Care Quality Commission

Crabtree Care Homes

Sunningdale EMI Care 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

This inspection took place on 11 January 2016 and was unannounced.

During our previous inspection on 24 June 2015 we identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to make improvements in relation to; the management of medicines, care records and governance systems and processes. During this inspection we checked improvements had been made in these areas and re-rated the quality of the service provided.

Sunningdale EMI Care Home provides residential care for up to 41 people. The home was full on the day of our inspection. The home specialises in providing care and support to people who live with dementia. The building is a large Victorian house which has been extended to provide additional single en-suite bedrooms. Accommodation is on two floors with passenger lift access. Some of the larger rooms in the older part of the house are shared between two people.

Summary of findings

The home has a registered manager who has been in post for over six years. 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.

We saw some improvements had been made to the systems and processes for managing medicines. However, further improvements were needed to ensure accurate and complete records were maintained.

We found poor standards of hygiene throughout the home. We found communal areas, people's bedrooms and bathrooms had not been thoroughly cleaned and some beds were made with stained bedding.

Risks to people's health and safety had not been appropriately assessed, monitored and mitigated. Many risks were managed through a collective approach, rather than adopting an individualised and person centred approach to risk management.

Staff told us they had completed safeguarding training and could identify the different types of abuse. A new safeguarding policy had been introduced however we found this needed to be reviewed to ensure it was fit for purpose.

People told us they felt safe living at the home. However, our observations and other evidence showed there were not enough staff to ensure people were kept safe and that they received responsive care.

The provider operated recruitment procedures to ensure the staff they employed were suitable for the role and safe to work with vulnerable people. We found some improvements were needed to ensure their recruitment procedures were consistently followed.

Staff told us and records showed that staff received supervisions and regular training updates. However, our observations showed that staff did not always apply their training to ensure their caring practices were appropriate and person centred.

The environment and care practices adopted in the home were not always appropriate to the specific needs of people who lived with dementia. We found many care practices were based on routine and a common approach about how staff thought they should care for people living with dementia. Such approaches to care delivery meant that people were not being supported in a person centred manner.

People were not always offered and explained choices in an appropriate way. This meant people were not empowered to make decisions about their care and treatment. We saw examples where staff did not take appropriate action to ensure people's dignity was maintained. People who lived with dementia did not always have a voice and where they did express their views these were not always heard and acted upon.

Regular checks of the building and equipment took place to ensure it was safe.

People told us the food was good. However, where people were at risk of malnutrition or dehydration we identified concerns that staff were not always ensuring that their needs met. There was also a lack of monitoring of people's daily food or fluid intake to establish if they had received sufficient food and fluids. We found meals lacked attention to detail and a person centred approach.

Assessments and applications had been made to ensure the rights of people with limited mental capacity were protected in line with the legal framework of the Deprivation of Liberty Safeguards and the Mental Capacity Act 2005. However, we found an absence of appropriate documentation and staff knowledge to ensure that people were protected from the risk of being unlawfully deprived of their liberty.

Staff supported people to access other health professionals to help maintain their health and wellbeing. Health professionals told us that staff listened to their advice and knew people well.

People who used the service told us they felt safe and that staff were kind. The feedback provided by people and staff about the registered manager was also positive.

There was a lack of stimulating and meaningful activities for people to engage with. People told us they were often bored and relatives told us they had raised this with the provider but nothing had been done to address this.

Feedback about the registered manager was positive. However they were also managing another home which we saw impacted upon the quality and frequency of the management checks they completed.

Summary of findings

The governance systems and processes in place were not effective and did not consistently improve the quality of the service provided. Robust improvements had not been made to address issues previously identified by the Commission with regards to care records and quality assurance systems. Where people provided feedback this was not always appropriately acted upon to improve the quality of the service.

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

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

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

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

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

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

We found poor standards of hygiene throughout the home.

Risk was not managed effectively to ensure the delivery of safe care.

Some improvements had been made to the medicines management systems. However, further improvements were needed to ensure accurate and complete records were maintained.

There were not enough staff to ensure people were kept safe.

Staff had been trained in safeguarding and could identify different types of abuse.

Is the service effective?

Inadequate

The service was not effective.

The environment and care practices were not always appropriate to the specific needs of people who lived with dementia.

Staff received supervisions and training. However, they did not always apply their training to ensure their caring practices were appropriate and person centred.

People's feedback about the food was positive. However, we identified concerns that people did not always have their nutrition and hydration needs met. The mealtime experience was not organised or person centred.

We found an absence of appropriate documentation and staff knowledge to ensure people were protected from the risk of being unlawfully deprived of their liberty.

People were supported to access other healthcare professionals to help them to maintain good health.

Is the service caring?

Requires improvement

The service was not always caring.

People told us the staff were kind and looked after them well.

We saw that people were not always treated with dignity and respect. Collective approaches to care delivery meant that people's individual needs and preferences were not always identified and respected.

People who lived with dementia did not always have a voice and where they did express their views these were not always heard and acted upon.

Summary of findings

Is the service responsive?

Requires improvement

The service was not responsive.

Staff were not regularly present in communal areas which meant they were not always available to respond to people's needs and provide timely and appropriate support. There was a lack of stimulating and meaningful activities for people to engage with.

Care practices were often based on routine and a common approach which meant people were not always supported in a person centred manner.

A complaints procedure was in place and the registered manager operated an open door policy to encourage people to raise any issues with them.

Is the service well-led?

Inadequate

The service was not well-led.

The governance systems and processes in place were not effective and did not consistently improve the quality of the service provided. Where people provided feedback this was not always appropriately acted upon to improve the quality of the service.

Robust improvements had not been made to address issues previously identified by the Commission with regards to care records and quality assurance systems.

Feedback about the registered manager was positive. However they were also managing another home which we saw meant the quality and frequency of the management checks they completed was inconsistent.

Sunningdale EMI Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

The inspection took place on 11 January 2016 and was unannounced.

The inspection team consisted of three inspectors.

Before the inspection, we reviewed the information we held about the provider. We spoke with two healthcare professionals who visit the service, the local authority commissioning team and local authority safeguarding team and asked them for their views on the service. The commissioning team last visited the home in May 2015.

They provided a copy of the service's action plan which was in place to address some areas where they had identified improvements were needed. We also reviewed information sent in by the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We used a variety of methods to help us to assess the quality of care provided and to understand the experience of people who used the service. We reviewed six people's care records and other records relating to the management of the service such as policies, incident records, audits and staff files. We also spent time observing care and interactions between staff and people who used the service. During our inspection we spoke with 13 people who used the service, three relatives of people who used the service, four members of care staff, the cook, the kitchen assistant, the housekeeper, the registered manager and the provider.

Inadequate

Is the service safe?

Our findings

At our last inspection we found medicine management to be unsafe and issued warning notices to the provider and registered manager. During this inspection we looked at the systems in place for managing medicines at the home to check they had made improvements to ensure medicines were managed in a safe and appropriate way.

We found action had been taken to comply with the warning notices. For example when we checked a sample of medicines to see if the amounts available concurred with the amounts recorded as received and administered, we found them to be correct. We saw that medicines were stored safely and administered in line with best practice guidance. We also saw that time critical medicines were being administered in line with the prescribers' instructions.

We saw further improvements were still needed to ensure accurate and complete records were kept in relation to people's medicines. For example, one person was taking a medicine which could result in side effects if they ate grapefruit products whilst taking this medicine. We asked the cook if they had been informed of this. They said they had and showed a list they had been provided of all of the people taking this medicine. However, we found this information had not been included within this person's care records to ensure all staff were informed of this potential risk. During our inspection we saw that care staff provided people with drinks and snacks, they therefore also needed to be made aware of this information.

The registered manager explained that forms to record the administration and effectiveness of 'as required' or PRN medicines had been put in place to ensure the use of such medicines was properly recorded and monitored. They said that the new PRN protocol forms enabled staff to record more detail than the MAR would allow, such as why a PRN medicine had been given and whether it had worked. However, we saw that these were not being consistently correctly completed by staff. For example, one person's medication administration record (MAR) showed the person had been administered eight doses of their two prescribed PRN painkilling medicines in the previous 48 hours. The PRN form had not been completed to show why these medicines had been given and what the impact of giving these medicines had been. Where PRN forms were being completed we saw staff did not always record sufficient detail. For example, another person had been given a dose of their PRN Lorazepam, a medicine which was prescribed to reduce their anxiety. A PRN form had been completed but the reason recorded was that this person had been 'shouting and swearing.' There was no information to indicate what alternative de-escalation techniques had been tried and no record of what the impact of giving the PRN medicine had been on this person. Without complete and accurate records we were unable to evidence that effective systems were in place to ensure that PRN medicines were being given appropriately, that their effectiveness could be monitored and that any associated risks were being managed.

We saw the instructions for the administration of one person's Lorazepam were conflicting and confusing. The senior care assistant and the registered manager told us they had recognised this and we saw records that confirmed they had contacted both the GP and the dispensing pharmacist to address the issue. However when we asked to see the previous MAR charts for this person, the senior care assistant and the registered manager were unable to locate them in their entirety. This showed us that MAR charts were not always being stored in a consistently organised manner.

Therefore, although improvements had been made to ensure medicines were administered and managed more effectively, further improvements were still needed to ensure that the records kept in relation to the medicines people took were accurate and complete. **This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

During our inspection we completed a tour of the premises with the registered manager. We found poor standards of hygiene throughout the home. Furniture in communal areas including dining tables, settees and chairs were visibly dirty and some chairs and settees smelled strongly of urine. Skirting boards in all areas of the home were dirty and dusty. The vents of the radiator covers in both communal lounges and the entrance were clogged with dust and dirt. One of the shower rooms had a dried brown substance which smelt like faeces in the shower tray and shower stool. We found the downstairs communal toilets were dirty.

In bedrooms we saw many beds were made with stained bed linen. Some bedroom floors were also dirty and stained. We saw a tap in the washbasin of one person's

Is the service safe?

en-suite which was smeared with a dried brown substance which smelt like faeces. In another person's en-suite we saw a bowl in the floor which was stained with a dried substance which smelt like urine. We found an incontinence pad heavily soiled with faeces in the drawer of one person's wardrobe.

Wheelchairs were used communally and we saw them to be dirty with food and other spillages. Plastic beakers used for serving hot and cold drinks were heavily stained and the hot trolley for serving food and the drinks trolley were both dirty.

We saw staff using personal protective equipment (PPE) such as gloves and aprons but found hand- wash facilities such as liquid soap and paper towels were not available in all areas. We also saw staff did not always adhere to best practice in relation to infection control, for example some wore rings and other jewellery during their shift.

In addition to our concerns with how infection control was managed at the home, we also saw a number of other areas where risks to people's health and safety had not been appropriately assessed, monitored and mitigated. This included the ineffective management of nutritional risk and a lack of a person centred approach to assessing and mitigating potential risks. This showed us that the provider and registered manager did not manage risk effectively to ensure the delivery of safe care. **This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

The Registered manager explained that one of the two domestic staff who had responsibility for cleaning the home had left unexpectedly 20 days before our inspection. The domestic who left usually worked 24 hours per week, with most of these hours being on a weekend. The staff rotas for four weeks prior to our inspection showed this meant there was no domestic cover during the weekends throughout that period. Our inspection took place on a Monday. The other domestic was rostered to work 6am to 3pm that day. Our full tour of the premises started at 2.45pm and our findings showed they had not had sufficient time to ensure the home was thoroughly cleaned to an appropriate standard. Following our inspection the provider contacted us to inform us they had appointed a housekeeper. However, this should have been addressed prior to our inspection to ensure there was no impact upon standard of cleanliness in the home.

Our review of staffing rotas showed that minimum staffing levels were not always being adhered to. For example, during a discussion about the minimum staffing levels needed in the home the registered manager explained that one senior in charge and three care assistants were required to cover the afternoon shift from 3pm until 10pm. We reviewed the staffing rotas to cover the four week period from 19 December 2015 to 15 January 2015. We found 10 occasions when only two care assistants were on duty to support the senior carer in charge. In addition to these minimum staffing levels not being met, on three of these occasions there was also no cook on duty to prepare and cook the meals. Although two night staff came on duty at 8pm to provide additional support to assist people to get ready for bed, on those occasions the shift was still left short for crucial times such as the tea time meal. Following our inspection the provider assured us that on nine of the ten occasions staff payroll records could demonstrate that minimum staffing levels were met. They also explained staffing changes had been handwritten with pen so were not clearly visible on the photocopied rota we reviewed.

On the day of our inspection the minimum staffing levels were achieved. However, throughout the day we saw that staff did not have time to provide people with responsive care. For example, we saw people were not always provided with drinks when they wanted them and did not always receive timely support with their personal care. We also saw that there was a lack of staff presence in communal areas of the home and that staff only engaged with people when supporting with a care task. We spent time in the quiet lounge and saw one person who used the service becoming distressed by the presence of another individual. There were no staff present to witness this or to intervene and offer any reassurance. We were concerned that the absence of regular staff presence in communal areas risked that staff would not always be available to identify and respond to potential safeguarding incidents such as this. This was confirmed by a visitor who told us about a potential safeguarding incident which occurred in the communal lounge between two people who lived at the home a few weeks prior to our visit. They described how they had to alert staff as there were no staff in the vicinity during the incident. We concluded that the minimum staffing levels identified by the provider were not sufficient to ensure safe and responsive care.

Inadequate

Is the service safe?

Overall we concluded there were not enough staff to ensure people were kept safe. **This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

The provider had recruitment procedures in place to assess staff's eligibility for the role and ensure they were suitable to work with vulnerable people. This included obtaining written references and Disclosure and Barring Service (DBS) checks. DBS checks are a check on people's criminal record and a check to see if they have been placed on a list for people who are barred from working with vulnerable adults. We spoke with a member of care staff who had recently started working at the home. They explained they had not been allowed to start work until their DBS check and references had been received. We checked the recruitment files of two staff members. We found some improvements were needed to ensure the correct recruitment procedures were consistently followed. For example, in one person's recruitment file we saw they had started work at the home 15 days before their second reference had been received. Although the reference highlighted no concerns, this should have been in place before they started work. The registered manager explained this person would not have worked alone until the reference had been returned. However, acknowledged that a formal risk assessment should have been in place to mitigate and manage any potential risks. They said they would ensure this was done in the future.

We asked people if they felt safe living at the home. One person said, "I feel safe here because staff look after me." Another person told us, "Yes, I feel safe here." Someone else told us, "I am happy here, I like it and feel safe with staff looking out for me." Two people told us they felt their relative was safe and one described how they knew their relative felt secure living at the home because whenever they went out for the day they always wanted to come straight back.

Staff we spoke with told us they had completed safeguarding training and could identify the different types of abuse which could occur. Staff told us they would report any concerns to the manager, but did not have any further understanding of the safeguarding processes. One of the senior care assistants we spoke with had received no training in relation to making a safeguarding referral, however they said if they needed to and the registered manager was not available they would contact the provider for support. A new safeguarding policy had been introduced in September 2015 however we found this needed to be reviewed to ensure it was fit for purpose.

The provider employed a full time maintenance person. They told us they usually worked 35 hours per week but were always on call and able to be contacted to come to the home should there be any issues or emergencies. They were also responsible for completing a number of safety checks such as fire alarm tests and water temperature checks. In specialist areas such as electrical or gas safety checks the provider employed external contractors to ensure these checks were completed. We saw that records were in place to demonstrate that regular checks of the building and equipment took place to help keep people safe. This included electrical wiring, fire safety equipment, gas appliances and the passenger lift.

Inadequate

Is the service effective?

Our findings

The provider advertises the home as a specialist care home to support people who live with dementia. This is reflected in the provider's Statement of Purpose and on their corporate website. However we found a number of practices within the home to be institutionalised rather than dementia friendly or person centred. This included use of communal toiletries and a lack of effective support to enable people to make informed choices. The environment did not always support the orientation of people living with dementia. For example, not all bedroom doors had identification to support people in finding their own room and some bedrooms had the wrong person's name on it. Although there was signage on the bathroom doors, there was no other signage or visual prompts to assist people in finding their way around the home and orientate them to the area or floor of the building. We also saw clocks were not always set to the correct time, in one person's bedroom they had three clocks which were all set at the wrong time. It is important for the correct time to be displayed to people who live with dementia to help orientate them to the correct time of day.

Staff told us and records showed that staff received supervisions and regular training updates. The training was a combination of class room based learning and distance learning where staff had to complete a workbook which was sent to an external company to be assessed. We saw evidence staff had received training in key areas such as safeguarding and moving and handling. Records showed that training was due in some key areas, such as fire safety and first aid. However, the registered manager explained that training updates had been planned in for these areas in the coming months. Training certificates were kept in individual staff files which meant it was difficult to get an overall picture of what training staff had received. However, the administrative coordinator explained that since coming into post in September 2015 they had begun to implement a new training log. We looked at this and saw it provided an overall picture of how many staff had completed training in key areas. Once complete this would ensure staff training could be more effectively recorded and monitored. We found that the training log did not include a record of the training courses which had been booked for the coming year. The administrator explained this was something they planned to complete once all of the information had been transferred onto the log.

Our observations during this inspection showed us that staff did not apply their training to ensure their caring practices were appropriate and person centred. This demonstrated that the training and development staff received was not always effective. For example, records showed most staff had received training in supporting people living with dementia but we saw little evidence of this being translated in their practice. We saw people were not supported to make choices in a way they could understand and staff did not give people explanations about what was happening. For example when a person living with dementia went into the dining room at tea time a member of staff told them to go out. When we asked why, staff said there was no room for them at that time, however they had not given this explanation to the person. This person's facial expressions and behaviour showed this had confused them. We also saw examples where people did not get choices explained to them in a way which facilitated them to make their own choice. For example, food and drink options were not described or shown to people so that they could make an informed choice. For example, during lunchtime we saw one staff member say "Are you okay with that drink or do you want a hot one?" The hot drink options were not explained and their facial expressions showed they did not understand what was being offered to them.

Overall we concluded that care staff did not always receive appropriate support and development to ensure they translated the training they received into effective practice. **This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

People we spoke with told us meals at the home were good. One person said, "The food is good here and there is plenty of it. You just ask if you want a drink but I think they are trying to knock that on the head because staff are too busy." Another person told us, "I like the food." A visitor told us they had a meal with their relative on a regular basis and said the meals were, "Wonderful." However, despite this positive feedback we identified concerns that where people were at risk of dehydration or malnutrition staff were not always taking appropriate action to ensure their nutritional intake was sufficient.

We looked at the weight records and saw there were five people who had been losing weight. One person had lost 7.2kgs between March 2015 and December 2015. We

looked at their care plan which gave the following instruction to staff, 'Staff to supervise at mealtimes to make sure they eat their meals. To maintain a healthy well balanced diet.' The nutritional assessment stated they were a 'medium risk.' At breakfast time we saw they were given a small bowl of porridge and received some assistance to eat this. At lunchtime they were given a bowl of pureed fish dinner. It looked unappetising; the top of the meal had a 'crust' on it as it had been kept warm on the hot plate before being served. We saw the person kept pushing the plate away from them and only ate a few small mouthfuls. They were not offered an alternative. We looked at their care records and saw they were not always having a mid-afternoon drink, snack or supper. The fluid intake records for the last two weeks showed their daily intake ranged from 480ml to 1280mls. There was no overall monitoring of their daily food or fluid intake to establish if they had received sufficient food and fluids.

We saw one person had lost 3.2 kgs in weight since July 2015. At lunchtime we saw this person was given a small plastic bowl of pureed food and a spoon. We also saw another person was given the same as they needed a soft diet. Neither person was informed of what the meal was. Both people ate all of the food and were scraping their bowls when they had finished. This action suggested both people wanted more food. Second helpings were not provided to either person, despite an inspector asking a care worker if more food was available. Staff told us both of these individuals were very active and walked around the home continuously. This meant they should have been encouraged to consume additional calories where ever possible.

At tea time we saw one of these two people go into the dining room. They were turned away by staff as there was nowhere for them to sit. When space was available we saw they were given a bowl of soup, quite a lot of which got spilt on the tablecloth. They were then given a blended pizza and blended baked beans. The meal had formed into a lump of the plate which looked unappetising. The person was observed struggling to eat their meal and pushed their plate away. They were not offered an alternative.

We saw a fourth person had lost 4.9kgs since September 2015. Their nutritional risk assessment had not identified any risk and the nutritional care plan had not identified the weight loss. There was no plan in place to inform staff what action they needed to take to mitigate the nutritional risk to this person.

We saw no drinks were available in the lounge areas for people. Drinks were available at mealtimes, mid-morning, mid-afternoon and at suppertime. Staff told us drinks could not be left out as people using the service would often throw them if they became upset or anxious. We also saw the dining room was locked after breakfast and not opened again until lunchtime. Staff told us this was because the hot plate may have been dangerous if people touched it.

Overall our observations, discussions with staff and review of records led us to conclude that appropriate action was not being taken to ensure people received adequate nutrition and hydration to meet their needs. **This was a breach of the Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** We also found that where people were identified as being at risk of malnutrition or were losing weight this risk was not being effectively assessed, monitored and mitigated. **This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

During our previous inspection we identified that improvements were needed to ensure that people were provided with a person centred mealtime experience. During this inspection we observed breakfast, lunch and tea. These improvements had not been made. We found all three mealtime experiences lacked attention to detail and a person centred approach.

At breakfast time we saw some tables in the dining room had tablecloths but none had been set with crockery, cutlery, condiments or serviettes. People were offered cereals or porridge followed by toast. The toast had been prepared and buttered in the kitchen and then left on a tray on the hot plate so was not freshly made as people wanted it. No one was offered any jam or marmalade for their toast. There was no fruit juice on offer and people were served hot drinks in a plastic cup. People were served their cereals and toast in plastic bowls or plates. We heard one person ask staff for another bowl of cornflakes. Staff told them they couldn't have any more as there would not be enough left for other people. When we asked the member of staff why the person could not have more they said they

might not eat their lunch if they had more. However we saw the person continued to ask for more. They were eventually given another bowl of cornflakes. We asked the kitchen assistant if people could have a cooked breakfast and they told us there were set days for cooked breakfasts, one of these days was a Sunday.

At lunchtime there was a choice of two meals, chicken or fish. Tables had been set in the dining room with tablecloths, cutlery and plastic tumblers which had been filled with blackcurrant juice, before people entered the dining room. This meant people were not given a choice of drink. Again there were no serviettes or condiments on the table. The choice of main meal came with chips and vegetables; no one was offered salt, pepper, vinegar or sauce to accompany their meal. Food was not served in an organised manner. Some people had finished their meal and were asking for second helpings before the other people at their table had been served.

There was also a dining table in the quiet lounge. This had not been set with a tablecloth, cutlery, condiments or serviettes. Eight people were sitting in this area, four were sitting at the table waiting for their lunch. One person looked uncomfortable as they had fallen asleep in their wheelchair and there was no support for their head. The meals for the eight people arrived ready plated on a trolley. Staff did not ensure that people were supported to eat their meal in a comfortable manner. For example, the people who remained in their wheelchair to eat their meal were all observed struggling to reach their plate as they were either too low down or too far away from the table. Another person was given their meal whilst they were standing up and another person was given their meal on the seat of their walking frame. Three people required a soft diet. We saw they were given bowls of pureed food which had all been blended up together. This made it look unappetising, uninteresting and did not allow people to taste the individual components of the meal. By the time people were given their food it was only luke warm.

There was one care worker in the quiet lounge room providing assistance. Three people needed full support and others required prompting. We saw that no one was supported with their meal in an appropriate way. We saw one person eating off their knife. One of the inspectors gave them a fork, which we saw made it easier for them to eat. However, as they were sitting in an armchair they were not in a good position to eat their meal in a comfortable way.

We saw some people in this room waited for over half an hour between finishing their first course and being served pudding. None of the people in this room were offered a drink with their meal. There was a bottle of lemonade on the trolley which some people were served in plastic cups after the main course. These were the same plastic cups which had previously been used for tea and coffee. Although they had been washed the cups were stained from the hot drinks which may have caused the lemonade to taste unpleasant.

Our observations showed us that mealtimes were not organised in a person centred or appropriate way. **This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager told us one person living at the home was subject to a DoLS. We saw the relevant paperwork for this person and that there were no conditions in place. The registered manager told us applications had been submitted to the supervisory body for a number of other people living at the home and that they would be submitting applications for all of the people living at the home.

When we spoke with a senior care assistant they told us several people living at the home had DoLS in place and showed us what they believed to be confirmation of this for one person. However we saw the document was an application for a DoLS which had been submitted but not yet authorised. It is important that staff are aware of which people are currently subject to DoLS.

Inadequate

Is the service effective?

We saw that one person's medication records included a fax from the dispensing pharmacist confirming that the person's GP had given permission for two of their medicines to be crushed and put in their food. This means the person would not know they were taking their medicines and is called covert administration. The registered manager said the person's relative had been contacted and agreed the medicine could be administered in this way. However, we found insufficient documentation to evidence this decision had been made in this person's best interests. There were also not appropriate arrangements in place to ensure that this decision was reviewed to ensure it remained in the person's best interests.

During our inspection we saw recorded in two care plans relatives had Lasting Power of Attorney (LPA) for care and welfare and or finance. We asked for confirmation of these arrangements but this could not be provided during our inspection. This meant the provider could not demonstrate that they were meeting the requirements of the Mental Capacity Act 2005 Code of Practice where people were subject to an LPA.

Overall we found an absence of appropriate documentation and staff knowledge to demonstrate that, where people lacked capacity to give consent, the provider and care staff acted in accordance with the Mental Capacity Act 2005. **This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

We asked people who used the service what happened if they felt unwell. One person told us they would go to their GP with a relative. Another person said, "They (staff) get the doctor if you need them." We looked at the care plans and saw people had been seen by GP's, district nurses, specialist nurses and opticians. We saw some people had been seen by the chiropodist. However, we did note one person, who was a diabetic, had lived at the home for almost four months had not been seen by a chiropodist. Foot care is very important for people living with diabetes. We looked at the records with a member of senior care staff and staff had got the district nurse to look at some redness on this person's toes. The record stated 'refer to chiropodist' however, it was not clear if the district nurse was going to do this or if it was the responsibility of care staff. This person's foot care should have been assessed in their care plan on admission.

We spoke with two healthcare professionals who visited the home on a regular basis. Both told us that they felt the communication between staff and visiting health professionals had improved in the past year. They also described how staff were now more knowledgeable about pressure care and would make timely referrals to ensure people received appropriate healthcare support. Both said when the visited staff always seems "very busy" but had a good knowledge of the people they supported and listened to their advice.

Requires improvement

Is the service caring?

Our findings

People who used the service and their relatives provided positive feedback about staff. One person told us, "The staff are really lovely." One visitor told us, "[My relative] is loved here and I appreciate the love and care they are given, but feel I have to prompt them (staff) sometimes." Another visitor told us that, "Staff are good with the little details, such as remembering to encourage [my relative] to wear their glasses." Our discussions with staff showed they cared about the people they supported and enjoyed working at the home. One member of staff told us, "I love my job and I miss people when I go home."

Despite this positive feedback about staff we observed a number of examples of people not having their dignity needs met. This included people with food stains on their faces, glasses and clothing, people wearing dirty shoes and people with unkempt hair and dirty fingernails. During the afternoon we saw one person sitting in the lounge by the dining room. Their leg urinary catheter bag was full and was showing under the leg of their trousers. When staff came into the room they did not take action to address this to preserve this person's dignity.

When we looked in a number of people's bedrooms we saw beds had been made with stained, dirty and threadbare bedlinen and a number of pillows were flat and lumpy. Several chairs in people's bedrooms were dirty and the upholstery worn and torn. We saw the material from the base of one person's bed had come off and was on the floor. We saw most towels available for people to use were torn and frayed.

We saw broken furniture in a number of rooms. This included one room which the registered manager told us had been used to admit a person as an emergency. The wardrobe in this room did not have any doors, the wallpaper had been ripped off and the curtains had been pulled off the rails. The registered manager told us this person did sometimes pull their curtains down, when we brought it to their attention they arranged for the maintenance man to fix the curtains. When we asked the registered manager how long the person had been living in this room, they told us approximately one month. We saw the name of the person who had previously occupied this room was still on the door. The registered manager told us this person was deceased.

We saw during the morning one relative had to stand throughout their visit as there were no chairs available for them to use. In the afternoon we saw a relative kneeling on the floor as no chairs were available for them to use.

We also saw a number of practices during the mealtime experience which demonstrated that people were not always treated with dignity and respect. Such as people not being provided with serviettes or being prompted or assisted to wipe their hands and face after eating. We saw a number of people with food stains on their hands and face and one person who had food in their beard and on their nose.

This demonstrated that people who used the service were not always treated with dignity and respect. **This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

We saw that people had very little or no toiletries in their bedrooms or en-suite toilet/wash rooms. The registered manager told us that was due to the risk of people eating the toiletries. We asked when a person had done this and they could not give us an example. We also saw a number of washbasins in the en-suite rooms did not have plugs. When we asked about this the registered manager told us it was because people would flood their rooms. Again the registered manager was unable to tell us of an occasion when this had happened. We asked the registered manager how people would be able to wash. They told us staff went round with trolleys with toiletries and plugs on them which they took into people's rooms when supporting them with their personal hygiene. This meant people did not have their own personal toiletries. We asked to see the toiletries and were taken to the cellar where they were stored. The registered manager showed us containers (one being a powdered soup container) in which were razors, shower gel, toothpaste and hair brushes. The toiletries available were all the same and were supermarket value brand. This meant people did not have a choice. The hairbrushes were full of hair and were not named. This approach meant there was a risk that the toiletries and hairbrushes were used communally and demonstrated a lack of regard for the dignity of people living at the home.

People living at the home were served meals and drinks in plastic plates, bowls and beakers. The registered manager told us this was because some people might throw them.

Requires improvement

Is the service caring?

This had not been individually assessed to ensure it met people's individual needs and therefore the use of plastic tableware appeared inappropriate, institutional and undignified.

During our inspection we saw that some people who lived with dementia did not always have a voice and where they did express their views these were not always heard and acted upon. For example, at lunchtime one person said they were cold. One of the care workers said they would get them a warmer blanket. However, this was not done and the care worker went off duty.

We also saw staff did not always offer and explain choices to people in an appropriate way. For example, during lunchtime we saw people were verbally offered a choice of chicken or fish. However, people who lived with dementia would have benefitted from being shown the food options so that they could make an informed choice. We also saw examples where staff offered people choices but then didn't give them sufficient time to understand and respond. For example, after one person had finished their meal staff said to them, "Do you want more or do you want your pudding?" We could see from this person's facial expressions that they did not understand what was being offered to them so they just said "Yes" and staff brought them their pudding.

Staff's collective approach to care delivery meant that the care and support people received was not person centred or tailored to their specific needs. Equally because people were not always appropriately supported to express their views staff were not able to always provide care and support which met people's needs and preferences. **This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Requires improvement

Is the service responsive?

Our findings

During our inspection we saw there were long periods of time when no staff were available in the lounge areas and the only contact they had with people was when they were performing a specific care task. We asked people what they did to keep themselves occupied and if any activities were on offer. One person told us they went out twice a week to Bingo and sometimes staff organised card games or dominoes in the home. When we asked other people they pointed at the television. One person said, "I'm browned off there is nothing to do." One member of staff told us there were no activities staff, but the person who was cooking on the day of our visit did activities "sometimes". Other staff told us there was a lack of activities and things to keep people occupied. The care rotas we reviewed did not show that a member of staff had been assigned to provide activities. People's relatives also confirmed there was little on offer. One relative said, "I wish there was more entertainment, there never seems to be anything going on anymore." We therefore concluded there was a lack of stimulating and meaningful activities for people to engage with.

Staff were not regularly present in communal areas which meant they did not always respond to people's needs and provide timely and appropriate support. For example, at tea time one of the people using the service came and told one of the inspectors, "I'm wet through," and pointed at their trousers. They had been incontinent of urine and were visibly upset about this. The inspector found a member of staff who then attended to their needs. Another person was standing up in the lounge and was clearly uncomfortable they told another inspector, "I've been naughty," and pointed to their trousers. They had also been incontinent of urine and needed assistance to change. We also noted a third person, had also been incontinent and their trousers were wet. There were no staff present in this area and inspectors had to find staff to provide them with the assistance they needed.

Overall we concluded there were not enough staff to ensure people received responsive care and were engaged in meaningful activities. **This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

We found many staff practices were based on routine and a common approach about how staff thought they should care for people living with dementia. Such as the common approach that plastic plates and cups were used for everyone due to the risk some people had previously thrown and broken china ones. We also saw people queuing up by the back door. When we asked what they were doing one person said "We are waiting to go out for a smoke, we get our cigs every two hours." We saw people went outside together but had to knock on the door to get back into the home. Such approaches to care delivery meant that people were not being supported in a person centred manner. This meant that people were not being supported in a way which met their individual needs and preferences. **This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

We saw the provider had a policy in place which detailed how people's complaints would be dealt with. Information about how to make a complaint was available to people in the entrance to the home. Records showed there had been no formal complaints since October 2013. The registered manager confirmed this was correct. People using the service told us they would tell the registered manager or provider if they had any concerns or complaints. One person said, "I'd tell [manager's name] if something was wrong and they would sort it out." The registered manager explained they operated an open door policy, whereby they encouraged people to come and discuss any concerns or issues with them at any time. They said this approach helped to resolve issues for people quickly which was successful in stopping issues escalating into a formal complaint. During our inspection we saw a number of people knocked on the registered manager's office to discuss issues with them. In all cases the registered manager responded with prompt and appropriate advice and guidance which appeared to help reduce people's anxiety and address their concerns.

Inadequate

Is the service well-led?

Our findings

At our last inspection we found care records did not always contain complete and relevant information and that potential risks were not always being assessed, monitored and mitigated. We also found that the service did not have an effective system in place which assessed, monitored and improved the quality and safety of the service provided. We asked the provider to address these issues and during this inspection we checked to ensure that improvements had been made.

The registered manager explained that all care records had been reviewed since our last inspection and were now up to date. However, we found care records still did not always contain accurate, complete and appropriate information. This demonstrated that the systems in place for reviewing and checking the accuracy of care records were not effective. We spoke with the registered manager about the systems in place to ensure care records were fit for purpose. They explained that they had responsibility for developing and writing all care records with input from care staff. They said the provider checked care plans when they visited to ensure they were completing them correctly and accurately. However, no record was kept of these checks. This meant the provider was unable to evidence that robust checks of care records were taking place.

The registered manager had introduced a number of audits and checks since our last inspection. However, we found that these were not always fully effective in improving the quality of the service provided. For example, we reviewed the mattress and bed checks which had been completed in November and December 2015. The records did not state which beds or rooms had been checked, so we were unable to review the full audit trail to ensure appropriate action had been taken to address any issues. The registered manager said no other records were kept so they were unable to confirm which bedrooms had been checked in the past 6 months, but said that all beds should have been checked now. However, during our inspection we saw that the majority of beds were made with pillows which were flat, lumpy and lacked support. This had not been identified and addressed through the checks of beds and mattresses.

We saw that the Bradford Infection Prevention Team had completed an infection control audit of the home on in July 2015. The home had scored 93.56%. A number of areas for improvement had been identified. For example, the dining room received a score of 70%, it was noted that there were 'marks to walls, some chairs had visible stains and areas of the flooring required re-sealing.'

The registered manager explained the floor had now been re-sealed. However, we found visible staining to the floor, walls and chairs in the dining room. This showed that appropriate action had not been taken to ensure this area was kept clean, despite this being raised as a known risk by the Infection Prevention Team six months prior to our visit.

The registered manager explained that they also completed monthly infection control audits to ensure appropriate standards of cleanliness were maintained. However, they had not completed an infection control audit since October 2015. During this inspection poor standards of cleanliness were identified throughout the home. This demonstrated that the home would have benefitted from a more robust and timely infection control audit.

We spoke with registered manager, about the systems and processes in place for assuring that there were sufficient levels of staff on duty. They explained the computer system included a dependency assessment which indicated the level of risk for each person depending on the level of support they required. We saw this assessment of people's dependencies had not been translated into the number of staff that were therefore required to ensure safe and effective care. The registered manager confirmed they did not use any other audit or tool to calculate the number of staff required, but said if someone's needs changed or they felt an additional staff member was required they would arrange for this. During our inspection our observations and review of records led us to conclude there were not enough staff to ensure people received responsive and appropriate care. Without a robust dependency tool or audit the provider was unable to demonstrate that their calculations of the levels of staff required were sufficient to meet people's current needs.

During our last inspection we found that appropriate arrangements were not in place to ensure policies and procedures were fit for purpose. The registered manager explained the provider had reviewed most policies since our last inspection and purchased them from an external company. However, we found that the provider or registered manager had not reviewed these policies to ensure they were appropriate to the service. For example,

Inadequate

Is the service well-led?

the Safeguarding policy, which was dated September 2015, referenced the 'Adult Support and Protection (Scotland) Act 2007.' This legislation does not apply in England. Equally the policy detailed that 'Any suspicion or evidence of abuse should be reported immediately to the nurse in charge or any member of the management team.' The home is not registered for nursing care, so there would not be a nurse in charge on shift. This could cause confusion to staff. The registered manager told us that they "didn't realise" these errors were in the policy. This demonstrated that they had not thoroughly reviewed the policies prior to their introduction to ensure they were fit for purpose.

We saw that the provider sought people's feedback through annual quality questionnaires. However, where people provided feedback this was not always appropriately acted upon to improve the quality of the service. For example, four of the nine people who had completed the most recent quality questionnaires had raised the issue that there were not enough activities. We spoke with the registered manager about what they had done in response to this feedback. They confirmed there was no action plan in place to demonstrate what they had done in response to people's feedback. However, they explained that since the activities coordinator had left they had sent two care staff on activities training but they had both left the home. No other staff had received this training and staff were not allocated to focus on activities on each shift. The comments people and their relatives made and our observations on the day of our inspection demonstrated that this was still something which needed to be improved. One relative told us, "I wish there was more entertainment, there never seems to be anything going on anymore. I completed a feedback form a few months ago and raised this issue. I said there should be more activities, but I have never heard anything about that." This demonstrated that the registered manager and provider had not taken appropriate action to ensure this issue was addressed for people.

At our last inspection we asked the provider to make improvements to ensure the mealtime experience was more person centred. During this inspection we observed breakfast, lunch and tea and found all three meals lacked a person centred approach. For example, we saw that people were not provided with appropriate support to ensure they could make informed choices. This demonstrated that the provider and registered manager had not taken appropriate action to evaluate and improve the mealtime experience in response to the feedback provided by the Commission.

The registered manager explained that since the beginning of October 2015 they had also been providing management cover to the provider's other residential home. They said it was the provider's intention for them to cover both locations permanently. The registered manager explained that they now had a full time administrative coordinator so they felt able to do this and they were in the process of training the senior carers to fulfil some management checks. However, we saw there had been a direct impact upon the quality and frequency of management checks completed since they had taken on this additional responsibility. For example, we saw that a number of management audits had not been completed since October 2015, such as the infection control and staff competency checks. This showed us that this had impacted upon the quality of the systems and processes in place at the home.

We saw that the registered manager had introduced checks of staff competency since our last inspection. We found that this process needed further refinement to ensure it was fully fit for purpose. For example, there was no evidence that feedback had been provided and received to the staff member so that they were informed of what practices they had done well and where they needed to make improvements.

We found a lack of effective shift leadership to ensure staff were supervised, deployed and managed in the most effective way. For example, one member of care staff went on their break during the peak lunchtime period when some people had not yet received their meal and other staff were observed supporting two people at once.

The issues with care records and audits had not been identified or addressed prior to our inspection. We also identified widespread concerns with a number of other aspects of care delivery which demonstrated that there was a lack of effective leadership and robust quality assurance systems. As part of a robust quality assurance system both the registered manager and the registered provider should actively identify improvements on a regular basis and put plans in place to achieve these and not wait for the Commission to identify shortfalls. This demonstrated that

Inadequate

Is the service well-led?

they failed to operate effective governance systems and processes. **This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

The staff we spoke with told us the manager was, 'firm but fair' and was very supportive. We saw that staff meetings were held approximately once a month. A positive feature of the service was that the registered manager used staff meetings as an opportunity to praise staff for good practice and hard work, whilst also identifying areas for improvement. We saw that the Commission's previous inspection report had been discussed during these meetings to ensure staff were aware of the areas where improvements were needed. We saw the last record of a service users meeting was dated May 2015. The registered manager confirmed this was the last time a meeting had been held.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Dignity and respect. Service users were not always treated with dignity and respect. Regulation 10(1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs Meeting nutrition and hydration needs. The nutritional and hydration needs of service users were not being met. Regulation 14(1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Need for consent. Where people were unable to give consent because they lacked capacity, the provider did not ensure that they acted in accordance with the 2005 Act. Regulation 11(3).

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Person Centred Care. Care and treatment was not always appropriate to and did not always meet the specific needs and preferences of people who used the service. Regulation 9(1).

The enforcement action we took:
We served a warning notice on the registered manager and provider which had to be met by 29 April 2016.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Safe care and treatment. Care and treatment was not always provided in a safe way. Regulation 12(1). Risks to the health and safety of service users were not always being assessed. Regulation 12(1)(a). Appropriate action was not always being taken to mitigate risks. Regulation 12(1)(b). Appropriate action was not always being taken to assess, prevent, detect and control the spread of infections. Regulation 12(1)(h).

The enforcement action we took:
We served a warning notice on the registered manager and provider which had to be met by 29 April 2016.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staffing. Sufficient numbers of suitably qualified, competent, skilled and experience staff were not always being deployed. Regulation 18(1).

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
We served a warning notice on the registered manager and provider which had to be met by 29 April 2016.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Good governance. Systems and processes were not established and operated effectively to ensure the service; Assessed, monitored and improved the quality and safety of the service provided. Assessed, monitored and mitigated risks relating to the health, safety and welfare of service users and others who may be at risk. Maintained accurate, complete and contemporaneous records for each person, including a record of the care and treatment provided. Sought and acted upon the feedback people provided for the purposes of continually evaluating the service. Regulation 17(1)(2)(a)(b)(c)(e)

The enforcement action we took:
We served a warning notice on the registered manager and provider which had to be met by 29 April 2016.