Roseacres Care Home Limited

Roseacres

Inspection Report

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Date of inspection visit: 16/04/2014
Date of publication: 03/09/2014

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Overall summary

Roseacres residential care home provides accommodation and personal care for up to 35 people who have dementia. There is currently no registered manager for the service. The recently appointed manager is in the process of submitting an application to register.

We found that the service is not always safe for people because care is not always planned and delivered to meet people's needs safely. People are not always protected from harm in the delivery of care and from some hazards in the home. Medicines are being managed safely.

We observed several aspects of care provision that are not effective. Care needs are not fully assessed, care is sometimes not delivered to meet people's needs and capacity assessments are not made.

Most people and those significant to them told us that staff are caring and kind. However we did observe some disrespectful actions from some staff.

The care provided is not always responsive to people's needs or delivered in a timely way. This includes people not always having access to their call bells whilst in bed and people's continence needs not responded to in a way that maintains their dignity.

Most people and staff were supportive of the manager. Staff and the manager told us of improvements that had been made. However we were told of significant problems that had been encountered in managing the home and that further improvements were planned.

The provider is not meeting the requirements of the Deprivation of Liberty Safeguards as some restrictions were being placed on people's movements without obtaining the necessary approvals. People's human rights are therefore not being properly recognised, respected and promoted.

The problems we have found breached twelve health and social care regulations. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Staff knew how to recognise and respond appropriately to incidents or allegations of bullying, harassment and abuse, but there had been some poor practice in the past and some staff members had left before actions were completed.

People were not protected from avoidable harm. There had been instances of staff misconduct which the manager had dealt with however this had not all been resolved which meant that people were at risk of harm.

We observed and saw records that indicated some unsafe and poor care was continuing. This included poor manual handling, poor continence care, insufficient monitoring of people to prevent falls and inadequate risk assessments.

We saw that the premises were in poor decorative condition and found some disrepair which was hazardous to people. Contaminated waste was stored in an area which was accessible to people living in the home. We were told that refurbishment works had commenced and further works were planned.

There was equipment available within the home to meet the needs of the current people however some of it was in poor condition and inappropriate.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards. We found that Roseacres was not meeting the requirements of the Deprivation of Liberty Safeguards. People using the service were found to be subject to a number of significant restrictions on their liberty, and applications under the Deprivation of Liberty Safeguards should have been considered. Most staff we spoke with and the manager were not clear about the requirements of the Mental Capacity Act 2005. People's human rights were therefore not being properly recognised, respected and promoted.

We found that arrangements for the management of medicines were safe.

Are services effective?

People's needs were not fully assessed and care was not delivered to meet those needs. People were not consulted about their care plans, preferences or decisions about their care. Capacity assessments had not been made.

Summary of findings

Continence care did not meet people's individual needs. There were no end of life care plans; there were no pain assessments even though people were in pain; there were no diabetic care plans even though there were five people with diabetes living at the home.

Many of the people living at the home had dementia. However the home environment did not take into account the needs of people with dementia.

People were offered choices of food and drink in sufficient quantities. However there were not adequate safeguards to ensure that this met people's needs.

Are services caring?

We saw that most staff behaved in a caring and respectful manner toward people. Most people and their visitors told us that staff were respectful and kind. However we did observe and were told by people of some staff behaviour that was not respectful. For example the poor way in which people were assisted to eat, most staff walked through the lounge area without acknowledging people and staff not calling people by their preferred names. Some staffs interaction with people was brief and superficial.

Some people's dignity was not maintained as staff were slow to respond to people's care needs including peoples toileting needs as staff were dealing with the care of other people.

Are services responsive to people's needs?

People were not supported to express their view or be involved in their care or support.

The service was not responsive to people's needs for example people in bed did not have access to call bells to call for assistance and people's continence needs were not responded to in a timely manner. Staff were focused on tasks and told us there was no time for activities or social engagement with people. There had not been an activities co-coordinator in post for some time.

People told us the manager was responsive to their concerns but were not able to tell us how to make a complaint. Information about how to make a complaint was available in the reception area of the home.

Are services well-led?

The service did not have a registered manager in post. However the home's manager who had taken up post in October 2013 had recently submitted an application to register with CQC. A deputy manager had been in post for two months at the time of our visit.

Summary of findings

The manager recognised the challenges that the home had and had prioritised staffing, staff conduct and care planning. They told us of the improvements that were planned which included improving the environment, care for people, ensuring people's care planning and risk assessments were current, staff training and supervision and auditing the service. The manager and deputy manager were often in the lounge and dining area during our visit and engaged positively with people and staff.

There was recognition amongst staff we spoke with that the manager was trying to change the culture of the home and improve the service to people. Some staff were not supportive of the changes.

People were at risk from mistakes or accidents at the service being repeated. There had not been an analysis of incidents and accidents to learn from mistakes or regular audits to establish if improvements were needed to the service.

There had recently been a high turnover of staff and the manager had recruited permanent staff. However there was a lack of staff to provide social support to people and to prevent them from being socially isolated.

There were gaps in people's records and there was no improvement plan or timetable for improvements identified to be implemented. This presented a risk that improvements to the care of people would not be made.

Summary of findings

What people who use the service and those that matter to them say

We spoke with ten people using the service and two people significant to people who were visiting. People told us the manager was responsive to their concerns but were not able to tell us how to make a complaint. Most people told us that staff were kind and one person told us "you can talk to staff if you want to." Another person told us "they bought tea out to us, and always ask if we want it."

Some people we spoke with said they were comfortable and well supported and one person told us there are carers walking around all day. Another person told us staff were very good at looking after them and that they would be listened to and there were plenty of staff. However we observed one person calling out repeatedly "can you talk to me please" and observed that staff did not respond to this person. Another person told us "This pain is so terrible I wish I could die." and cried out several times and was not responded to by staff until we raised this with them.

People told us they could make choices about the food they ate but they were not consulted about their care, the service and there had not been any surveys. One person told us "I don't think it has been explained to me."

Some people told us that their privacy and dignity was respected and one person said "I can sit with others or go to my room." One visitor told us that "my friend is treated with dignity and respect." However one person told "staff don't talk to me as an individual and call me 'darling' all the time and not by my name which doesn't mean a thing."

Roseacres

Detailed findings

Background to this inspection

The inspection team included an inspector, an expert by experience of dementia services, a specialist nurse advisor, a specialist occupational therapist advisor and a CQC pharmacist.

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 regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process under Wave 1.

We reviewed the information we held about the home before our visit including information we requested from the provider and previous inspection reports.

There were 29 people using the service on the day of our visit. We spoke with 10 people using the service and two people significant to people using the service. We looked at care or treatment records of 13 people currently using the service and two staff records. We spoke with five staff, the manager and deputy manager of the service. We spoke with a visiting District Nurse and GP.

We observed people throughout the day and also using the Short Observational Framework for Inspection (SOFI) during lunch time. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We toured the premises, looked at records and reviewed information given to us by the provider and manager. We looked at incidents and accidents logs during the visit, the provider's policies, procedures and audits of the service following the visit. We spoke with the safeguarding team of the local authority following our visit.

Are services safe?

Our findings

People were not protected against the risks of receiving inappropriate or unsafe care. The care provided did not always meet their needs or ensure the welfare and safety of the person. This was a breach of the relevant legal requirement (Regulation 9). The action we have told the provider to take can be found at the back of this report.

Records showed that people's risk assessment had been reviewed and updated. However some had not been reviewed and updated monthly in accordance with the provider's policy. The slips, trips and falls assessment tool had not been completed this calendar year. We spoke with some care staff who were aware of people's risks but were not aware of what the risk assessment stated. We observed that people were in a lounge area for several periods of 10 minutes and one of 15 minutes without care staff being present. People were at risk of harm during these periods. We saw two near miss falls from chairs during our observation.

We observed some good practice in relation to staff assisting people who were able to weight bear. However we also observed three unsafe transfers of people who needed two care staff to assist them. One person's records stated "Two staff to transfer" but not how. This did not provide staff with sufficient information about how to support the person to stand. As a result, risk of injury to the person and the staff supporting them was increased.

We observed a person leaning heavily on two care staff. The person's care plan had not been updated since January 2014 and stated "At risk of falling. Needs assistance of one carer". One carer would have been insufficient to ensure the persons safety.

Steps were being taken to deal with emergencies. Our records showed that the London Fire and Emergency Planning Authority (LFEPA) had sent a deficiencies letter to the provider in 2013. The manager told us that all the work required had been completed. We spoke with the Fire Prevention Officer at the LFEPA who confirmed the works had been completed. Staff we spoke with were aware of some fire safety procedures but were not aware of what actions they should take for people who were bed bound in the event of a fire. The manager sent us a schedule of planned refresher fire safety training for staff following our visit.

People were not protected from avoidable harm. This was a breach of the relevant legal requirement (Regulation 11). The action we have told the provider to take can be found at the back of this report.

Most people and people significant to them we spoke with told us they felt safe. One person said "you can talk to the staff if you want to." Another person said "staff come looking for me if I go wandering off in the building." However we observed and saw records that indicted some unsafe care. Records showed that one person had a moisture lesion. The District Nurse records in March 2014 stated this was due to "water damage". The nurse wrote "Have advised the manager that moisture lesions are on the rise with several residents developing sores. Hence staff should be toileting and changing pads more frequently. This situation needs to be monitored". The records did not evidence that this was happening. One person sat in the same chair for five hours during our visit. When staff moved them we could see the person's clothes were soaked through. We saw from the records that this person used incontinence pads. This incident indicated that continence pads were left on for too long and this was a reflection of poor and unsafe care.

Most staff we spoke with knew how to recognise and respond appropriately to incidents or allegations of bullying, harassment, avoidable harm, abuse or breaches in people's human rights. Staff were aware of the provider's safeguarding and whistleblowing policies and procedures. Staff told us who they would report concerns to. However the provider's policy did not provide contact details for the relevant external agencies and staff we spoke with did not know where to locate these.

The manager had taken some steps to ensure that people were safeguarded against the risks of abuse; however people were still at risk. The manager told us that several staff members had left before actions could be completed. The manager told us that people's call bells had been and continued to be placed out of reach and a care plan template had been removed and was being investigated. We observed that some call bells for people who were in bed were still out of reach and some were not available. The manager told us that new call bells had been ordered.

The provider was not meeting the requirements of the Deprivation of Liberty Safeguards as some restrictions were being placed on people's movements without obtaining the necessary approvals. People's human rights were

Are services safe?

therefore not being properly recognised, respected and promoted. Risk assessments and best interests meeting were not being held to consider if it was necessary to restrict individuals' movements within the premises. Most staff we spoke with and the manager were not clear about the requirements of the Mental Capacity Act 2005 and the requirements of the Deprivation of Liberty Safeguards (DoLs). One person's records stated that the person "lacks capacity to make complex decisions" but there was no reference to what these were to guide staff and there was no capacity assessment in the person's records. We heard that one person had full capacity and wanted to go out but was told that they would not be able to do so without being accompanied by staff. The manager told us that this was a misunderstanding.. The person had not been involved in making decisions about the risks they could take. There were keypad controlled doors throughout the premises restricting the movements of all people using the service. People were required to ask staff for access through each door. People's records did not include risk assessments of why each person's movements had been restricted.

CQC were not notified of requests by the registered person to a supervisory body to deprive a person of their liberty. This was a breach of the relevant legal requirement (Regulation 18 (4A) The Care Quality Commission (Registration) Regulations 2009). The action we have told the provider to take can be found at the back of this report.

The manager told us that three urgent Deprivation Of Liberty Safeguards (DoLS) short term applications had been made to the local authority but they were not aware that they needed to notify CQC.

People were not protected against identifiable risks of acquiring an infection. This was a breach of the relevant legal requirement (Regulation 12). The action we have told the provider to take can be found at the back of this report.

Staff were wearing personal protective equipment. However some soap dispensers in bathrooms were not adjacent to the wash hand basins so they were less likely to be used and could therefore increase the risk of an infection being transmitted. The manager told us that new gels and soap and towel dispensers were to be installed and sited suitably by a new company. There was no hot water in one of the bathrooms; an extractor fan was not working and there was poor cleaning.

Contaminated waste stored in a metal container with an unattached metal lid was found in a WC compartment accessible to people using the service. We spoke to the manager during our visit and the contaminated waste bin was re-sited to an area not accessible to people using the service. At lunchtime we saw a care worker sit on a coffee table to feed a person which showed a lack of awareness of infection control.

People were not protected against the risks of unsafe or unsuitable premises by means of a suitable design and adequate maintenance. This was a breach of the relevant legal requirement (Regulation 15). The action we have told the provider to take can be found at the back of this report.

The physical environment in some areas for people who were independently mobile was potentially hazardous. It included steeply sloping corridors with handrails which visually blended in. This created further difficulty for individuals with poor vision or dementia. The home was in a poor state of decoration. One area had been redecorated and we were told by the manager that further decorative and other works were programmed. We observed a range of hazards and brought them to the attention of the manager. This included loose hinges on a door at the top of stairs, broken protruding grills at the base of a storage heater, and an unattended step ladder. The design of the premises the lack of maintenance presented a risk to people. In addition, there was a holed partition to the lobby door between rooms 26/27 which meant that the partition to the room did not provide the required 30 minutes fire protection. There was a landscaped garden, however staff told us that people could go into the garden but only if accompanied by staff as it had trip hazards. The design of the garden was not suitable for the needs of some people using the service.

People and others were not protected from the risks of unsafe equipment that is properly maintained, suitable for its purpose and is used correctly This was a breach of the relevant legal requirement (Regulation 16). The action we have told the provider to take can be found at the back of this report.

A passenger lift served the ground and first floors. A domestic stair lift was also provided to one of the staircases. The manager told us that this was only used in an emergency if the main lift was broken and there was a care worker present. Staff told us this had occurred once in the last year. However we did not see a risk assessment for

Are services safe?

this equipment to ascertain which people were able to use it safely, how it should be used and how staff should support people. We did not see any staff training for this equipment. People could be placed at risk of injury if they used the lifts inappropriately.

Most equipment available within the home met the needs of the people living there, however some equipment was not appropriate and the condition of some items was poor. There were typed and laminated procedures for staff to follow when bathing and showering people in each bathroom and also thermometers for testing water temperature. Servicing and maintenance records were up to date and equipment was inspected frequently. However, one of the mobile hoists viewed had clear signs of wear and tear. Another of the mobile hoists was of a type which provided a less comfortable lifting experience for most people and was onerous for staff to use. The manager informed us that it was not used and he was seeking a replacement from the provider. However we later viewed it in a person's room and a care worker told us it was used for that person. Another care worker told us that they could do with another hoist. There was also a powered bath lift in one of the baths. The seat material was dirty, discoloured and worn. The manager told us he was not aware of this bath lift and did not believe it was used by people anymore. He did not know where the handset was located. It was not clear if this equipment was obsolete and out of use.

There were two mobile hoists in one of the bedrooms on the ground floor. The manager acknowledged there was a lack of storage facilities and the bedroom was used for storage as the occupant got up early and left their room for the day.

We found that some bed rail protectors did not fit the bed rails thereby presenting a hazard of entrapment to the person using the bed. The manager told us that an order had been placed to rectify this.

Staff handled medicines safely. We found that arrangements for the management of medicines were safe. Medicines were available for people when they needed them and records showed that they were administered as prescribed. We saw that the recent introduction of an audit system to check medicines and medicine records had ensured that medicines were given safely as prescribed. If discrepancies were noted, these were dealt with promptly and appropriately. We saw evidence of medication reviews by visiting medical staff and noted that the changes requested by consultants had been implemented and recorded. We looked at the arrangements for recording the use of creams; this was not always recorded accurately. We also saw that some creams were labelled to be used 'as directed'. This meant that the prescriber's instructions were not clear to the care staff. Some people were prescribed medicines by injection. These were given by community nurses and their records were available to care staff and other healthcare professionals to refer to if needed.

Are services effective?

(for example, treatment is effective)

Our findings

People were not always protected against the risks of receiving care of treatment that is inappropriate or unsafe and reflected good practice. This contributed to a breach of the relevant legal requirement (Regulation 9). The action we have told the provider to take can be found at the back of this report.

We spoke with one person who told us they were then and were often in severe pain. The person told us "This pain is so terrible I wish I could die." and cried out several times whilst we were present. The person's call bell was out of reach. Two carers responded when we used the call bell but they were not aware of the pain management for the person or did they understand the amount of pain the person was experiencing. Their initial response was to turn the person and when we asked about any medication to offer aspirin for pain relief. The person's records indicated that the person was in pain when turned but there were no records to indicate a pain management plan. We spoke with the manger about this who told us that the locum doctor had made a referral to the homes general practitioner for a pain assessment, prescribing medication and a plan for staff. Another person told us they could not drink their tea as the mug was too heavy to hold due to their arthritis and trying to do so caused the person pain. This presented a potential risk of spilling liquid and the person not receiving enough fluids. The manager told us the Abbey pain assessment was in use. This is a method of assessing pain for people with dementia who are unable to verbalise. Staff told us they did not use this but relied on their knowledge of the person. The absence of a systematic assessment places people at risk of pain that is poorly identified.

One person's care plans stated the person should be encouraged to use the toilet every two hours. The record showed the person used large pads but there was no frequency of change and no guidance for staff about how to support the person in personal hygiene. Another person's care plan indicated the person can use the toilet independently, wears continence pads and needs assisting to the toilet when required. There was no reference to what "when required" means. As a consequence staff may interpret this in different ways and the person may not always receive care and support that meets their needs. People's care plans did not reflect their changing continence needs.

Some people's records contained a history of urinary tract infections (UTI); however there was no reference to the potential for prevention. There was no guidance for staff to help them recognise the developing signs and there were no instructions for staff about the care they should provide to reduce the common symptoms of UTI such as pain, chills and increased confusion.

People's records did not show any end of life care plans or power of attorney authorities. The manager told us that the district nurse had been supportive with end of life care. However staff and the manager told us staff had not been trained in end of life care. The manager told us they were to arrange staff training in end of life care with the local authority and contact the local hospice for advice on palliative care. We found Do Not Attempt Resuscitation (DNAR) located in the middle of peoples records. These had mostly been completed correctly however they were not readily available which presents a risk that people may receive inappropriate care.

Staff may not respond appropriately in response to signs that a person's diabetes was out of control. There were five people with diabetes living at Roseacres. We looked at the records of two of these. There was no monitoring of dietary intake. There was no record of blood glucose recording for insulin dependent and dietary controlled diabetics. The Deputy Manager told us "the District Nurse sorts out the insulin dependent diabetic, we don't have to do anything". We asked how they would know if the person was hypo or hyperglycaemic in between the nurse's daily visits. We were told that they would do a blood glucose test if the person "went a bit off." We asked about the four people with dietary controlled diabetes and were told that they don't need to do anything with them, as their diet sorts them out. The home had cut down the number of biscuits that diabetics could eat but this was not reflected in their care plans. There were no instructions for nutritional intake or the signs that staff should look out if the person who was insulin dependent became hyper or hypoglycaemic. We were told that staff did not look in care plans for dietary information. People were at risk of receiving inappropriate or unsafe care.

Are services effective?

(for example, treatment is effective)

One person records stated "Cannot swallow solid food. Choking risk". There was no risk assessment since 30 January 2014. The last entry by the Speech and Language therapist was 1 June 2013. The records did not show if the person had deteriorated in this time. There was no dysphagia care plan that would provide instruction to staff about what they should do if the person was choking. This person was not protected from the risks of choking. Records we reviewed did not indicate that the provider anticipated the risks to people with dementia of dysphagia and did not provide staff with appropriate training to either identify the risks or respond in the event of a choking emergency.

Records showed one person had been admitted to hospital in February 2014 with Community Acquired Pneumonia and Dehydration. The person's monthly evaluations for all care areas were written on 1 April 2014. One of these, breathing stated that the person had no problems breathing whilst in hospital at the time of the report with the severe breathing difficulties caused by pneumonia. All of the other care plans reviews were dated 1 March 2014 but were inaccurate because the person was in hospital. No care plans or risk assessments were updated following the person's return to the home.

Records showed that one person's weight had dropped from 87.1 kilos in January 2014 to 77.1 kilos in February 2014. We pointed out this significant loss to the deputy manager who told us it was before she started so she did not know why she had lost so much. The records did not contain any reference to what is a large and unplanned weight loss and what action to take. Other people's weight records had not been updated. This presented a risk to people's welfare and safety.

One visitor told us that the mobility of the person had improved since they were living at the home.

People were not protected against the risks of acquiring an infection. This was a breach of the relevant legal requirement (Regulation 12). The action we have told the provider to take can be found at the back of this report.

One person smelt very strongly of urine and their pad was bunched at the front which is an indication that the pad is full. The persons care plan stated "To toilet 2-3 hourly". We observed the person was sat in the same location without moving from 09:30 to 14:30. Poor continence management placed people at the risk of infections.

Choices of food were provided to meet people's needs. The manager told us that when they arrived the home had not been offering choices of food and drinks to people but they had instructed the head chef to obtain people's likes and dislikes. People told us they had a choice for their meals. One person said that they had a choice for lunch and could choose from a list. Another person said they were asked what they wanted for breakfast. One person told us that the food was good; however another person said it was 'awful' although she did also say that she was happy to have a fried egg for breakfast. One visitor told us that her friend seems to have the same dessert every time she comes – sponge and custard. We observed that staff offered people drinks at regular intervals throughout the day and supported people to eat.

We spoke with the assistant chef who told us they were not aware that people had any allergies but they were aware that there were some people who had fresh fruit because they were diabetic. We asked for but did not see any records in the kitchen which indicated if people had been assessed for allergies or which people were diabetic. Staff were not aware of what to do if people had been given inappropriate food and what arrangements were in place to determine dietary needs if the permanent kitchen staff were not present. Staff told us if people did not like the food they would be offered something else. We observed one person asking for tea, bread and jam which was given to them immediately. Staff told us that one person did not eat pork as they were Jewish and another person had a cultural preference for noodles.

Records of a recent relatives meeting showed that there were concerns that some people were losing weight. The manager stated that people would be referred to their GP or District Nurse and that they could not force people to eat. We saw that people had to wait for a long time sat at the table for their food to arrive and some people who did not sit at the table did not get assistance to help them eat for half an hour after their food arrived. However the food looked plentiful.

People were not protected against the risks of unsafe or unsuitable premises by means of a suitable design and layout. This was a breach of the relevant legal requirement (Regulation 15). The action we have told the provider to take can be found at the back of this report.

Many of the people living at the home had dementia. However the home environment did not take into account

Are services effective?

(for example, treatment is effective)

the needs of people with dementia. For example there were no pictorial signs used which are known to help people with dementia understand their environment. There were no distinguishing colours between different areas to make finding people's way around easier. There were no reminiscence areas to help promote recall. There were no memory boxes. The bathrooms were plain white which made it difficult for people with dementia to discern different areas such as the toilet. There were two slopes on the first floor which was not visually identified and this posed a slip and trip hazard. In the lounge areas the television was the main entertainment at one end which was showing morning television with a fair amount of anger and tension. At the other end a radio was playing a pop music station, also loudly and inappropriate for the age of people using the service. The manager told us that they would be installing memory boxes and they had plans to develop a care worker as a dementia champion.

People were not enabled to participate in making decisions relating to their care. This contributed to a breach of the relevant legal requirement (Regulation 17).The action we have told the provider to take can be found at the back of this report.

People told us that they were not consulted about their care plans and preferences. People's records did not show that that people were involved in making decisions about their care and support or in evaluating their care or in planning for the future. Some staff we spoke with were not aware if people were consulted about their care. However records showed that staff had been instructed to ask people when they wanted to get up in the morning. The care plans did not reflect the provider's care planning policy of involving people in their care. We asked the deputy manager about this who told us "this is something I am going to do next month." The provider's March 2014 audit of the service had identified failings in care planning, risk assessments and record keeping and the manager had been tasked with making improvements the following week. The manager told us that care plans had been put in place but needed to be personalised.

Suitable arrangements were not in place for obtaining consent from some people and establishing and acting in accordance with people's best interest. This contributed to a breach of the relevant legal requirement (Regulation 18). The action we have told the provider to take can be found at the back of this report.

Most people had dementia however people's records did not show that capacity assessments had been made.

Appropriate information and documents were not maintained for each person to protect them against the risks of unsafe or inappropriate care. This was a breach of the relevant legal requirement (Regulation 20). The action we have told the provider to take can be found at the back of this report. For example the slips, trips and falls assessment tool had not being completed this calendar year when monthly updates were required for people who were at risk of falls. People's records contained an audit form of oral healthcare but this had not been completed since January 2014 for any of the records we reviewed. The provider information return stated that there were no people using a dentist or orthodontist. People were at risk of unsafe of inappropriate care.

Suitable arrangements were not being fully made to protect the health welfare and safety of people where responsibility is transferred to others. The manager told us that a brief profile of the person is sent to the receiving service however this is an area for improvement. There was a risk that people's needs, wishes and choices may not be met when they are transferred between services.

Are services caring?

Our findings

Some delivery of care was inappropriate or unsafe and did not meet service user's individual needs. This was a breach of the relevant legal requirement (Regulation 9). The action we have told the provider to take can be found at the back of this report.

We saw one person having food placed quickly into their mouth by a care worker without giving time to see if the person had finished the previous mouthful, whether they wanted any more or whether they liked what they were eating. We saw people's mouths being wiped without permission being obtained or interactions by staff. We saw one person having a bib placed on them whilst they were asleep. People were told it was lunchtime and were not asked if they wanted to go to lunch. Another person was woken up to be taken into lunch. We had observed the person eating about an hour before. We saw the person being fed by a care worker who told the person that they needed to eat more and to 'open your mouth'. People were not invited to go to the toilet or wash their hands prior to lunch. We spoke with one person who was in their bed with nothing to watch or listen to. The person told us they liked to listen to the radio. The persons care plan review stated "enjoys the company of others in the lounge", The person's call bell was out of reach which meant they were not able to call for assistance and were socially isolated. Another person told us "staff don't talk to me as an individual and call me 'darling' all the time and not by my name which doesn't mean a thing." These interactions and practices showed a lack of caring and compassion.

We saw one person who had difficulty in weight bearing being transferred four times from a chair to a wheelchair using a handling belt during the lunch break to enable the person to sit at a chair in the dining area for lunch. However this may not have been appropriate given the person's difficulty in weight bearing.

Suitable arrangements were not being made to ensure the dignity, privacy and independence of people. People were not enabled to make or participate in making decisions relating to their care or treatment. This contributed to a breach of the relevant legal requirement (Regulation 17). The action we have told the provider to take can be found at the back of this report.

Staff told us that some women preferred female carers and some men preferred male carers which they were not always able to accommodate. One person told us being taken to the toilet by a male carer was degrading and they had not been given a choice.

The provider's dignity policy stated that all service users will be encouraged to maintain their own culture, religious beliefs and practices. One care worker told us that one person needed help with dressing in their Sari and a relative bought in food for the person to eat sometimes. Staff and the manager were not able to tell us of the person's cultural and religious needs or if the person had a first language that was not English. The manager told us that spiritual guidance and support could be arranged if required but we did not find any evidence that this was occurring. Care was not being provided with due regard to peoples sex, religious persuasion, cultural or linguistic background.

We saw a person in the presence of a care worker and a visiting healthcare professional in the toilet lobby area. The visiting healthcare professional was trying to administer an injection to the person. The visiting healthcare professional had not been initially shown to a suitable space to be able to administer an injection to a person in privacy in order to maintain their dignity. However the injection was abandoned when they noticed we were observing and they all moved to the person's room. We observed instances throughout the day when one person's trousers were left down and care workers did not respond in a timely manner. None of the shower rooms had shower curtains or nursing/carer screens to respect the privacy and dignity of people that could shower with supervision rather than manual assistance. These instances are not in accordance with the provider's dignity policy dated September 2013 which states that staff will treat all service users with dignity when assisting in bathing, dressing, feeding, continence and all other personal needs.

Some people told us that their privacy and dignity was respected and one person said "I can sit with others or go to my room." One visitor told us that "my friend is treated with dignity and respect." One person told us that staff gave them time to make decisions. They told us that they could speak to people on the phone or in their room and "staff are comfortable to talk to." Another person told us they could go to the manager if they were not happy and said they 'had good times here' and that they could treat the

Are services caring?

home as their own home. However we saw that some people were not being listened to. One person kept calling out "can you talk to me please". The person's care plan stated "loves talking" and that they were blind. Staff did not respond to the person until the person removed their trousers. During lunchtime we saw staff say to the person "Is it too hot?" then leave the person for five minutes without saying when they would return. Another person told us that nobody bothers to talk to them and that staff just came and did things without asking. We were told that they felt that all the days were the same. The manager told us that there had been meetings for people who used the service in the past but they had been poorly attended. Some people were not treated with consideration and respect or encouraged to express their views.

Records of a relatives meeting in February showed that relatives had concerns regarding staffing, people being toileted timely, people losing weight and charges. The record included actions that would be taken to address those concerns and meetings would be held every three months which could include evenings and weekends to make them more accessible to relatives. The manager and deputy manager were available for individual concerns. The manger had moved his office into the main building from the annexe in the garden to make himself more accessible.

There were not sufficient numbers of suitably qualified, skilled and experienced staff to safeguard the welfare of people. This contributed to a breach of the relevant legal requirement (Regulation 22). The action we have told the provider to take can be found at the back of this report.

We saw that when staff were in the lounge they were mainly engaged in task focused work for example helping people to move and assisting people with eating and drinking. They were busy but their interaction with people was brief and superficial. We spoke with staff about the time they had to spend with each person. They told us they usually had to do things in the quickest way to get the "work done". They told us they loved working with the people at the home but they needed to get everything done in the time available. This meant that people sat for very long periods with no social interaction or engagement.

We observed some good interactions between staff and people during lunch such as the kindly way some staff spoke with people, and gave people time. We observed staff using equipment with people e.g. wheelchairs in a caring and appropriate manner and staff generally communicated with a caring and empathetic approach when transferring or mobilising with people. Some people we spoke with said they were comfortable and well supported and one person told us there were care staff walking around all day. Another person told us staff were very good at looking after them and that they would be listened to and there were plenty of staff. Some staff called people by their preferred names indicated in the person's records. We spoke with one person and their visitor in the garden who told us "they bought tea out to us, and always ask if we want it."

We observed people sitting in the lounge which was used as the main thoroughfare by staff. Most staff, with the exception of the deputy and the manager walked through and did not acknowledge people. The deputy stopped and spoke to people on their way through each time. The manager noticed a person was leaning over the side of the chair, stopped and spoke with the person and put a cushion under the person's arm. We looked in the person's care plan and found there was no guidance for staff about how they should support this person. Although the person looked more comfortable we do not know if this was a correct intervention or otherwise. However the manager had noticed the person when almost all staff had walked through the lounge many times without being aware of the person's discomfort.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Care was not being delivered to ensure the welfare and safety of people. This contributed to a breach of the relevant legal requirement (Regulation 9). The action we have told the provider to take can be found at the back of this report.

We found several people were in bed as we went on our initial orientation tour of the home. Three of these did not have access to their call bells which were hung on the wall behind their bed and far out of their reach. These people were all on the first floor and had no ability to call for assistance when they needed help. One person's records stated "Staff to encourage xx to use the call bell if she needs help". This was not possible when the call bell was three feet behind the head of her bed looped across a plug in the wall. This meant it was not possible for staff to be responsive to people's individual needs.

We saw that some people did not use the toilet or were not changed for periods of up to five hours. This meant that they were likely to be wet, staff were not responding to their needs and this increased the likelihood of an infection or wet related injury such as a pressure sore.

People's records showed that initial assessments, care plans and risk assessments had been made, however we found that there were gaps in the records including risk assessments. The manager told us that they had initially developed the care plans and people's records and were reviewing all the care plans and records in the next month. We were told the review would include making people's care plans and care delivery more personalised to include needs in relation to their age, religion, culture and sexual orientation.

There were no records of activities in people's records. We saw that staff were involved in their tasks but most staff did not interact socially with people. We observed there were long periods where people were sat facing a television which was on at high volume. No one has selected the programme and there were no other activities. The manager told us "We have not had an activities co-ordinator for some time but we have contacted the National Association for Providers of Activities for Older People to provide advice and training." Staff told us they did not have time to support people with activities. Staff offered people drinks at regular intervals but for many this was the only time staff engaged with them. The deputy manager told us that they were organising activities for people at Easter. Care was not being planned and delivered to meet people's individual needs.

People were mostly not supported to express their views and be actively involved in making decisions about their care, treatment or support. This contributed to a breach of the relevant legal requirement (Regulation 17). The action we have told the provider to take can be found at the back of this report.

Most people told us they were not involved in planning or decisions about their care or support. One person told us "I don't think it has been explained to me". The manager told us that people were asked about their preferences for personal hygiene e.g. bath or shower but we saw no evidence of these choices being discussed or recorded in people's records. The manager told us that people and those significant to them would be involved in the review of all people's records including care plans and risk assessments.

We were told that people had not been asked for their opinions or choices in the recent decoration of one part of the home or the decoration that was planned. However people did tell us that they were given choices of food to eat. One person told us their relative was involved in their care and records showed that relatives meeting were being held. One person told us that some staff were difficult to understand.

Suitable arrangements were not in place to for obtaining and acting in accordance with the consent of people or their representatives or establishing and acting in accordance with people's best interest. This contributed to a breach of the relevant legal requirement (Regulation 18). The action we have told the provider to take can be found at the back of this report.

Many of the people using the service had dementia. However people's records did not show that capacity assessments had been made and decisions had been made in their best interests. The manger and deputy manager told us that this would be dealt with next month. Staff we spoke with were unable to tell us the requirements of the Mental Capacity Act 2005 and records showed they had not received training. We asked the manger to send us details of staff training which showed three staff had received training in the Mental Capacity Act which had

Are services responsive to people's needs?

(for example, to feedback?)

expired and none was planned. We did not see details of advocacy services and people's records did not show if they had been supported to access those services. The provider's information return stated that they did not have advocacy services. There was a risk that people or their representatives consent was not being obtained when providing care or in accordance with the persons best interests.

The manager told us and records showed that they had referred people who had falls for a review of their medication which had been changed and their mobility and behaviour had improved. Staff told us that they would recognise people's changing needs by changes in the person's mood, bowel movements, food intake, temperature and people not engaging in the way that they would normally. We were told people had access to and had been referred to visiting professionals including a tissue viability nurse, dementia specialist and chiropodist. We spoke with a locum GP and locum District Nurse during the visit but they were not able to tell us about the home as they told us they were not familiar with the home.

People were enabled to maintain relationships with their friends and relatives. Most people we spoke with told us they had contact with their relatives and friends. Records showed that some relatives were involved in peoples care by attending relatives meetings and the action that was being taken in response to relatives concerns. For example the meeting would be held in the evening and weekends to allow more people to attend.

Although the provider had a system in place to identify, receive, handle and respond to complaints, appropriate steps were not being taken to respond appropriately to complaints. We saw a complaints information pack displayed in the reception area. Most people told us they could speak to the manager or staff with any complaints or concerns. Some staff we spoke with were not aware of the provider's complaints policy but told us they would try to help the person and then pass on any issues they could not deal with to the manager. However we did observe one person crying out in pain which was not responded to by staff until we bought it to their attention. The manager told us that there had not been any formal complaints. However we were told of an incident where one person had called the police when they were told they could not leave the home unaccompanied and this had been a misunderstanding. The manager told us this had not been dealt with as a complaint. Complaints were not being responded to appropriately in accordance with the providers policy

We asked to see any compliments of the service and the manager told us there had been one since they were at the service but this was not available as it had not been unpacked from the office move.

There were not sufficient numbers of suitably qualified, skilled and experienced staff to safeguard the welfare of people. This contributed to a breach of the relevant legal requirement (Regulation 22). The action we have told the provider to take can be found at the back of this report.

Records showed and the manager told us that staff were deployed based on the needs of people. The home had been divided into groups of people using the service with a summary of their care needs and tasks that staff were allocated to those groups. The manager told us that this was to ensure enough care staff were provided to meet people's specific needs. The manager told us they would be increasing care staff on days when there were visiting professionals to assist them with providing care to people. We did not see completed group shift duty allocation sheets as we were told they had not been unpacked from the recent move. However we observed that staff provided task orientated personal care to people, however this did not include social and emotional care.

Are services well-led?

Our findings

People were not protected against the risks of inappropriate of unsafe care. There was no regular assessment or monitoring of the quality of the services provided. People and those acting on their behalf views were not regularly sought to provide an informed view in relation to the standard of care provided to people. This contributed to a breach of the relevant legal requirement (Regulation 10). The action we have told the provider to take can be found at the back of this report.

Some steps had been taken by the manager to include and empower staff. Staff told us that they could participate in staff meetings and there had been several in the last few weeks. There had not been any surveys of people, those significant to them or staff. This demonstrated that there was no system in place to enable anonymous concerns or trends to be bought to the attention of the manager or provider. The provider was not gathering feedback in accordance with their Equality Policy. People were at risk of inappropriate or unsafe care going undetected and continuing by not being bought to the attention of the manager or provider.

The service was not learning from mistakes, incidents, complaints or audits. The manager told us that there had been few audits by the home as they had been "firefighting" the service. We were told audits should be conducted monthly. Records showed medication audits had commenced. However although individual incidents and accidents had mostly been dealt with there had not been any analysis to establish if there were any trends. Records showed a provider audit in March 2014 and included actions to be taken, the timeframe and who was responsible. It included the manager moving from the annexe building in the garden to the main building to make them more visible and we saw this had been done. The manager had been instructed to fully audit 10% of care plans. The provider's audit did not show whether there were actions outstanding from any previous audits or when the next audit was taking place. The provider was not regularly assessing and monitoring the quality of the service to protect people against the risks of unsafe or inappropriate care or identifying, assessing and managing those risks.

Most people told us that the manager, deputy manager and most staff were approachable and they could approach them with any concerns. However the manager told us that there had not been any meetings for people using the service as they had in the past been poorly attended. Records showed and the manager told us that people had not been consulted in planned improvements to the service or in their care planning or reviews. Records showed that when plans are confirmed or decisions made then families will be informed by letter or at a relative's meeting. This demonstrated that although relatives were being asked to raise concerns at the relatives meeting they were not being consulted.

Accurate records were not maintained in relation to the care of each person and the management of the service. This contributed to a breach of the relevant legal requirement (Regulation 20). The action we have told the provider to take can be found at the back of this report.

Prior to our visit we were told of some concerns of people's records being falsified which we were unable to substantiate during our visit. We found that there were gaps in people's records including risk assessments. We asked the manager to see records of staff meetings but were told some records had not been unpacked from the recent move. Following our visit we were sent minutes of the staff meeting in January 2014 which did not show how staff participated in the meetings.

There were not enough suitably qualified, skilled and experienced staff to safeguard the health, safety and welfare of people. This contributed to a breach of the relevant legal requirement (Regulation 22). The action we have told the provider to take can be found at the back of this report. Records showed and staff told us that there had been problems with staff phoning in sick and obtaining staff cover that was suitable for the home. Permanent staff had been recruited and we were told there would be less reliance on agency staff. Staff incentives had been introduced to try to keep permanent staff. Most people told us there were enough staff. The manager and staff told us that an additional care worker had been deployed in the mornings to assist with visiting professional visits. People's social needs were not supported as we saw that care staff were task focused and they did not have time to engage in social activities with people and there was no activities co-ordinator. People's preferences for male or female carers could not always be met.

Are services well-led?

Staff were not appropriately supported to enable them to deliver care to people safely and to an appropriate standard. This was a breach of the relevant legal requirement (Regulation 23). The action we have told the provider to take can be found at the back of this report

Some steps had been taken by the manager to recruit staff and to ensure that all staff had the skills to meet people's needs. However the manager told us this was a "work in progress." Staff we spoke with were aware of the values of dignity, respect, equality and independence but were not aware of the provider's policies. We saw some poor practice during our visit from some staff. The provider's audit stated that one care worker had been observed hoisting a person on their own although they had recently received manual handling training. The care worker stated that this was because staff were busy. The auditors action was that operational supervision must be put in place following training. The record did not state what action should been taken concerning this care worker and we did not see any records that observations of manual handling had taken place. The audit stated that two staff files were to be reviewed. It was not clear if this had been done but the comments stated that "Staff being performance managed must have recorded supervisions with clear goals that are followed up." The deputy manager told us that there were 28 supervisions to do and two had been done so far during the week of our visit. The provider information return showed that 60% of staff that had been employed for more than two years had an appraisal in the last year.

The manager told us and records showed that training was outstanding for most staff and the training provider was being changed. At the time of our visit appropriate training, professional development, supervision and appraisal to ensure that staff are supported to provide care to people safely had not been provided. Following our visit we were sent details of planned training for staff and were told that this would be completed in May and June 2014 when all would be up to date. People were placed at risk of receiving unsafe care as staff did not receive appropriate training, professional development, supervision or appraisals.

At the time of our inspection there was no registered manager, however an application had been recently submitted by the home manager to register with CQC who had been in post since October 2013. The provider's information return stated that there had been three managers in post at the service in the last year. The manager told us there had been problems with staff conduct and they had concentrated on getting these issues resolved. The manager had recruited a deputy manager in February 2014 to provide a more visible management presence around the home and assist with making improvements. We were told that several staff had left following the commencement of disciplinary procedures and new permanent staff had been recruited. The manager told us that they had been dealing with the most urgent issues since they had been in post which included staff conduct, staff recruitment and care planning. We were told this had left little time to deal with some issues but improvements were planned which included staff supervisions, appraisals and training. We saw the manager and deputy were in the lounge and dining area frequently and often engaged in positive ways with people and staff.

The January 2014 staff minutes showed the improvements that were planned for the service which including two choices of food for lunch and pay increments for those staff undertaking additional National Vocational Training. Most staff told us that there had been improvements in the service since the manager and deputy manager had been in post. This included employing more permanent staff in recent months, setting the rota so that staff could plan their lives and planning training.

We spoke with the local authority safeguarding team who informed us that there had been problems with the service but there had been improvements to the service since the current manager had been in post. The manager told us that the provider had been supportive in providing resources to make improvements in the home. This included dealing with staff misconduct, employing permanent staff, the commencement of decorating and the purchase of new furniture. This report demonstrates the need for further improvements.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 10 (1) (a) (b)(e) HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision** The registered person did not regularly assess, monitor, identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk form the carrying on of the regulated activity or regularly seek the views of service users or those employed.

Regulated activity	Regulation
	Regulation 11 (1) (a) (2) (a) (b) HSCA 2008 (Regulated Activities) Regulations 2010 **Safeguarding service users from abuse** The registered person did not take reasonable steps to identify the possibility of abuse and prevent it before it occurred and did not have suitable arrangements in place to protect service users against the risk of control or restraint being unlawful or otherwise excessive.

Regulated activity	Regulation
	Regulation 12 (1) (a) (b)(c) (2) (a) (c) (i) HSCA 2008 (Regulated Activities) Regulations 2010 **Cleanliness and infection control** The registered person did not ensure that service users, persons employed and others are protected against risks of acquiring an infection by having an effective system to assess risks, and to prevent and control the spread of an infection. There were not appropriate standards of cleanliness and hygiene of the premises and equipment.

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
	Regulation 15 (1) (a) (c)HSCA 2008 (Regulated Activities) Regulations 2010 **Safety and suitability of premises** The registered person did not ensure that service users and others were protected against the risks of unsafe or unsuitable premises by means of a suitable design and layout, and adequate maintenance of the premises.

Regulated activity	Regulation
	Regulation 16 (1) (a) (b) HSCA 2008 (Regulated Activities) Regulations 2010 **Safety, availability and suitability of equipment** The registered person did not make suitable arrangements to protect service users and others from the risks of unsafe equipment by ensuring that it is properly maintained, suitable for its purpose and is used correctly.

Regulated activity	Regulation
	Regulation 18 (1) (b) (2) HSCA 2008 (Regulated Activities) Regulations 2010 **Consent to care and treatment** The registered person did not have suitable arrangement in place obtaining and acting in accordance with the consent of service users or their representatives or for establishing and acting in accordance with, the best interests of the service user.

Regulated activity	Regulation
	Regulation 20 (1) (a) HSCA 2008 (Regulated Activities) Regulations 2010 **Records**

This section is primarily information for the provider

Compliance actions

The registered person did not ensure that service users are protected against the risks of unsafe or inappropriate care and treatment arising from the lack of proper information about them by means of the maintenance of an accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided to each service user.

Regulated activity

Regulation

Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010

Staffing

The registered person did not take appropriate steps to ensure that at all times there were sufficient numbers of suitably qualified, skilled and experienced people employed to safeguard the health, safety and welfare of service users.

Regulated activity

Regulation

Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010

Supporting workers

The registered person did not have suitable arrangements in place to provide appropriate training, professional development, supervision and appraisal to ensure that persons employed were appropriately supported t enable them to deliver care to service users safely and to an appropriate standard.

Regulated activity

Regulation

Regulation 18 (4A) The Care Quality Commission (Registration) Regulations 2009

This section is primarily information for the provider

Compliance actions

The registered person did not notify the Commission of requests by the registered person to a supervisory body made pursuant to Part 4 of Schedule A1 to the Mental Capacity Act 2005 Act.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 9 (1) (b) (i) (ii) (iii) HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of service users** The registered person did not take proper steps to ensure service users were protected against the risks of receiving inappropriate or unsafe care by planning and delivering care that met the their needs, ensured their welfare and safety and reflected good practice.

Regulated activity	Regulation
	Regulation 17 (1) (a) (b) (2) (a) (b) (c) (i) (ii) (d) (f) (h) HSCA 2008 (Regulated Activities) Regulations 2010 **Respecting and involving service users** The registered person did not make suitable arrangements to ensure the dignity, privacy and independence of service users and enable them to make or participate in making decisions about their care. The registered person did not treat service users with consideration and respect, provide appropriate information and support, encourage to understand their care and express their views, involve them in decisions and take care that care and treatment is provided with due regard to their age, sex, religious persuasion or cultural or linguistic background.