Ringdane Limited

South Park 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

South Park Care Home is a purpose built home registered to provide nursing care for older people. There are two separate units. Ebor accommodates up to 44 people with mental health and / or dementia care needs on two floors. Jorvik accommodates up to 36 people with general nursing needs. Jorvik has three floors, with most of the communal areas on the ground floor. The unit though does have an additional communal lounge on the third floor.

The two units have their own staff teams and each has a 'Head of Unit', responsible for the day to day running of the unit. There are lifts on each unit. People living downstairs on Ebor have access to a safe garden area. People living upstairs on Ebor mostly require more personal care and support than those living downstairs. The service is situated in a residential area to the west of the city centre, and on a bus route to the city. There are parking facilities on site and local shops and other amenities close by.

Summary of findings

At the time of this inspection there was a total of 57 people using the service. On Ebor there were 34 people with mental health conditions and / or dementia care needs and Jorvik supported 23 people with general nursing needs. We were told by the deputy manager that there was no one on end of life care so we did not look at this during the inspection.

This inspection was unannounced and took place on the 13 and 14 August 2015.

The last inspection took place on 3 and 4 December 2014. At that inspection we found the registered provider was breaching three of the essential standards of quality and safety (the regulations) relating to The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

In April 2015 the legislation changed and the above breaches now correspond to Regulation 11, 17 and 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) including Need for consent; Good Governance and Fit and proper persons employed.

This inspection showed that the provider had met two of the three breaches of regulation, but a further six breaches of regulation were found. You can what action we told the registered provider to take at the back of the full version of this 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 the 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 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.

There has not been a registered manager at this service since December 2013. A new manager was appointed in January 2015, but they have yet to submit an acceptable application to register with the Care Quality Commission. This has been discussed with the registered provider's regional management team at this inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service was not safe. There were insufficient numbers of suitably qualified, skilled and experienced persons employed in the service to meet people's needs. The registered provider had employed a number of agency staff to fill the staff vacancies, but people who used the service said they did not feel safe when these workers were on duty and we observed some unsafe care practices during our inspection.

The registered provider failed to protect people who used the service against the risks associated with the unsafe use and management of medicines. We saw evidence of unsafe handling of medicines when staff left trolleys unattended with the doors unlocked or medicines left on top of them.

We found problems with the cleanliness and hygiene within the service. In particular there was a significant and unpleasant odour in three bedrooms, two sluices and a number of bathing facilities on both units.

We had a number of concerns about the skills and knowledge of the staff on duty. The registered provider had an induction and training programme in place, but we found little evidence that care staff were supervised

Summary of findings

appropriately. The care staff told us the online training programmes were difficult to access and use and that they lacked the time to complete the e-learning sessions. People and relatives who spoke with us expressed worry about the competency of some of the care staff and we witnessed examples of poor care during our inspection which were brought to the attention of the management team.

We saw that the premises had not been made safe in all areas of the service. We found that bathrooms and shower rooms were being used as storage facilities for equipment whilst people were still using the areas for bathing or toilet needs. We saw the service was untidy and cluttered with boxes and miscellaneous items stored in corridors, dining rooms and in every available space. This created trip and fall hazards to people using the service.

Observations of the dining rooms and bedrooms on both units in the home showed that some people had a very good dining experience and others did not. We saw that a number of very dependent people were unable to access drinks and others were left struggling to eat their meals when they needed full assistance. Staff were very task orientated, although we did see them being kind and patient with people.

People, relatives and staff told us that communication within the home was poor. People and relatives were not involved in the planning and delivery of care and treatment within the service and they felt their opinions were not listened to by the staff. We were told that sometimes there were delays in obtaining personal and health care within the service. We found that people's care plans and risk assessments did not always represent their needs or ensure staff had the information to help meet people's needs. Staff had made efforts to offer people choice, but people were not enabled to be fully independent in their actions or decisions.

People were not consistently treated the way they wanted to be treated. People told us the staff were kind and did their best to see to everyone, but were too busy to spend time with them other than when carrying out care tasks. We observed people calling out for attention and being ignored by some staff and others received less than acceptable standards of care. We saw that one or two staff knew people using the service well and were polite and friendly when speaking to them. However, the staff were so busy there was little time for them to engage in casual greetings or day to day banter. People's privacy and dignity was not always respected.

We found evidence of poor record keeping during the inspection. Care plans were difficult for staff to read and complete and staff had not been keeping the kitchen cleaning and temperature records up to date which resulted in a poor star rating from environmental health. Archived records were not being kept appropriately as the cupboard they were stored in was left open and used to keep items of unwanted equipment in.

We found that the quality monitoring system was ineffective and had not been used to ensure the safety of people who used the service and staff. The registered provider had introduced a new electronic system called TRACA, but we found that this had not been utilised appropriately by the home manager. During this inspection we have found breaches of regulation with regard to staffing, medicines, infection control, staff training and supervision, nutrition, health, premises safety, personal care, privacy and dignity, care assessment and planning, quality assurance, notifications and record keeping.

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 is not safe.

The premises were not properly maintained and some areas of the service were not cleaned to a hygienic standard. This meant people were put at risk of harm from falls, trip hazards and acquired infections.

Improvements had been made to the recruitment practices within the service. However, insufficient staffing levels meant people's needs were not always met and there was a deterioration of quality standards of care within the home.

Medicines were not handled appropriately and inadequate risk assessments meant people who used the service were put at risk of harm.

Is the service effective?

Inadequate

The service is not effective.

Improvements had been made to the staff's understanding of The Mental Capacity Act 2005 and the completion of capacity assessments in the care files. This helped protect people's rights.

Staff did not receive effective training or supervision and the standards of care in the service did not meet best practice standards. This meant people's needs were not always met.

People's rights to be independent and autonomous were not always upheld and people were not fully included in the decisions about their care and treatment.

People's nutritional, hydration and health needs had not always been satisfactorily addressed. This had an impact on people's health and wellbeing.

Is the service caring?

Requires improvement

Some aspects of the service were not caring.

Staff had made efforts to offer people choice, but people were not enabled to be fully independent in their actions or decisions. People were not consistently treated the way they wanted to be treated.

Staff did not always treat people who used the service with dignity, consideration and respect. However, we also saw some limited evidence of good interactions between staff and people using the service and staff were kind, friendly and non-patronising when carrying out care tasks.

Is the service responsive?

Requires improvement

Some aspects of the service are not responsive.

Summary of findings

People and relatives were not involved in the planning and delivery of care and treatment within the service and they felt their opinions were not always listened to by the staff.

Staff found the care files difficult to read and we found that people's care plans did not always represent their needs or ensure staff had the information to help meet people's needs.

People did have access to a range of activities and their religious needs were being met.

The registered provider did have a complaints policy and procedure on display and an anonymous electronic feedback system for staff, people and relatives in the entrance hall. However, a number of people still felt their complaints were not always responded to appropriately and there was some evidence of this in the complaint records we looked at.

Is the service well-led?

Inadequate

The service is not well led.

The registered provider's quality monitoring system was ineffective and had not been used to measure or ensure the safety of people who used the service and staff.

The service had been without a registered manager since December 2013. The manager in post had been there since January 2015 and had failed to submit an acceptable application.

The service had failed to submit required notifications to CQC with regard to people being on Deprivation of Liberty Safeguard Authorisations. This is an offence under the Care Quality Commission (Registration) Regulations 2009 (Part 4)

South Park 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.'

This inspection took place on 13 and 14 August 2015 and was unannounced. The inspection team consisted of four adult social care (ASC) inspectors from the Care Quality Commission and two experts-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The experts-by-experience who assisted with this inspection had knowledge and experience relating to older people and those living with dementia.

Before this inspection we reviewed the information we held about the service, such as notifications we had received from the registered provider, information we had received from the City of York (CYC) Contracts and Monitoring Department and Safeguarding Team. We did not ask the registered provider to submit a provider information return (PIR) prior to the inspection. The PIR is a document that the registered provider can use to record information to evidence how they are meeting the regulations and the needs of people who receive a service.

At the time of this inspection the home manager was on sick leave. During the inspection we spoke with the regional managing director and the regional manager (collectively spoken of as 'the managers' in this report), the deputy manager, one member of the dementia team, two members of the quality team, the administrator, ten care staff and two ancillary workers. We also spoke in private with eleven people who used the service and seven relatives.

We spent time in the office looking at records, which included the care records for six people who used the service, the recruitment, induction, training and supervision records for six members of staff and records relating to the management of the service. We spent time observing the interaction between people, relatives and staff in the communal areas and during mealtimes. We used the Short Observational Framework for Inspection (SOFI) on one unit. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

At our last inspection on 3 December 2014 we found that effective recruitment processes were not in place. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection on 13 August 2015 we found that improvements had been made to the recruitment of permanent staff and agency staff and the breach of regulation was now met.

We looked at the recruitment files of six members of staff. Application forms were completed, references obtained and checks made with the disclosure and barring service (DBS). These measures ensured that people who used the service were not exposed to staff who were barred from working with vulnerable adults. Interviews were carried out and staff were provided with job descriptions and terms and conditions. This ensured they were aware of what was expected of them. The deputy manager carried out regular checks with the Nursing and Midwifery Council to ensure that the nurses employed by the service had active registrations to practice.

We saw that the managers had obtained employment profiles for all the agency workers before they started work in the service, the profiles were supplied by the agencies and included their personal details, employment checks and a summary of the staff member's training and qualifications. A one page induction check sheet was completed for the majority of the agency staff and the deputy manager told us that this was completed before the agency staff started work in the home. We saw that the check list covered medicine administration, the environment, cleaning, policies and procedures, waste disposal, infection control, incident reporting and fire safety. Each induction sheet had been signed and dated by the agency worker and the member of staff employed by the service who had been their mentor.

At this inspection we asked people who used the service if they felt safe. One person told us, "If I'm looked after. Not safe when the agency ones are in. I won't let them in they don't know what to do." Another person said, "No, because of the shortage of staff and the language problems. I don't get turned as often as I should." They told of trying to explain to carers and said "Those with poor English didn't understand what I was asking and just shrugged their shoulders." Other people said "Yes, I feel confident in the staff. They all want to make things better."

We asked visiting relatives if they thought the home was a safe environment for their family members. One relative told us, "I don't know if [relative] is safe. I don't think they are unsafe but I think they are being ignored." Other relatives told us, "Safe enough, yes" and "Yes, when they first came they were very mobile, a bit too mobile and there wasn't a day went by when the staff didn't ring and say they had fallen. That's stopped now".

During our observations of the service we were concerned about the safety of certain people due to the actions of two agency workers. Our concerns and those above from relatives and people who used the service were fed back to the managers. On the second day of our inspection we found action had been taken to remove the agency workers concerned from the service and feedback had been given to their employers. We also saw visible signs that action had been taken to improve the care received by people living in the home.

Our observations of the service showed that there did not appear to be sufficient staff to provide care and socialisation for people who used the service and the service was dirty, untidy and cluttered.

We were given a copy of the staff rota by the deputy manager for the four weeks leading up to our inspection on 13 August 2015. These showed that a large number of agency workers were used both nurses and care staff, although the managers told us that the amount of agency hours was much reduced from three months ago. A recruitment campaign was on-going and the managers were confident that new permanent staff would soon be in place to cover all the staff vacancies.

One care staff told us that in the last week their unit had worked short staffed on three days. Other staff we spoke with told us they felt that staffing numbers were sometimes not adequate. Ancillary staff said "We are really short staffed". They added that they felt they had been "Short staffed for ages" but acknowledged that there had been a recruitment drive and "So hopefully two more cleaners are starting next week".

People said there was not enough staff around and observation showed a visible lack of staff to respond

promptly to call bells and there was no socialisation going on with people who were in bed. We saw one person who was crying and crying, asking to be turned. A carer was called and asked to resolve the issue, but they had to go and try to find someone to help. This took about 10 minutes and they both were then reminded to wear personal protective equipment (aprons and gloves) and they had to go and find some. Other people using the service told us “There aren't enough staff to look after me. You have to wait quite a while if you want something" and "I often have a very long wait for a change of pad - there aren't enough staff to do it."

At 11:50 on the ground floor of the Ebor unit we saw there appeared no staff ‘on the floor’. We saw that there was one carer sitting in the lounge – on their own away from people - working on files. We saw there was a nurse and two carers sitting at a desk in the office. We saw one carer washing up in the kitchen area.

Staff said they did not have sufficient time to get to know new people. We were told, “Everything is rushed because of the lack of staff. Time is against us and we are not happy.” One member of staff said “The agency staff do not do paperwork and do not keep up with the one to one support for the person who needs this. You find them on their phones when they should be caring for people. We tell the management and they are not given shifts for a week or two then they come back. The staffing levels would be sufficient if all the staff were permanent and not agency.”

We fed back to the managers at the end of the first day of our inspection our concerns about the levels of staffing and the fact that people’s care needs were not being met.

This was a breach of Regulations 18 (1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives told us that medication on a personal level was handled well. One person told us they were on regular pain killers and said they got them “Pretty well on time.” We saw the nurse enquiring if people were in pain and administering pain relief medicine as prescribed where needed. People were given drinks to swallow their tablets with and time to take them without rushing.

However, our observations of the qualified staff giving out medicines showed that these were not always administered on time. For example, we saw one nurse still administering the morning medicines at 10:30 and then the administration of the lunch time medicines ended finally at 15:10. We saw that the nurse was constantly distracted by the staff, visiting GP’s and relatives and each time they stopped the medicine round to deal with the individual. This meant people did not receive their medicines on time and as prescribed.

The handling of medicines did not follow best practice guidelines in that on Jorvick unit we saw the medicine trolley left outside of a bedroom in the morning, it was locked but had two medicated gels, one mouth spray and a calogen drink left on the top. In the afternoon when the nurse was interrupted by the GP we saw that a medicated cream was left on top of the trolley. The nurse did eventually pass by and lock it away.

We also had concerns about the ‘security’ of the medicine trolley on Ebor unit. At 13:17 we saw the nurse on the ground floor of Ebor unit leave the trolley in the corridor outside of the dining room whilst they went to get beakers of juice. The trolley was closed and presumably locked but there were packs of tablets out on the top of the unit. At 13:20 we saw the trolley had been left in the corridor unattended whilst the nurse was in a bedroom having a conversation with a person and a visiting relative. This time we noted that the trolley was unlocked and open. Again there were packets of tablets on the top of the trolley. This meant that prescribed medicines were accessible at times to anyone present in the units, which could have resulted in a risk of harm to certain individuals who used the service.

Checks of the medicine administration records (MAR) showed that on the whole these were completed correctly. However, we looked at the medicine records and stock for one unit and found that one MAR was not signed but the nurse in charge did this immediately and the day before our inspection an agency nurse had given a medicine that had been stopped by the GP. The nurse on duty, who we spoke with, said they had picked up this error and had removed the medicine from the trolley to prevent this occurring again.

This is a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

We found problems with the cleanliness and hygiene within the service. In particular there was a significant and unpleasant odour in three bedrooms, two sluices and a number of bathing facilities on both units.

Inadequate

Is the service safe?

We asked people if they felt the home was clean. One relative said, "The place is lovely, no smells, well occasionally if someone has a mishap. It is clean". Another relative said, "It does smell of wee sometimes but again some of the carers are more slapdash than others."

On Ebor unit one bathroom had a bath seat ingrained with dirt, the toilet seat was dirty with faeces and there was a bar of soap left on the side of the bath. This facility also had broken tiles on the walls. A communal toilet facility had a floor covering that was coming away at the edges so that it could not be cleaned effectively without water seeping under the flooring. We found that no hot water came from the hot tap, certainly beyond the time that people would wait if washing their hands. The toilet flush handle was hanging loose with the mechanism showing. We saw there was an empty 'kitchen/drinks' type plastic jug sitting by the toilet bowl. We asked a carer and a cleaner what the jug was for and they said "No idea" and "No idea, I'll take it out."

We saw that a shower room was completely full with two hoists and an easy chair as well as the shower chair. The 'hook' on the inside of the door, presumably for hanging clothes was a Phillip's screw that was actually loose. The shower chair was dirty and used aprons and paper hand towels were thrown onto the easy chair. On Jorvik unit we found that the main bathing facility being used was a shower room, this had a ceiling covered in large areas of mould and the extractor fan was so noisy it was difficult to hear the staff speak.

One member of domestic staff said "The recent cover for laundry and domestic workers has been terrible. New staff have not been recruited when old staff leave. It is impossible to cover even the basics. More jobs are given to us but we don't even have time for our breaks. Today we have another cleaner from another home with us to help out."

This is a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)

In the last 12 months the Care Quality Commission (CQC) had received 26 safeguarding alerts about the service. This information was passed onto the City of York Council (CYC) safeguarding team who looked the information given to them and investigated the concerns raised. In July 2015 CYC got in touch with the regional managers for the service as it was felt that the home manager was not responding to safeguarding requests for information and whistle blowing. We were shown the action plan that the regional managers had put into place to address these shortcomings.

The registered provider had policies and procedures in place to guide staff in safeguarding vulnerable people from abuse (SOVA). We spoke with staff about their understanding of SOVA. Staff were able to clearly describe how they would escalate concerns both internally through their organisation or externally should they identify possible abuse. The staff told us that they had completed SOVA training in the last year and this was confirmed by their training records. The training records we saw showed that the majority of the staff were up-to-date with safeguarding training.

Care files had risk assessments in place that recorded how identified risks should be managed by staff. These included falls, fragile skin, moving and handling and nutrition; the risk assessments had been updated on a regular basis to ensure that the information available to staff was correct. The risk assessments guided staff in how to respond and minimise the risks. This helped to keep people safe but also ensured they were able to make choices about aspects of their lives. The home manager monitored and assessed accidents within the service to ensure people were kept safe and any health and safety risks were identified and actioned as needed. We were given access to the computerised records for accidents and incidents which showed what action had been taken and any investigations completed by the home manager.

We saw that security to the building was maintained by the use of coded locks between the units and to exterior doors. People visiting the service had to ring for admission at the entrance and staff in reception or on the units would let them in once their business was verified. Staff used an electronic clocking in system and visitors signed the fire book, so an accurate record of who was in the building was available in the event of an emergency. However, we found side doors left open and not monitored which meant people could leave the building unaccompanied. This was fed back to the managers. Action was taken to improve the security by ensuring the doors were closed.

We spoke with the maintenance person and looked at documents relating to the service of equipment used in the home. These records showed us that service contract agreements were in place which meant equipment was

Inadequate

Is the service safe?

regularly checked, serviced at appropriate intervals and repaired when required. The equipment included alarm systems such as fire safety and nurse call, moving and handling equipment such as hoists and slings, portable electrical items, water and gas systems and the passenger lifts. Clear records were maintained of daily, weekly, monthly and annual checks carried out by the maintenance person for wheelchairs, hot and cold water outlets, fire doors and call points, emergency lights, window restrictors and bed rails. These environmental checks helped to ensure the safety of people who used the service.

Inadequate

Is the service effective?

Our findings

At our last inspection on 3 December 2014 we found that people living at South Park were at risk of not having their decisions and choices respected and followed because some of the staff did not understand the Mental Capacity Act (2005) and how this may affect the way care was delivered.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

At this inspection on 13 August 2015 we found that staff had completed training on the Mental Capacity Act 2005 (MCA) and we saw in care records the staff had taken appropriate steps to ensure people's capacity was assessed to record their ability to make complex decisions. This regulation was now met.

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that any decisions are made in people's best interests.

The deputy manager told us that five people at the service had a DoLS in place and this was confirmed by the documents we looked at. The paperwork in the care records showed the steps which had been taken to make sure people who knew each person and their circumstances had been consulted. This ensured decisions were made in their best interests.

One DoLS authorisation had a condition attached to it in that the person was to be asked on a regular basis if they wished to go outside of the service on trips and given the support to do so if wished. The condition also said that the service was to notify the Authorising body on a regular basis about how this was working in practice. We looked at the person's care file and activity folder and saw that although they did participate in a number of activities within the home, they had only left the service once in the last three months to go sit in the gardens. Nothing was recorded about them being asked if they wanted to go out on a trip or outing and there was no evidence that this was being fed back to the authorising authority.

We observed the person was settled and happy in their bedroom during our inspection and staff did say they had heard the person being asked if they wanted to go out, but said "They always say no, as they like to spend time with others in the lounge area or sit on their own in their room." The individual did not wish to talk with us during the inspection, which we respected. We gave feedback to the deputy manager about the need to record this more appropriately in the person's care file and to ensure the authorising body was kept up to date with the person's preferences.

The majority of staff who spoke with us were aware of how the Deprivation of Liberty Safeguards (DoLS) and MCA legislation applied to people who used the service and how they were used to keep people safe. One staff member told us "People have the right to make their own choices about everyday things. We would not make anyone do something they do not want to. People have the right to say no and we respect that."

We looked at induction and training records for staff within the service. Although staff had completed induction and training deemed mandatory and necessary by the registered provider to meet the needs of people, we had a number of concerns about the skills and knowledge of the staff. For example, during the inspection we asked one member of staff about a person's health and they told us "Oh, they are palliative care." As the deputy manager had said no one was on end of life care we looked at this person's care file. It clearly showed the individual had had a stroke, but other than that was in good health. We asked another carer about service protocol / policy for ensuring that any people who lost their appetite, stopped drinking or was losing weight was monitored. This carer said "Well, I think we tell the nurse. They'll sort it. I don't know what they do then."

The staff we spoke with said the training was mostly e-learning (computerised). Some staff said the training was "A bit of a nightmare". They explained that the web page had altered and the layout was different and difficult to move around on. It put staff off a bit and so far they had not completed any of the new training sessions. One staff member said " The website is complicated and we do this at home. We do not have the time for this."

People were asked if they thought staff had the skills/ training to look after them. One person told us " I don't know if they're trained or not but the agency ones don't know what they're doing." Another person said, " I don't

think they are very skilled for what they do" and a third person told us, "I don't know. They look after me in their own way but when I'm coughing and coughing no one comes."

We spoke with one member of staff about people who required one to one support. We were told the person(s) carried out tasks with the staff or they were observed from a short distance away. The staff member told us " The support is designed to keep them and others safe. They can demonstrate anxiety and stressful behaviours, but staff have not had training to manage this. I don't know how to manage at times. These individuals can spit at you and hit you. I think training would help me be more confident." The staff we spoke with told us that restraint was not used within the service and this was confirmed by relatives, visitors and people who used the service.

We asked the manager about best practice within the service looking at external awards, dementia work and research. The managers confirmed there were none in place, the only best practice input came from the registered provider's internal dementia care team.

We asked the nurses and care staff what support / supervision new employees received. We were told that new employees could shadow a more experienced worker for a couple of shifts and that they would receive a supervision session at the end of their three month probationary period. However, of the six new starter staff files we looked at only the two nurses had received supervision. This meant that new employees did not receive appropriate supervision during their first three months of employment. This put people who used the service at risk of harm from staff who potentially lacked the skills and knowledge to meet their needs. We also found no evidence to suggest that appraisals had been carried out for any of the staff.

This was a breach of Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

Observations of the dining rooms and bedrooms on both units in the home showed that some people had a very good dining experience and others did not.

People were asked about meals. One person told us, "The food is horrible - pies, pasta bake, meatballs. Poor choice. Sunday lunch is not bad. We've been given out of date milk, mouldy bread and often get cold food", but another individual said, " I like the food. I'm vegetarian and I think the choice is good." We observed that people were offered a choice of meals at lunch time. The food looked appetising and fresh.

On one floor only four people sat in the dining room and everyone else was eating lunch or being assisted to eat lunch in their bedrooms. Those not requiring assistance were not re-positioned to facilitate eating and some were almost horizontal so eating was a difficult and not wholly enjoyable experience. This was not following the risk assessments or specific care plans to help ensure their nutritional needs were met and placed the person at risk of harm. Additionally, no one was seen being offered hand hygiene prior to eating.

There was fresh fruit and drinks in one of the lounges but no way of people getting them without asking. Many people didn't have fluids in their rooms until after 12 noon. Some were seen to have a drink poured and left within reach but some were seen to have no fluids within reach. Many people were seen to have dry mouths and poor oral hygiene. One person told us "I waited two hours yesterday for a drink"; they were waiting for a drink when we spoke with them.

On a second floor we saw that choice was given to people who could communicate. For example, did they want a clothes protector on? What choice of drink would they like, such as fruit juice or tea? One lady asked for a coffee and another a cup of cocoa and this was given also. We spent some time observing staff and people's interactions and noted that staff gave people appropriate support with verbal prompts to help them understand what was happening. Staff were very positive and polite to people in the dining room.

On the ground floor of Ebor unit we saw a member of staff bring a person into the dining room in a wheeled 'easy chair'. The carer had no interaction with the person until they left the person in their chair against a wall in between two tables, when they said "There you are". However, we also saw another carer gently wake up one person who was sleeping at a dining table and tell them it was dinner time. They did this in a kindly, quiet manner reassuring the person with appropriate touching – stroking their arm.

We saw that drinks were offered to people as soon as they were seated in the dining room. We saw one carer ask a person if they were "Ok" with a glass or if they wanted a cup

with a handle. Of necessity most of the interaction taking place in the dining room was task orientated but this was undertaken in a kindly, patient and non-patronising manner. There was little banter and little social interaction but the meal experience did appear to be a pleasant one for people on this floor.

We gave feedback to the managers at the end of our inspection about the different levels of skill and caring we had witnessed during the two days we were in the service. The managers were aware of a number of the issues in the service and had drawn up an action plan to resolve a number of the concerns we raised. However, the implementation of the action plan still had some way to go to resolve the issues.

This is a breach of Regulation 14 (1) & (4)(a) & (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

Many of the people spoken with were very anxious to talk with us. People told us that communication at the home was bad. This was between staff and between staff and relatives. A visiting relative said, “Lack of communication is a problem … you have to keep asking and no-one knows anything”. One visitor said " I don't know who to speak to about things - I've not been given any information about that." We observed one person crying and clearly unhappy. Staff tried to cheer them up and asked what was wrong, but did not wait to hear the answer and walked away.

Discussion with people who used the service indicated that they did not always receive appropriate care and support with their health needs and conditions. We asked people about how they accessed external health care professionals. One person told us, "The nurse gets the doctor if I need them." This person (in bed) had very evident inflammation of their gums and poor oral hygiene so was asked about access to teeth cleaning/dental care. They said "I don't get asked if I want to do my teeth. I can't walk so good so I can't do it." Another person with their own teeth and poor oral hygiene said " My teeth don't get cleaned as often as I'd like. The GP comes but not always when I ask." One person had been in the home a short while but had not had their belongings unpacked including their toothbrush, which indicated their oral care had not been attended to.

We were told by people and relatives that there was some delay in obtaining personal and health care within the service. For example, a visiting relative told us that, ”The home was closed to visitors a few weeks ago – for three weeks which is a long time so I took chance to come in on a Tuesday and they (relative) seemed okay. On Thursday they were hot and clammy so I asked for them to get a doctor. The GP came and said no infection but on Friday [relative] really wasn’t very well and I asked them to get the doctor again. They had got a chest infection which quickly turned to pneumonia. (The nurse) acted very quickly then, if they hadn’t I think it would have been a bad outcome …I just think that thank goodness (Nurse) was there. Regrettably I had to ask them to get the doctor every time”.

We observed people sitting on pressure cushions with no covers on so their skin was coming into contact with the rubber covers. This put people at risk of developing pressure sores. We asked the nurse if anyone had need of wound care. The nurse said “One person has just come in with a wound to their foot. I should have looked at this today but I have not had time. I checked that the dressing was intact but that is all.”

We asked why so many people were in bed and we were told that this was because of their physical health. We were informed that the second floor on Jorvik was designed for people in bed. Some people did not want to get up, as they were too tired or uncomfortable in chairs. Pressure care charts were kept in bedrooms along with food and fluid charts, those we saw were completed for most days with the odd date missing.

This is a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)

We were shown around the service by the deputy manager. We were told that the rooms were for single occupancy and some had en-suite toilet and wash hand basin facilities but not all. One side of the service (Ebor) supported people living with dementia and the other side of the service (Jorvik) supported people with general nursing needs. We found the design and adaptation of the environment did not always meet the needs of people who lived there.

The environment on Ebor had some dementia design aspects to it such as plain carpets, neutral wall colour and contrasting colour for the handrails, but it lacked things for people to interact with such as rummage boxes. We saw some pictorial signage on bathroom and toilet doors but people’s room doors were poorly signed to aid people’s

orientation and were in a poor state of maintenance. This prevented the approach to the rooms having any homely feel. Doors had marks and holes where old signs, numbers or locks had been removed but the area was not 'made good'.

We saw little visual stimulation in the Ebor Unit. There were framed black and white newspaper 'Front Pages' showing significant events from the past but we suggest these were set too high to offer much interest to most people at the home, being at eye level for someone approaching six feet tall. There were however more colourful posters set at a lower level in the corridor on the ground floor of the Ebor Unit. We saw some radiator covers had broken grills and one also had a screw missing from a fixing bracket meaning it was not fastened to the wall at all at one end presenting a fall and / or injury risk should anyone put weight on it.

We saw that the Ebor unit had a secure courtyard area which could be accessed by people from the ground floor. We saw that during the course of the visit several people and visiting friends and relatives made use of this and appeared comfortable in the courtyard - one person saying "It's a nice area of garden." We saw however, that it was in need of maintenance. Large weeds were growing through the gravelled areas and weeds were growing through the gaps in the paved areas. Discussion with the managers indicated the service had just employed a gardener for 10 hours a week to take care of the exterior areas.

It was accepted that there was extensive decoration going on around the communal area of the Jorvik unit which necessitated some stacking of furniture. However, even allowing for this the home appeared cluttered. This started in the main corridor from reception area which we saw had cardboard boxes of supplies piled to some four feet high along most of its length. Just around the corner from this we saw two plastic crates marked 'Boots' and full of plastic satchels. Next to these were three empty plastic boxes. All these restricted passage and could present a trip hazard.

We saw that in the Ebor unit first floor dining room there were empty plastic pallets on the floor by the door. We saw there was a dustpan, brushes and mops leaning up in a corner by the unit holding the toaster and microwave. These presented both hygiene and trip hazards. We also saw that a wooden board approximately three feet by two feet displaying photographs of aircraft was propped up behind the corridor hand rail. This could present a fall hazard.

A number of shower facilities and bathrooms were being used to store moving and handling equipment such as hoists, wheelchairs and slings. So much so that people often only had one bathing facility on each floor free of clutter. These facilities were not locked and were not signed to say 'do not use'. Therefore, these areas could be a trip hazard for people trying to use the toilet facilities. Door handles to bathrooms, bedrooms and sluices were broken - too many to count.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

Requires improvement

Is the service caring?

Our findings

Some aspects of the service were not always caring. People were not consistently treated the way they wanted to be treated. We observed some good interactions between staff and people living in the service. However, we also saw some evidence of poor care practices. This was echoed by the comments from people who used the service and relatives visiting the service.

One person said "The staff are very kind, they try" and another told us "Yes, they are kind but they're too busy to spend time with you other than when they are changing the bed." A third person told us "The staff are very task orientated. They do what they need to do, not what you need or when you need it." This was borne out by observation. The care staff - particularly from the agency - seemed only able to do the task they'd been given and didn't appear to be flexible or accommodating as per individuals needs. For example, when someone asked for something when the carer was doing a task they were told they'd have to "Do this first".

One visiting relative told us they came to visit twice a week and that their family member was "Not always up and dressed … the last three or four times they were still in bed at 13:30."

A large proportion of people who used the service were left in bed all day and appeared to have little contact with anyone outside actual care procedures. There was no general chit-chat or banter going on between staff and people or between the people living in the home. There were one or two staff who clearly knew the people using the service well and spoke with them in a polite, friendly and appropriate manner.

At 10:45 we heard one person calling "Can someone help me please" and "Nobody is being helpful here". We saw that this was a person who was lying in a bed in their room. At 10:52 no member of staff had been to see them. There was no call bell within reach but it was explained that this person was confused and therefore unlikely to be able to use a call button. However, we saw carers walk past the open room door without any interaction with that person or even a glance to check that all was alright. At 10:55 we drew staff's attention to the person calling for them.

At 11:45 we again saw staff walking past open room doors without checking on, or having interactions with people in their rooms. We spoke with one staff member who told us an agency worker was seen to cancel a buzzer without going to see the person who had called for assistance. The member of staff said "I told them you don't do that here. If you cancel the buzzer other staff will think you have attended the person who called."

One relative told us they were continually trying to get staff to shave their family member's beard every day. They said, "They have only been shaved once this week and if you leave it for two days it gets too rough. We got a really good Wilkinson razor but that's gone and they are trying to shave them with one of those disposable things again. I tell them every time I go to the office – I got them a good £30 razor – went on fine but now they can't find it. I said why not keep it in their room and they told me no sharp blades in rooms. But I found it twice left on their sink. The reason why I make a big thing about it is that if you leave it be and they try later it will be difficult and [person] will get upset."

Another visitor told us in regard to staff with their relative "I've watched the staff with [relative] and said "Do you know they are blind" and some have said "No." When I mentioned it to the nurse I asked them if they could put on their notes so that staff knew. The nurse said "Oh we don't give out negative information like that" I asked another and they said "We're not allowed to say". It's bizarre". The visitor added they had asked the nurse what (relative's) PSA count was as they have had Prostate cancer for about 6 years and the staff had said "Oh I didn't know they had Prostate cancer – it must be in their notes."

We raised concerns with the managers about other staff practices during our inspection. We observed staff sat down whilst people using the service were calling out for assistance, one member of staff was found to be assisting a person, who was lying in bed, with eating lunch. The staff member was standing up behind the person, out of sight, just using a spoon to put the food into the person's mouth. There was no conversation going on. The person wasn't able to see where their lunch was coming from or who was delivering it. Another person was laid flat on their back in bed trying to feed themselves with lunch. This last person had a care plan which identified that they must be sat upright at meal times and have full assistance with eating and drinking.

This is a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

Requires improvement

Is the service caring?

Some people in the service felt that staff did respect their privacy and dignity. One person told us "The staff speak to me very nicely. They look after my privacy and dignity" and another said "I've forgotten what dignity is (they were laughing). They do respect you." We also saw staff knocking on people's bedroom doors before entering, even if the door was already open.

However, during the inspection we raised a number of concerns with the managers about maintenance of people's dignity. For example, at 10:12 we saw that the clothes of a female person in an easy chair in a lounge in the Ebor Unit were caught up almost to their waist exposing all their legs and their underwear. We saw that no member of staff present made any attempt to pull the person's clothes down or help them do that. At 11:17 we saw a person walking around wearing a track suit / jogging trousers. We saw that one leg of the trousers had caught up on their knee and that no-one, including the carer with them, helped them to pull it down.

One visitor told us "Everything concerns me. Lack of hygiene for [relative's] needs. Leaving them, not washing their hands, leaving their mouth and face dirty when they have eaten. Neglecting them- it's a lack of dignity for them. They should have clean nails, a bit of make-up and they should be dressed." We saw that one person, who was in bed in their bedroom, was asleep after lunch and they had the remains of their meal around their mouth and on their clothes.

This is a breach of Regulation 10(1)(2) a-b of the Health and Social Care Act (Regulated Activities) Regulations 2014 (Part 3)

We saw that some attempt to share information about health and medical conditions with people, relatives and staff was undertaken in the service. We found there was a range of advice leaflets in the entrance hall covering subjects such as Parkinson's disease, eye care, diabetes, care for the elderly, dementia care mapping and 'Your Rights, Your information' which spoke about confidentiality of records. These were easily available to visitors or people who used the service. There was also a monthly newsletter on display giving visitors an opportunity to see what is going on in the home and the activities planned for the coming month.

Discussion with the deputy manager and the administrator indicated that no one in the service used an outside advocacy service. We were told that either individuals looked after their own monies or this was delegated by individuals to their families or they had an appointee. The administrator said there were a couple of people who had Court of Protection orders for finances and a number of families had Power of Attorney for finances and / or health and welfare.

Requires improvement

Is the service responsive?

Our findings

The service was not responsive. We found that people who used the service and their relatives had little or no input to the development of their care plans. Staff found the care files difficult to read and we found that people's care plans did not always represent their needs or ensure staff had the information to help meet people's needs. We discussed this with the managers who showed us the new format for the care files that was being slowly introduced. We were not given a date for when all the care files would be on the new format.

Discussion with people who used the service indicated that no one was familiar with the term "Care plan" although one person did say they had been involved in a review of their care with their family and social worker. We saw evidence of care reviews taking place in some of the care files we looked at.

We asked relatives if they had been included in planning their family members' care. No one we spoke with told us they had awareness of, or involvement in formal, Care Planning. One relative said in regard to their family member, "When they came I was told there was a care plan behind the door. Where is it? I've never sat down and talked about (family member's) needs in a meeting." Another relative told us "The deputy manager came out to talk about (relative) before they came here but a care plan? I think the answer is no. Oh no. I don't think I've ever seen one or signed one, not sat down and discussed it."

We looked at six care files for people who used the service. We found that all the files were untidy, not in good order and information within them was patchy and inconsistent. Staff who spoke with us either couldn't find the information we asked for in the files or were unaware of people's care needs because they had not read the care files.

For example, in one care file there was a care plan for mobility that had been reviewed on 3 June 2015. The care plan said the person was fully mobile with use of a walking frame. However, we saw this person sat in a chair with an 'in situ sling' in place. When we queried this with the staff they told us "[person] is not mobile, they are hoisted." The last monthly review of this person's mobility needs took place on 7 July 2015, but there was no clear update of the care plan. When we asked staff where we would find the up to date information in the person's care plan they eventually found it in the past history of the review notes. Discussion with the managers indicated this was one of the reasons why they felt the care files had to be put onto a new format so that this information was easier to find and kept up to date.

The care staff described the care plans as "A mess". They said they would read care plans and work with someone familiar with the unit to help them support people they did not know. They said, "It is not easy to understand the information in the care plans as it is all over the place. The care files are split into sections but information is put anywhere." We asked if this affected their ability to care for people and was told "It is difficult if you do not know much about them. We can ask their families." We asked the staff how the agency workers would cope with the care plans and we were told it would be "A tragedy. They would not be able to use them."

We asked if any new people had come into the home and we were told "Three or four in the last month." Staff told us they were not up to date on these people's needs as "We don't have time to sit and read stuff." We were told that staff "Get a handover every morning, this covers basics but if you have been off for a week on leave then you need to know more." The staff said "Communication between the staff is quite bad. Agency workers don't know much they often say "You tell me" when asked a question."

This is a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

During our inspection we saw little evidence of activities taking place within the service except mid-afternoon cake decorating. Most people in their bedrooms were unable to say what activities there were to take part in and one relative told us "There's a minibus out there. I don't know if they use it for trips but I've not known it used for that."

We were told by other people that activities did take place. One relative told us of the "Activity lady" and that a man had been in to play his ukulele and sing. They also said the home now had a Chaplain which they thought was "A good thing as there must be people here who went to church."

We were told by the managers that the service now employed two 'Personal Activity Leaders' (PALs) We spoke with both PALs. They told us they felt supported in their role by management and that management "Had

Is the service responsive?

explained fully what they wanted." One PAL said "Prior to us the home had two activity ladies who provided mainly group activities and a lot didn't want to join in – it wasn't person centred to them."

The PALs told us that on a Wednesday the hairdresser came to the home and one of the PALs did pamper sessions of nails and shaves at that time. On a Friday afternoon they held a 'pub quiz'. On Mondays they had outings on a one to one basis such as trips out shopping. They had arranged clothes parties. One PAL said "Since I've started I've made the little room next to the pub into a quiet room and library. In the Jorvik unit I'm constructing a cinema. Everyone can go to that". They did baking where people weighed and mixed ingredients for cakes and cup-cakes and then these were baked in the kitchen. During the afternoon of the visit we saw that people were decorating cup-cakes that had been made earlier. Some people just wanted to eat the cupcakes without decorations and we saw this was allowed. We saw evidence of activity information on the notice board and in the monthly newsletter which were both on display in the entrance hall.

One PAL was also the Chaplain and they told us they offered "Pastoral support" as well as helping with activities. She said there were planning "Holy Communion every four to six weeks but if it was popular they would do small prayer sessions, as it had been asked for by a person's relatives". They told us they were providing large print Hymn sheets. We saw posters in the entrance hall about the proposed services.

We found that a copy of the registered provider's complaints policy and procedure was on display in the entrance hall, high up on the wall and written in clear, large print. We fed back to the deputy manager that it should be sited lower down where more people could read it. We saw that the managers had introduced new touch screen monitors in the entrance hall where staff, visitors and people who used the service could give feedback to the registered provider. This could be anonymous if wished. We were shown the print out of this information which was monitored as part of the quality assurance system. There was also a suggestion box on the wall in the entrance hall.

A constant theme expressed by visiting relatives was that their views on their family members care were frequently not listened to and that even when they were, agreements reached on that care were not communicated and followed across the whole staff group. When we asked if staff at the home responded to requests and concerns raised one relative said "I think so, if you keep up the pressure." A visiting relative told us "We've been trying to get a reclining chair for four or five months, it's not materialised….following the meeting with (manager) we're told we'll be getting one in a couple of weeks."

One relative told us that despite frequent requests for fitted bottom sheets for their family member's bed and being told this was acceptable, they were still finding them tangled up in flat sheets. They said "The staff told me [person] had a fall – getting out of bed. I asked how and they said "Because his sheet was round his ankles." Later during the inspection the deputy manager told us that they had just appointed a new housekeeper and that this would be their responsibility.

Some people were happy with the response from the manager and staff. We were told that one person had been given a room at the end of a corridor away from the sound of call bells at the request of the family as they were ex-navy and responded almost automatically if they heard bells when trying to sleep. Another person told us how staff had made arrangements for them to get a lighter whenever they wanted to smoke out in the quadrangle. One relative said "I made a complaint about a year ago about my relative's care. I feel that things have improved 100% since then. The food and care are much improved and I have met the new manager who listens to you. The deputy manager is great. I am confident that action is taken if you speak up."

We looks at the complaints register for 2015 and saw that 12 had been formally recorded between February and June. The complaints had mostly been received from family members and one from a neighbour regarding noise levels coming from the home. All appeared to have been dealt with in accordance with the provider's policy dated April 2013, including the acknowledgement of the complaint within two working days of receipt and a full response within 20 working days. It was not clear whether all the complaints we looked at had been resolved to the complainant's satisfaction and we also found in the complaints folder others dated April and July 2015, which did not appear to have been recorded and processed in the same way. The provider's policy was due for review in March 2015.

Requires improvement

Is the service responsive?

We gave the managers feedback about how people and visitors were feeling when their concerns were not addressed. They told us that they had already identified the fact that responses needed to improve and had addressed this in their action plan for the home manager.

Inadequate

Is the service well-led?

Our findings

At our inspection on 3 December 2014 we found the registered person did not have effective systems in place to monitor the quality of service delivery.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

During this inspection we have found breaches of regulation with regard to staffing, medicines, infection control, staff training and supervision, nutrition, health, premises safety, personal care, care assessment and planning, quality assurance, notifications and record keeping. We found a breach of regulation remained for Regulation17: Good Governance.

The service had been without a registered manager since 2013. Between then and now in 2015 there had been interim managers. The manager in post had been there since January 2015, they had sent in an application form to CQC which was rejected due to errors in June 2015. This had not been resubmitted and the issue was discussed with the managers at this inspection.

When we considered the culture and ethos of the service and how people felt about it we found individuals had a mixed response to this question. We heard that relatives did want to feel positive about the home but they felt the home could extend more care and understanding to relatives. One relative told us "I want it to be good, it's (relative's) home". Another said, "You cannot expect young people to understand what it is like to be old; they maybe don't understand that relatives get anxious. I wish they had more time to sit with people and talk and reassure them."

We were told by staff and visiting relatives that they felt the home's management team were approachable. A visiting relative said "The Manager (name) is very approachable but I don't see a lot of them. They do seem to listen". A member of staff told us "I feel we can approach management."

We have already spoken of our concerns about the inconsistent level of communication between staff and the provision of meaningful and timely information given to relatives. Whilst it is accepted that care provided to people and decisions made regarding that care by the home may well be in the best interests of those people, we saw that information and explanations of that care were not always "Heard" or understood by relatives. We also had some concerns that people's complaints were not been addressed appropriately by the manager.

We were told by the deputy manager that there were "Head of Unit meetings once a month for nurses, PALs, head of kitchen, the home manager and deputy manager. Care assistants had their own meetings". We saw the meeting minutes for everyone but the care assistants. When we enquired about these meetings we were told by the deputy manager "I cannot remember the last time we had one for the care staff." Discussion with the care staff indicated that they felt notices for staff meetings were put up at the last minute so they could be difficult to attend. Staff told us, "We get little memo's about what was discussed but not full meeting minutes." The managers told us that they had tried to arrange meetings with staff on a number of occasions but no one had attended.

We found that DoLS applications had been authorised for five people in July 2015, but the required notifications to CQC had not been sent by the service. CQC did receive retrospective notifications following feedback to the managers at the end of this inspection.

We had some concerns with regard to record keeping in the service. We have spoken about the poor quality of the care plans earlier in the report. We also found that a recent visit to the service by the environmental health officer (in the last month) had resulted in the kitchen scoring one star or poor as it's rating. The environmental health report stated that this was due to the poor record keeping in the kitchen by agency staff, who were not completing the cleaning and temperature checks for the HACCP file. In response to this report the managers had put a protocol in place that timesheets would only be signed in future if the records were completed. Checks of the HACCP file at this inspection showed this was now working and the records were being completed by all staff. We saw that a cupboard on one of the care units was used to store archived personal records for people who had used the service. This information should have been kept confidential within a locked environment. However, we found the cupboard door to be left open and staff had been filling the space between the boxes of files with old equipment and other debris.

The home had two I-pads and a new quality assurance process (TRACA) that was electronic. We were given an explanation of how the system worked. If used

Inadequate

Is the service well-led?

appropriately it looked to be a robust way of reviewing and monitoring the service. The system covered different aspects of the service such as care, the environment and housekeeping. We were informed that it was recognised that the system had not been used appropriately in this service since May 2015.

No one was able to say they had been asked for feedback about the service, but one person who used the service said they had been asked which wallpaper they liked when some decorating was taking place. Satisfaction questionnaires were electronic and could be anonymous. Only four had been completed since May 2015 – there should have been one completed every week. No person who used the service had completed a survey since May 2015. The regional manager felt that staff and people should have been told about the new feedback system in the service, but they were not sure if this had happened in meetings. Information in the meeting minutes indicated that it had not. This meant the registered provider failed to establish effective mechanisms to enable individuals to have an informed view in relation to the standard of care and treatment provided to people who used the service.

Audits were not being completed by the home manager. These had been delegated to the nurses and the deputy manager, but was deemed mandatory by the registered provider as part of the home manager's role. We were informed that the home manager should have done a daily walk around the service and input the information gathered from their observations into the system. Checks of the system showed that this had not been completed.

The regional manager and regional managing director were aware of issues in the service, the scores seen on the TRACA system were well below 100%. They had produced an action plan to address the issues they had found in addition to the action plan for CQC from our previous visit. The managers had put in additional resources to the service to help the home manager, which included the registered provider's dementia team (three days a week), and the quality team one day a week. The regional manager was also attending the service two days a week.

This was an on-going breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The registered person failed to ensure that people who received care and treatment, were treated with respect and dignity by the staff.** Regulation 10(1)(2) a-b

The enforcement action we took:
CQC is considering the appropriate regulatory response to resolve the problems we found and will report on this when completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) : In safe care and treatment** **The registered person failed to provide safe care and treatment to people who used their service.** Regulation 12 (1)

The enforcement action we took:
CQC is considering the appropriate regulatory response to resolve the problems we found and will report on this when completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **The registered person failed to ensure service users were protected from the risks of inadequate nutrition and dehydration through inadequate assessment and monitoring of service users intake, and insufficient staff support to enable service users to eat and drink sufficient amounts to meet their needs.** Regulation 14 (1) (4) (a) (d)

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
CQC is considering the appropriate regulatory response to resolve the problems we found and will report on this when completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance. Regulation 15 (1) (2)

The enforcement action we took:
CQC is considering the appropriate regulatory response to resolve the problems we found and will report on this when completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance People were not protected against the risks of inappropriate or unsafe care and treatment because of ineffective operation of quality assurance systems to identify, assess and manage risks relating to the health, safety and welfare of people who used the service. Regulation 17

The enforcement action we took:
CQC is considering the appropriate regulatory response to resolve the problems we found and will report on this when completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure they could meet people's care and treatment needs.

This section is primarily information for the provider

Enforcement actions

The registered person failed to provide staff with appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

Regulation 18 (1) (2) (a)

The enforcement action we took:
CQC is considering the appropriate regulatory response to resolve the problems we found and will report on this when completed.