by the staff that any training they wanted, or needed to do was self-funded and in their own time.

No training was offered to nurses except for the initial DVD induction training. We had been made aware that the safeguarding team from Manchester City Council had offered to go into the home to facilitate some training but this had not been followed through by the registered manager. The nurse on duty had done no recent training and told us they had not completed the continuing professional development (CPD) training required by the Nursing and Midwifery Council (NMC) for registration compliance. This was of concern to us as the list of PIN numbers we received from the home were due to expire in 2015. Without being able to evidence their continued professional development the nurses will not be able to practice nursing.

In relation to cardiopulmonary resuscitation the nurses had not undergone any recent training. There were no notices around the home referring to emergency procedures. We saw nursing information in the office was out of date, for example, continence articles from 1992, and a work book from 2005. There was no evidence of current up to date information. The wound care information on the wall was from 2011. This meant people were at risk of receiving unsafe care.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. After the inspection we made a referral to the Nursing and Midwifery Council (NMC) to report our findings.

People were not supported to maintain their independence by the physical environment of the home. We were told of seven residents who could walk. We looked at their care plans and mobility assessments supported this. The registered manager had not completed a risk assessment on the premises making it safe for these people to walk without staff support. The home provided accommodation over three floors and areas of the home were hazardous for people who were able to mobilise. For example we found hoists left on landings and there was no signage to tell people what was behind the closed doors. On the upstairs part of the home one of the doors led out onto a stairwell which had a concrete floor. There were no keypads or locks on any internal doors to prevent people

Inadequate

Is the service effective?

from falling downstairs. As a consequence people were only able to walk when staff were available. Due to the number of staff on duty at any one time this was not very often. One family member told us "He is never encouraged to walk. He can do some walking. He could do more with more staff. His lack of mobility has kicked in." One person who used the service told us, "we are not allowed to walk or go out as the manager said we might fall, I don't know if I can walk now, you use it or lose it don't you?"

We found staff encouraged people not to walk and risk assessments were done to mitigate the provider in the event of a fall rather than to promote the independence of people living at the home. We found there was not enough staff on duty at any one time to encourage the seven people who could walk to maintain their independence even if they wanted to.

The décor of the Pines was not conducive to providing good care for people living with dementia. We had brought this to the attention of the registered manager at the last inspection in June 2014 when we found the unit to be cluttered with mismatched furniture, the floor in a state of disrepair and wheelchairs stored in the corner.

At this inspection we noted some re decoration of The Pines unit had taken place however the patterns were big and bold and not conducive to promoting the wellbeing of people who were living with dementia in line with current research and guidance. We discussed this with the registered manager who told us he was "not convinced" by the research done about supporting people who were living with dementia. We noted the wheelchairs were still stored in the corner.

We found the registered person did not make suitable arrangements to ensure the dignity, privacy and independence of service users; was respected and promoted and did not enable service users to make, or participate in making, decisions relating to their care or treatment. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

When walking around the building we saw that most residents had bedrails. People we spoke to were unsure why they had them and one person was upset as they wanted to get up but could not get past the bedrail. We asked if they would like a member of staff and they nodded their head. There were no staff present in the Pines unit so we went and got the registered manager who went to reassure her. We looked at the care plan which said "cot sides" not to be used because the person would become upset and agitated. We spoke with staff about their understanding of the use of bedrails and they told us "I don't really know I will get someone" and "yes we use them to keep people in bed". The registered manager told us he had told staff not to use bedrails in relation to this person. There was no evidence of this and contradicted what staff had told us and what was recorded in the care plans.

We saw one person was strapped into a wheelchair. We reviewed the file for this person. The file stated the person had "no capacity for care and welfare" yet when we asked them if their legs were cold, we were told "yes" and they were given a blanket. There were lots of contradictions in the file. There was not a completed capacity assessment to support the decision that the person lacked capacity nor were there any restrictive practice assessments to ascertain why the person was strapped in a chair. There were no Deprivation of Liberty Safeguards authorisations under the Mental Capacity Act 2005, or any best interest decisions noted.

During the inspection we also observed a person was confined to their room and was being nursed in bed. We noted the room was upstairs at the far end of the building. The person was unable to transfer to a chair or use the lift to come downstairs due to physical restrictions caused by being immobile which meant they could not utilise the lift. This meant this person had little or no social interaction and was confined to their room thus being deprived of their liberty. The provider had not considered least restrictive options for this person, for example a downstairs room. Again there were no Deprivation of Liberty safeguard authorisations under the Mental Capacity Act 2005, or any best interest decisions noted. We found this was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Following on from the inspection we sent a safeguarding alert to Manchester City Council.

We discussed the Deprivation of Liberty Safeguards (DoLS) with the registered manager. They told us they were waiting for support from the community nursing home team who were doing the capacity assessments and best interest meetings for the people who lacked capacity.

Inadequate

Is the service effective?

We saw notes from the nursing home team that included decisions around Do Not Attempt Cardiopulmonary Resuscitation (DNACPR). The notes were not supported by capacity assessments or best interest decision making processes which were the responsibility of the registered manager. The registered manager told us they felt the community nursing home team were responsible for providing capacity assessments for day to day decisions. As this is not the case it was clear to us the registered manager did not understand their duties under the Mental Capacity Act 2005. We found this was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At our last inspection in June 2014 we found people were not supported to have sufficient to eat or drink to maintain a balanced diet. The provider told us "We have improved support of residents particularly during lunchtimes on our Pines unit, in order to promote a better mealtime experience for Pines residents and to provide a more organised and enjoyable lunchtime period. We are currently recruiting additional care staff in order to provide this additional support. As a result of this improved support the staff will be able to record and monitor our residents' food and fluid intake more accurately. We will also arrange for jugs of water or juice to be available for residents of this unit during the day."

We carried out observations in both units within the home at lunchtime and spoke with people whilst they were having lunch.

We were told eight people needed support to eat their lunch and were having their daily intake of food and fluids recorded. There were not enough staff to provide one to one support to these people. We were told one member of staff sat with the people who needed support and supported them all. We reviewed the food and fluid charts on the Pines unit. We looked at the available charts at lunch time; seven of the eight charts did not have any entries for the day. A member of senior staff told us they had not had time to do them yet but remembered what each of the seven residents had had to eat or drink since they woke up. We did not see jugs of water available throughout the day in the Pines unit although it was available in the Limes unit.

On the Limes unit the carers maintained daily logs which recorded what individuals had to eat and drink. We saw In the dining room plates were cleared away before support staff could have noted what was eaten although the charts were filled in. These charts were completed without adequate information. The nurse was not seen to check these records during the shift. This meant that care plans were not being updated with correct information for people who were at risk of weight loss or malnutrition.

We found people were not always supported to have sufficient to eat or drink and maintain a balanced diet and effective monitoring of this did not take place because there were not enough staff. We found this was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The community nursing home team told us they had no concerns that people were not supported to access healthcare services when they needed it. It was reported by the home that there were regular meetings between the registered manager, nurses, community nursing homes service and GP to review people's needs. The minutes of meetings and actions taken were not available at the time of our inspection so we were unable to review the effectiveness of these meetings for the people who used the service.

Inadequate

Is the service caring?

Our findings

People in The Pines unit told us they were unhappy living at the home. We asked people on the Pines Unit if they were asked to be involved with anything or had an opportunity to speak with the registered manager. They told they didn't.

During our visit we observed interactions between staff and the people they were supporting. In the Pines unit staff were not attentive and made no attempt to engage with people sitting in the lounge or at the dining table. Staff spoke amongst themselves whilst they were supporting people to eat and over people's heads when there was a shift change. We saw one nurse enter The Pines lounge at the start of their shift and begin speaking to the staff, who were carrying out tasks, about things that were not related to work. They ignored the people sitting in the lounge and did not greet them nor respect the fact the staff were busy with the tasks.

During our observations on the Pines unit we noted four people were left unattended on three separate occasions. One occasion was for twenty minutes. Another person was left in the toilet area in the wheelchair whilst the member of staff went to attend to a call bell. A member of our team intervened when the person who had been wheeled into the toilet was asking for help and shouting for staff.

We spoke with the community nursing home team who told us they had concerns about the quality of life people experienced living at the home, and the calibre of support staff, but no concerns about the clinical care provided. They said the nursing staff were responsive when they were asked for information and were always helpful.

During our observations we saw lounges in the Pines and the Limes left unsupervised for periods of time throughout the morning. The care files we looked at stated people should "supervised at all times". This was a concern to us due to the vulnerability of some of the people who were left alone. We saw people in reclining and restrictive seating without appropriate assessments. Staff did not speak to the people nor take time to listen to what the people were trying to say.

In The Limes unit we did not observe staff spending any quality time with the people who lived at the home. People were sitting in chairs around the outside of the room with very limited interaction from staff. What interaction there was concerned offering people a drink or taking them to the toilet. The only entertainment for the people in the lounge was the television which was on one channel all day and at a very loud volume; no one appeared to be watching it. People who remained in bed had no interaction with staff except to meet their personal care needs.

We noted people were not offered a bath or a shower as part of their morning routine. We saw that most people we spoke with had dirt embedded under their finger nails. They were not able to recall when they last had a bath or shower but they said they did have a wash every day. We asked to see bath monitoring charts but none were available. We spoke with the registered manager who told us people were able to bathe when they wanted, although we did not see how this was possible given the number of staff on duty.

We spoke with the registered manager about the comments we had received from people who used the service and they told us because people did not generally have capacity it was difficult to know if they meant what they said. They told us they regularly walked round the home and people never complained. He said he regularly spoke with families and despite receiving a bad report from CQC they had not complained either. We asked the registered manager about the capacity assessments he had done to conclude people did not have capacity to make decisions about their care. He told us he had not done any but knew the people well. This was a concern to us as the Mental Capacity Act 2005 states a person should have "presumption of capacity" and staff must assume that a person has the capacity to make decisions and take steps to maximise that capacity to ensure people take all possible steps to reach a decision themselves.

We found the registered manager did not treat service users with consideration and respect or enable them express their views as to what is important to them in relation to their care or treatment. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We noted some staff had difficulty understanding some of the questions we asked as English was not their first language. The two staff we spoke with had to ask for questions to be repeated and one misinterpreted what was said. We had observed this being a problem at mealtimes when people wanted to know what they were eating and

Inadequate

Is the service caring?

the staff were not able to answer their questions. We observed people asking about their meal and the response they got suggested staff did not understand the question. This led to the person becoming frustrated and refusing to eat their meal. Another member of staff came and took their plate away saying “are you not hungry?” The person then sat with their head in their hands clearly upset but received no comfort or assurance from staff. We looked at the care plan for this person, it stated “Staff must ask X what she wants to eat each day. X prefers to snack rather than eat a full meal and often refuses food”. We spoke to staff about this and they told us they were not aware of this as they had not read the care plan.

Whilst we carried out observations in the Pines lounge area we saw a number of people in undignified states of dress and noted that the staff did not intervene. For example, people had skirts around their waist while sitting in wheelchairs and underwear on show when being moved in a hoist. We observed that whist the person was being hoisted the staff did not speak with the person to explain what they were doing nor offer assurances when the person became upset. We found staff did not consider people's dignity when supporting them to transfer.

We found people were not supported to manage their continence needs. People told us they were told to use the pad and had to wait a long time before it was changed.

We considered the home to have widespread and significant shortfalls in the caring attitude of some staff. We found some staff were unkind and lacked compassion and people who used the service were not treated with respect. We found there to be breaches of Regulations 9 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service responsive?

Our findings

We spoke to people in the Limes unit where the activities took place, comments included, "Sometimes they come from College to entertain us." And "A girl comes in to do a classic piano show." We spoke with people in the Pines unit who told us "we don't do anything here, it would be nice to go out and do a bit of gardening," and, "I've not been to the park since January (2014). I'm a bit disappointed about that." Most people we spoke with said they would like to go out more and get "some fresh air". People told us they were not allowed to go outside as they may fall.

At the last inspection we had identified people were not receiving personalised care which was responsive to their needs. This was because care plans were not person centred and staff did not access care plans so were not aware of people's clinical needs.

The registered manager told us "Staff are now encouraged to access the full care plan of each resident in order to gain more complete knowledge of the resident's needs. We intend to encourage more interaction between staff and residents, particularly on our Pines unit, in order to promote resident choice, where possible, subject of course to the resident's ability to engage and interact because of their condition."

The registered manager told us he encouraged staff to access care plans for the individuals they were supporting and was not sure if it happened. We were told this was not formally monitored or evaluated but he obtained information from nursing staff and from observations ensuring staff were supporting residents correctly and in line with their care plan. In the event staff were not following people's care plans no other action was taken other than asking staff to amend how they were providing support. We did not see evidence of this on the day of our inspection despite being privy to a number of poor practices which we brought to the registered manager's attention.

We found there was still limited communication between the nurses and support staff. What was recorded in the records maintained by the support staff did not always get transferred into the main records. The support staff were still not aware of what was in the main file so were unable to follow the care plan when delivering care.

A daily incident log was maintained by the support staff but the information in this was not consistently recorded in the nurse's records. For example we saw it recorded that one person had pain in her thigh; however in the main records maintained by the nurse it stated the person was 'pain free'.

At the last inspection in June 2014 we had identified that the registered manager needed to ensure all staff were aware of the risks to individuals by ensuring care plans were accurate and up to date. They told us in their action plan "Currently in progress, working groups with senior carers already set up, about 50% of life histories done, documentation being discussed currently in working groups, families are gradually becoming involved. Completion say within 2 months."

At this inspection we found only four care plans with life histories completed and inconsistencies in record keeping, for example, in one person's record there were gaps in recording the blood sugar, an instruction to check blood sugars pre meal and two hours after meals was not consistently followed. This meant this person was at risk of staff giving insulin without knowing the blood sugar level. We also found the effect of the insulin was not being recorded.

Care records contained risk assessments which were not person centred and had not involved the person who the assessment was for. A relative we spoke with confirmed that they didn't have much involvement in the risk assessments or care planning but were not concerned about this. We saw assessments were done in relation to moving and handling and specified the number of staff required to move people safely. These were not adhered to.

What we found meant the registered manager had not taken appropriate steps to reduce the risk of people receiving inappropriate care and treatment and was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At the last inspection people told us they were bored and we asked the provider to look at improving activities within the home. We reviewed the activity programme and any associated records. We saw music therapy was done for an hour a week by a trained therapist. A record was kept of each person's interaction with the therapy. It was clear from reviewing notes of the sessions it was positive as some residents who had not been involved previously had begun to play instruments including the keyboard.

Inadequate

Is the service responsive?

The home had also introduced pet therapy sessions although this had not been popular with people living at the home. Other activities included armchair massage but it had to be subsidised by the individual. Staff working at the home did not have any designated time to interact with people who used the service in any way other than to provide essential support.

We looked at how the home responded to complaints.

We spoke to one person who said they had items removed from their room. We brought this to the attention of the registered manager and were told they had not been able to investigate as they were unable to gain a timeframe within which items had gone missing. The registered manager had not investigated this as a complaint nor had they formally recorded it or responded to it.

There was no information visible within the home as to what to do if an individual or family member wanted to make a complaint. When we spoke with people who used the service some told us they didn't feel they needed to complain, others said they were not confident anything would get done. They said they did not know about the complaints procedure.

Staff told us they were not aware of a policy but would act according to the complaint. They said "'if the complaint was about being given food they didn't like they would ensure the nurse was told and they wouldn't be given it again. If it was about care they would, "get a nurse to talk to the relative". Staff did not understand the importance of speaking with the people who used the service about their experiences, and complaints were not captured or routinely analysed for learning and as an agent for change.

We observed two people had leg dressings in situ which were heavily stained. On checking their records and through discussion with the nurse we ascertained they both had suffered from chronic leg ulcers over a long period of time. Both had been assessed by the tissue viability nurse (TVN) in October 2014. The dressings should have been redressed three times a week according to TVN instructions. One person in particular was in need of an urgent review. According to the nurse they were have difficulty getting a TVN to visit. There was no documentation to this effect in the person's record or of whether they had utilised other members of the multi-disciplinary team, for example the GP to expedite a review. This was of concern to us as there was no clear audit trail of decisions made, when and by whom. Clinical staff should not be making decisions regarding dressing types without having undergone recent training as they may not be offering evidence based practice as wound management is a fast changing area. The nurse we spoke with had not completed any recent training in wound care. This meant the nurse was acting outside of their area of competence.

We found this to be a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service well-led?

Our findings

The home had a registered manager in place. The registered manager was also the director of Britannia Care Homes Limited, who was the registered provider. The registered manager was also the nominated individual at the home. This was a concern to us as it meant there were no lines of accountability in relation to the poor management of the home.

Before our inspection we spoke with the commissioning team from Manchester City Council who shared with us their findings at a recent inspection. We had also sent out a Provider Information Return (PIR) which the provider had a statutory obligation to return to us within a specified timeframe. The PIR had not been sent back to us. When we spoke with the registered manager about it he was unable to tell us why.

We were unable to review notifications from this home as we had not been sent any. We spoke to the registered manager who said he was not aware he had to notify us of things such as deaths or injury. This was a concern to us as it is important we receive notifications of deaths, injury and safeguarding so we can evaluate the information to ensure people are safe and well cared for. We were made aware during the inspection that people had died in the previous twelve months and we had observed bruising on people's arms during the inspection. We had not received notification of these deaths or injuries which meant the provider was in breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We found there was no evidence of leadership present within the home. Lines of accountability were unclear and the staff team did not work together cohesively. After the last inspection in June 2014 we were told "We are currently preparing a new organisational structure to clarify roles and responsibilities".

We saw a copy of this on the day of our visit but the chart did not define clear lines of accountability or responsibility. One of the key people responsible for training, supervision and audits we were told only actually worked three to four hours a week. When we discussed who did what it was clear roles were still being defined with the potential for some responsibilities to shift between staff. This had been brought to the registered manager's attention at the last inspection in June 2014 but we found little had changed at this inspection.

Staff told us they did not receive supervision. They said they were handed a supervision form to complete themselves. There was no clinical supervision for the nurses, which is a requirement for all nurses. Whilst it may not be appropriate to provide this 'in house', provision for it should be made by the registered manager. The nurses we spoke with confirmed they did not receive any form of supervision.

At the last inspection we asked for job descriptions to be produced for staff who were being promoted into new roles because staff were not clear about these roles, who they were accountable to and how much authority they had. In June the provider told us "We are preparing job descriptions for our Training and Activities Co-ordinator and our Administrator."

We found job descriptions had not been developed for any of these roles. We were told job descriptions had been drawn up to advertise the posts but they were not to hand. We said the registered manager could forward them onto us within 48 hours but we did not receive them. The training coordinator had not formally been recruited in response to a job advert despite the registered manager's assurances that consideration was being given to the management structure and job descriptions and advertisements being sent out. We found people were being recruited without any formal recruitment and selection systems being followed.

We found a cleaning programme which was formally monitored had not been developed but a number of audits had been done and some schedules had been formalised including commode cleaning which began in November 2014.

The provider also told us "We have promoted a member of staff to the position of Housekeeper, to take charge of the domestic and laundry staff and to supervise the cleaning programme."

We found the maintenance man had been promoted to housekeeper and was responsible for completion of audits and monthly checks on the premises. This role was complicated as the person was also responsible for some of the supervision of staff and how they interacted with

Inadequate

Is the service well-led?

people living in the home. The housekeeper did not have any formal experience of managing residential social care settings. We were told the responsibility for the audits may move to the training coordinator who had no management or residential care experience and was currently undertaking staff supervision. Whilst we found the maintenance man to be keen to learn and enthusiastic about their role we found management structures were confusing with no clear lines of responsibility or accountability above carer level.

Staff we spoke with did not recognise the new role of the maintenance man and did not know what the role involved. Some staff said they felt resentful because they thought they were acting outside of their remit and that the original maintenance post was being neglected.

In June the registered manager told us they were going to "re-introduce our internal control audits". We saw the housekeeper had begun to keep records and complete audits, the training coordinator had also undertaken a medicines audit. We reviewed a health and safety audit and an infection control audit. Actions had been identified and were RAG (red, amber, green) rated in order of urgency for completion. An infection control audit completed in August 2014 by Manchester Infection Control Team included a number of actions rated as red. We checked two of these actions and found they had not been completed. This included each person having their own personal hoists and sling if required for transfer. We saw all hoists and slings were kept together in a communal bathroom with no system to ensure they were used only for specific individuals.

At the last inspection we asked the registered manager to improve systems to capture the experiences of people who used the service and their families. They told us "We are introducing a recording system to record the (normally informal) interactions and discussions between the manager and residents and families."

At this inspection we saw notes of discussions the registered manager had had with three people's families We also saw the notes had been used to update assessments and the care plan.

We were told questionnaires had been completed with families. We were shown questionnaires from January 2014. The registered manager told us they had not decided whether to do the questionnaires six monthly or annually. No questionnaires had been completed since our last inspection. The results of the questionnaire from January 2014 had not been collated or actioned.

We did not see any overarching quality assurance systems used by the registered provider to enable them to assess and monitor the quality of service provision. We found the registered manager and staff did not understand the principles of good quality assurance and the service lacked any drive for improvement other than through actions they had to take from external auditors and regulators. We found the registered provider did not protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable them to regularly assess and monitor the quality of the services provided. We found this was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We were concerned the registered manager did not understand the concept of person centred support and so was unable to develop the staff team to make sure they displayed the right values and behaviours towards people. There was no evidence of a service promoting a positive culture which was person centred, open, inclusive or empowering.

Following on from the inspection we asked to see the training records of the registered manager. We did not receive this information.

The registered manager did not demonstrate that they had the necessary qualifications or skills to manage the regulated activities within the home. We found this to be in breach of Regulation 6 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.