Apsley Park Limited

Charnwood House

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?	**Inadequate**
Is the service well-led?	**Inadequate**

Overall summary

The inspection took place on 28 and 29 September 2015 and was unannounced.

Following this inspection, the provider submitted an application to the Care Quality Commission (CQC) to cancel their registration of the service. This was because the service was being sold to an established provider already registered with the CQC. The CQC continued to monitor the service and liaise with relevant agencies to ensure people were kept safe during this period of time. The CQC facilitated a swift cancellation of the outgoing provider's registration and registration of the service under the new provider. The provider of the service, at the time of this inspection, relinquished control of the service on 28 October 2015.

The service provides care for older people who are physically frail and who live with dementia. The service can accommodate up to 35 people. At the time of the inspection 16 people who required nursing care lived at Charnwood House.

We found the registered manager had left the service on 4 September 2015. A registered manager is a person who has registered with the Care Quality Commission to

Summary of findings

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. A nurse who had been employed just prior to the registered manager leaving was in the position of trying to manage the service but with limited resources. A representative of the provider based themselves in the home three days a week.

Local adult social care and health care commissioners had visited the service and found significant shortfalls in people's care. They had shared these concerns with the Care Quality Commission.

We found ten regulations not met. They included: not ensuring people's safety and well-being, not designing care which met people's individual needs, not ensuring good infection control, a lack of staff numbers, a lack of staff training, delivering care without consent and adhering to relevant legislation, not ensuring people's dignity and showing them respect, poor management of concerns and complaints and poor overall governance systems.

People's care and health needs not been appropriately met. In particular, risks relating to pressure ulcer development, wound care, nutrition and poor posture had not been robustly identified or properly managed. Some people's weight had not been correctly monitored and they had lost weight without it being noticed. Some people had wounds which had not been correctly assessed and this had an impact on how these were being managed. Staff lacked skills and knowledge to manage these risks effectively. People had not received the care they needed to prevent further deterioration in their health and well-being. Following this inspection, these risks were reduced by commissioners placing appropriate health care professionals in the home to work on a daily basis.

Whilst staff tried to act in a caring manner, they lacked the skills and time needed to support people in a compassionate manner. People received little support to interact with others and appeared withdrawn and low in mood. Inconsistent practice and a lack of knowledge had resulted in people not being sufficiently and appropriately protected under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Staff lacked support and adequate training to meet people's needs. Problems with staff retention and a lack of staff recruitment had resulted in a depleted staff team. Nurses worked no more than one or two shifts per week and the service was heavily reliant on agency staff. As a result, effective communication about people's needs did not happen. Inconsistent practices were taking place and care staff were not receiving appropriate guidance. Care staff had no senior structure to their team so inexperienced care staff received little direction and guidance. There were not enough staff to meet people's needs and therefore necessary care was not always being provided. Staff recruitment practices were not robust enough to fully protect people from those who may not be suitable to care for them.

Poor monitoring systems had resulted in people's well-being and safety not being maintained. Although the registered manager had completed audits, and the provider told us they talked with her about these, this process had not been robust enough to prevent the systemic failings identified during this inspection. There was no evidence of a program of on-going improvement and learning. The provider had not carried out effective monitoring checks and was unaware of the number of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 not being currently met.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not protected against risks that may affect their health as these risks had not been appropriately identified or managed.

Arrangements were not always in place to make sure people received their medicines appropriately and safely.

People were not as protected from abuse as they could be. Staff knew what constituted abuse and knew they needed to report any concerns but their knowledge of who they could contact was poor.

There were not enough staff to meet people's needs and recruitment practices did not always protect people from those who may be unsuitable to care for them.

Is the service effective?

Inadequate

The service was not effective.

People received care and treatment from staff who had not completed adequate training to enable them to recognise risks to people and meet their needs. Staff lacked skills and knowledge of people's specific needs such as living with dementia.

People were not sufficiently protected under the Mental Capacity Act (2005) because the legislation had not been followed and adhered to.

People did not receive sufficient support with their eating and drinking in order to maintain their health and well-being.

People's health care needs had not been met and despite the involvement of some health care professionals people had still not received adequate care.

Is the service caring?

Requires improvement

The service was not always caring.

Although staff wanted to care for people, a lack of skill, knowledge and time meant people did not receive caring and compassionate support.

People's dignity was not inconsistently upheld and at times people were not shown respect.

People's privacy was maintained.

People's friends and relatives were able to visit without restriction and staff were friendly towards them.

Summary of findings

Is the service responsive?

Inadequate 

The service was not responsive.

People's needs were not always responded to because staff either lacked time or did not recognise that there were needs to respond to.

People were not provided with opportunities for social and meaningful activity.

People or their representatives were not always involved in making decisions about their care and treatment.

Care plans were not personalised and sometimes these lacked specific guidance for staff to follow.

There were arrangements in place for people to raise complaints but the management of these had not always been to people's satisfaction.

Is the service well-led?

Inadequate 

The service was not well-led.

The service had lacked effective leadership and management for an undefined period of time which had resulted in systemic failings.

Staff morale was low and this had resulted in staff retention problems and staff feeling generally unsupported.

People were not protected against poor care or service delivery because the provider had failed to monitor the service effectively. The provider was detached from many aspects of the service and unaware of its shortfalls.

There were no on-going plans to improve the service and no lessons being learnt from things that went wrong.

Charnwood House

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 28 and 29 September 2015 and was unannounced. Two inspectors carried out the inspection.

Prior to the inspection we reviewed the information we held about the service. This included information forwarded to us by the service about significant events. We requested information about the service from relevant health care professionals. Concerns shared with us from local adult social care commissioners were discussed with them.

We considered information forwarded to us in the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR had been completed by the registered manager.

During the inspection we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with five people who lived at Charnwood House and six relatives. We spoke with eight staff members and two representatives of the provider.

We reviewed the care files of four people. We also inspected other relevant care records which included weight and food monitoring records, repositioning records, medicine and wound management records.

We inspected the recruitment and support records of seven staff. We also inspected a selection of records associated with the management of the service. These included a selection of audits, the maintenance records, staff duty rosters, the staff training record, accident and incident records and a “resident” survey.

Inadequate

Is the service safe?

Our findings

People were not safe. There were systemic failings in the way the service operated which meant shortfalls relating to people's safety continued despite people and their relatives raising concerns and the involvement of external health care professionals.

The risk of people developing pressure ulcers was not appropriately assessed or managed. Relevant assessments for assessing risks to people's skin were in place but not always completed correctly by the staff. This had resulted in people's levels of risk, in particular of developing pressure ulcers, not being properly identified. As a result, some people had more developed pressure ulcers than had been originally assessed.

Written care plans did not always give staff specific guidance on how to reduce the risks people faced. For example, one person had established pressure ulcers but their relevant care plan did not give staff directions on how frequently their position should be altered. People's positions should be alternated in order to alleviate pressure from specific areas of the skin. Details of how this person was repositioned were inconsistently recorded; sometimes present on their repositioning record and sometimes not. This person had periods of between six and nine hours without being repositioned. Guidance, when present, directed staff to alter the person's position every three to four hours. Even when present, the repositioning records showed that this instruction had not always been followed. As a result, their established pressure ulcers were at risk of deteriorating further.

Another person also had an established pressure ulcer. Although this person's care plan instructed the staff to check the person hourly, when staff did this, they did not recognise the potential risk the person presented with. We found this person had fallen to sleep resting on the limb where they had a pressure ulcer. When staff visited to check the person, they had not thought to alter the person's position. As a result, their pressure ulcer could potentially get worse.

Where people had developed pressure ulcers or where they had other types of wounds, these were not always managed correctly. Health care professionals had reviewed people's pressure ulcers. Where wounds required treatment, such as a dressing, the NHS Wound Pathway had been put into place. This documents information about the wound and then gives instructions on what dressing to use and how frequently the dressing should be changed in order to promote healing. We found the frequency of dressing changes were not always adhered to. For example, one person's daily dressing change had been missed on one occasion and another person's dressing, due to be changed every two days, had not been changed by 4pm on the fourth day.

We observed people receiving their medicines and from our observations the administration and general management of the medicines was in line with the Royal Pharmaceutical Society's guidance – The Handling of Medicines in Social Care. However, we found one person had been left with their medicine and they were not taking this properly. We alerted the nurse to this and they visited the person. They explained it was unusual for this person not to manage this. This person's mental and physical health had recently deteriorated. There was no reference in their care records to show their ability to take their medicine without supervision had been reviewed. On this occasion, this person did not receive their medicine successfully. For one other person's safety, there was a specific protocol in place which related to the management of their diabetes. This stated that jelly babies were to always be available in the medicine trolley to use in the event of their blood sugar dropping too low (they did not like the taste of the agent which would normally be prescribed for this situation). We asked a nurse to show us where these were kept and they could not be found. The nurse told us they must be out of stock and would ask someone to purchase these. In this case, the associated safety protocol had not been followed.

Some arrangements were in place to prevent the spread of infection. This included colour coded cleaning equipment. This prevented, for example, the same mop being used to clean the toilet and then the kitchen. Staff also wore protective aprons and gloves when delivering personal care and when serving food. However, staff practices did not always protect people from potential infection. For example, one person's bedding was placed on the floor and the floor had not yet been cleaned following incontinence. Another person's face was wiped with a cloth after the member of staff used it to wipe down their table.

Inadequate

Is the service safe?

Care and treatment was not always provided in a way that maintained people's safety and in a way that reduced risks to people. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not enough staff to meet people's needs. We asked to see how people's dependency had been assessed to evidence how the staffing numbers had been set. A representative of the provider confirmed they did not use a dependency assessment. They described setting the numbers of staff on duty according to the type of care commissioned by the local authority and the number of people using the service. For example, they considered whether someone was funded for nursing care or not. People's individual needs, and how long it took to meet these, were not considered. A member of staff told us, "Two years ago we had time for the residents. It has gone downhill in the last year."

Staff said one person liked to get up early but this was not always possible and it upset the person. On one day of the inspection staff finished supporting the last person to get up and dressed at 12.05. Staff told us this was because it took them this long to meet everyone's needs and did not mention people choosing to get up that late. Lunch was due to be served at 12:00. Staff confirmed that if people wanted to get up earlier they could not be supported to do this as there were not enough staff.

One person explained that staff came quite quickly when they rang their call bell but did not always return quickly to provide the support needed. This could potentially result in distress and have an impact on people's dignity. This person's care plan stated they needed rapid support to use the toilet to avoid incontinence. Another person told us, "sometimes I shout for help but it takes staff a while to respond. It can be upsetting when they don't come." We also observed people in the lounge area left on their own for significant lengths of time. People did not have call bells near to hand during these times so were unable to seek help if they needed it. On all occasions staff were busy helping other people.

On the first day of the inspection, at 6:30pm, we found the kitchen full of dirty washing-up. We asked where the kitchen assistant was and were told the kitchen staff hours had been reduced from 7pm to 5pm and they now finished at 3pm. We were told this had happened as the numbers of people using the service had reduced. We were told that this time of the day was busy for the care staff as they required a short break and people started wanting to go to bed. The reduction in kitchen support meant care staff needed to prepare and deliver food, support people to eat, return the dirty dishes to the kitchen and clear the kitchen up in addition to other care tasks. On this occasion, because the inspection was taking place, the clinical lead was still present in the home. They had started work at 7am and they cleared the kitchen up so the care staff could carry on delivering people's care.

There were problems with staff retention and sufficient additional staff had not been recruited. The service was using a high proportion of agency staff. When agency staff had either not turned up or could not be found, care staff had worked below the provider's allocated staffing levels, which were already insufficient.

The service's analysis of accidents showed minor lacerations on people occurring each month, for example minor skin tears. The most senior member of staff told us they felt these were occurring because staff were rushing through care with people who were particularly frail.

There were insufficient staff both employed and on duty to meet people's needs and ensure the smooth running of the service. The impact of this was people's needs could not always be met and their safety not maintained at all times. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The member of staff overseeing recruitment on a day to day basis did not know the provider had a recruitment policy. The provider confirmed there was a policy in place. We found a number of instances where recruitment practices did not protect people from being supported by staff that may be unsuitable to care for them. Four staff recruitment files had no evidence that the person's identity had been checked. One member of staff's check with the Disclosure and Barring Service had not been carried out by the provider and the one on file was more than three months old. In this case, the DBS clearance was not therefore valid. A DBS check allows employers to establish whether the applicant has any convictions that may prevent them working with vulnerable people.

One member of staff had not had their reasons for leaving and conduct in their past jobs where they worked with vulnerable adults checked. Specifically, one member of

Is the service safe?

staff had been dismissed from a previous job in care and the reason for this had not been checked with the previous employer. Four staff had gaps in their past employment history that had not been explored and followed up. Three staff did not have a written record to show their physical and mental health had been checked.

Recruitment practices were not sufficiently robust to protect people. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found some evidence of good recruitment practice where more information, in addition to the reference provided, had been sought verbally about a potential member of staff before they were employed.

People were not sufficiently protected against abuse. Staff had completed computer based training on what abuse looked like and how to report their concerns to the senior member of staff on duty. They were, however, unaware of the county's safeguarding protocol and the fact that they could contact relevant external agencies if needed. For example, if after reporting their concerns, the senior member of staff did not take appropriate action to protect people. Information provided to us from the service showed that in one case a concern had been reported to a senior member of staff who did not then report this further, either to the previous registered manager in a timely manner or to an external agency. Staff also did not know how to contact a representative of the provider when they were not present in the home. For example, if they wanted to raise concerns about safeguarding or confidential concerns about another staff members' practices.

There were not well established systems or processes in place to protect people from abuse or poor practice. People were not as protected as they could be. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Action had not been taken to address two potential health and safety risks. A large branch of a tree, located in the front garden, had split from the main trunk earlier this year. The branch remained partially attached but the majority of it rested in the garden. Along the other side of the garden sat rubbish. This included parts of old armchairs, other pieces of furniture, old piping and other potentially unsafe objects which we could not identify. The garden foliage had partially grown over these items. This made the only grassed area of the garden unusable. Staff told us they had spoken with the provider about the unsafe tree many times but no action to address this had been taken to date.

Some environmental risks and those relating to health and safety had been assessed and managed in order to protect people from harm. We spoke with the member of staff who was responsible for carrying out various health and safety and environment checks. They kept records of when they carried these out, which included window restrictor checks and visual checks on the condition of wheelchairs. They also kept a record of the tasks they carried out to maintain the safety of the water system.

An audit completed by the previous registered manager just prior to her leaving in September 2015 stated that a contract was in place with a company for managing risks relating to Legionella. A representative of the provider explained this was not the case although various checks were carried out to ensure the water system was safe. For example, records showed that taps in unoccupied bedrooms and showers were flushed regularly. Cold and hot water temperatures were checked on a regular basis to ensure the water system was healthy. Hot water temperature valves were in place to lower the hot water temperature to reduce the risk of scalding.

A fire safety risk assessment was in place and personal emergency evacuation plans were completed. These informed staff and the emergency services which bedrooms people were in and their ability to evacuate the building in the event of a fire. However, the senior member of staff told us she had needed to review these recently because people had changed bedrooms and their mobility and cognitive abilities had since altered. The provider informed us that a service contract was in place for all mechanical moving equipment and hoists used to help move people had been checked in August 2015.

Accidents such as falls had been recorded and strategies put in place to prevent further injury or further occurrences. For example, a person at risk of falling out of bed had been provided with a bed that lowered almost to the floor. Padded mats were placed on the floor around the bed to break a potential fall from the bed. This equipment was used when bed rails were not suitable, for example, in cases when people were at risk of climbing over these.

Inadequate

Is the service effective?

Our findings

People did not receive effective care. There were systemic failings in the way the service operated which meant this shortfall continued despite people and their families raising concerns and the involvement of external health care professionals.

People's nutritional needs and risks had not always been adequately identified or monitored. Health care professionals found staff had sometimes completed the nutritional assessment tools incorrectly which resulted in an inaccurate risk rating. Care staff were not always completing people's food and fluid intake monitoring charts so people's eating and drinking was not adequately monitored. Health care professionals found some people had lost weight and the reasons were not properly addressed or monitored. Despite feedback from health care professionals, nutritional assessments and monitoring charts were still not being completed accurately and people's nutritional risks were still not being adequately addressed.

One person had lost over six percent of their body mass between May and June 2015. When their eating and drinking care plan was reviewed in June 2015, no reference was made to this weight loss. The care plan review comments were, "No problems in eating and drinking". This comment was replicated the following month. The person was then not weighed during August 2015 as the scales were broken for a period of three weeks. The person who would have mended these was away and no alternative arrangements were made. By the time the person was next weighed, in September 2015, they had lost further weight. Staff told us this person often did not want to eat but this was not mentioned in their care plans and there was no guidance to staff about how to support the person when they said they did not want to eat.

We were told that one relative had raised concerns recently about their relative not eating their food because it sometimes arrived cold. Information shared with us by local commissioners showed that another relative had been concerned about food being delivered cold and their relative not eating. We used SOFI to observe four people receiving support during lunch time. Food left the kitchen hot but people who required support to reach their meal or with eating it had to wait up to 15 minutes for help. By this time the food was no longer hot. One person who ate their meals in their bedroom received a meal which was just warm. In this case, the person ate it.

Some people were asleep when their food was put in front of them and at times staff did not notice when people had fallen asleep without eating. Some people were initially woken up by staff but fell asleep again before finishing their meal. The food was then cool. One member of staff said, "Not enough time" and another said, "We have four feeds down here. We are rushed with just three staff at lunch". The impact of this was that mealtimes were not enjoyable events and arrangements did not encourage people to eat in order to maintain their weight and well-being.

One person had been reviewed by a dietician two weeks prior to our inspection because they were losing weight. Records showed that the dietician had suggested finger foods. These were to be provided in-between meals and a record of when the person refused them was to be recorded. We were told the finger foods had not been successful but there were no records of these being provided or refused.

The risk of people choking when eating was not appropriately addressed. Some people were unable to maintain a good posture when seated and staff did not address this before helping them with their food. This made it harder for one particular person with poor posture to eat and increased their risk of choking. This person appeared to be keeping food in one of their cheeks and staff repeatedly asked them to chew and swallow properly. Three different staff helped this person to eat. The third member of staff finally identified that their slumped posture was resulting in food gathering in their cheek. Once they were helped to sit up they were able to chew and swallow more effectively. It was not clear why the other two staff did not consider the person's posture to be a contributory factor to their inability to swallow effectively.

People's nutritional risks and needs were not adequately assessed, monitored or managed. The impact of this was people had lost weight and had not received the level of care needed to maintain their well-being. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Inadequate

Is the service effective?

When staff helped to feed people they did not rush them. Some people needed their food to be pureed or their drinks thickened so they could swallow safely. Where this was the case, the person had been referred to a speech and language therapist. One person told us, "you can ask for a different meal if you don't like it". Most people said the food was "acceptable" or "good". The cook told us if people did not like the option on offer they would aim to provide an alternative which the person would prefer. We saw examples of this.

Staff supervision records showed they were taking part in regular meetings to discuss their training needs and performance based on an assessment of their practice beforehand. A staff supervision contract required six meetings per year to be completed and most staff were on track to meet this target. The Provider Information Return form stated staff would also be provided with annual appraisals and for these to be introduced. We were not aware during the inspection that these plans had been formulated yet.

A representative of the provider told us they carried out care staff supervisions. Staff we spoke with said they saw this person at the home but were not aware of him spending time observing their practice. The most senior member of staff had not been asked by the representative for feedback on the performance of care staff. The representative told us they had not received any specific training to help them conduct effective observations of care. We looked at the supervision records for two staff. The comments on the supervision records regarding their approach to supporting people were very similar and did not always address the question being asked. For example, "Attitude towards residents: works well with everyone. No problems." We observed both of the staff during our inspection and had concerns about the way they engaged with people, their understanding of postural management, infection control, their understanding of the Mental Capacity Act 2005 and safeguarding reporting. None of these issues were identified during their supervision meeting with the provider's representative.

The staff training record indicated that staff had not completed the training updates required by the provider's own training schedule. Some staff were up to two years behind. Training was delivered predominantly by staff completing computer based modules. The most senior member of staff working at the service did not yet have the ability to monitor the electronic training staff had completed. This meant they were unable to monitor the electronic training being completed by the new staff. An external trainer was employed twice a year to provide a daylong update in all

subjects the provider considered staff needed to carry out their tasks safely. This involved covering twelve significant topics in one training session. Staff who had completed this training told us it was a lot to cover in one day. One member of staff said, "it's a lot to take in".

Additional training relevant to people's needs was limited. Four staff out of twelve had completed dementia awareness training but three of these had completed this in 2010 with no subsequent updates. There was no evidence of staff receiving training to improve their knowledge in wound care management or pressure ulcer prevention. One nurse had completed training in nutritional needs. There was no evidence of on-going competency checks being carried out. A representative of the provider told us this was what the supervision sessions did. The recorded supervisions did not evidence that staff competencies were being adequately checked. The most senior member of staff told us she had recently been watching four staff manoeuvre people and had been concerned about their practice. The previous registered manager had provided moving and handling training at the service and an alternative trainer had not been arranged. In the meantime, the senior member of staff intended to help these staff improve their practice by working with them. They had previously been a moving and handling trainer but had not kept their trainer qualification up to date. They were, however, up to date in their own moving and handling practice.

Staff had not received appropriate support or training to be able to perform their tasks safely or appropriately. The impact of this was people's health and care needs were not being identified or managed correctly. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The training record showed seven care staff had an update in nutritional care in July 2015 but our observations showed that this training had not improved staff members' skills in managing people's nutritional needs or risks.

Inadequate

Is the service effective?

People's rights under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were not being fully protected. The MCA protects and empowers people who may lack the mental capacity to make their own decisions about their care and treatment. A decision can be made in their best interest if they are unable to do so themselves. DoLS aim to make sure that people are looked after in a way that does not inappropriately restrict their freedom. There was no written record to show whether people or their legal representative/s had given consent for the care and treatment they received on a daily basis. Some people required a mental capacity assessment to determine if they were able to consent to aspects of their care and treatment and this had not been completed. There was therefore no record to show whether care was being legally delivered with the person's consent or in the person's best interest.

Staff spoken with had little knowledge of the MCA and DoLS and how this was relevant to their practice. Staff were aware it was unlawful to make someone do what they did not want to do and we observed refusals of care being accepted by staff. Staff in senior positions, including representatives of the provider, did not know if anyone had a DoLS authorisation in place. They did not know if the previous registered manager had made any applications to restrict someone's freedom to the local authority. During the inspection we contacted the local authority MCA/DoLS team and ascertained that applications for three people had been submitted and were awaiting review. There was no information in people's care files about why these applications had been made. At the time of the inspection senior staff confirmed that none of these were urgently required.

People's consent had not been obtained for the care and treatment being provided to them. Care and treatment was not being delivered lawfully and people who lacked mental capacity were not always being protected. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found some people had been supported and represented by an Independent Mental Capacity Advocate (IMCA). This support had been provided when a decision had to be made about where the person was to live, for example, at Charnwood House.

Care records showed that people had access to their GP, a chiropodist and optician when needed. We did not see any information about access to dental care and staff were unsure about this. Assessments had been carried out when people had problems maintaining their continence (toilet needs) and aids had been provided where needed.

Requires improvement

Is the service caring?

Our findings

The service was not always caring towards the people that lived there. Whilst staff clearly wanted to care for people, a lack of appropriate skills, knowledge and the time to meet people's needs meant people's needs were not met in a caring and compassionate way. One relative told us, "staff are generally caring but are often too busy to spend as long with people as they should". They went on to say some staff missed their own lunch in order to meet people's needs.

People were not being respected. Staff members' lack of skill and knowledge and their need to move from one task to the next prevented them from picking up on some people's verbal and in particular, non-verbal communication. A member of staff described people as "feeds" and "doubles" which showed a lack of respect for the individual. Staff did not always acknowledge or address people's distress. For example, one person tried to communicate with a member of staff whilst their face was being wiped. The member of staff talked at them during the process but did not actually engage with them or seem to notice they were trying to communicate with them. This person was trying to communicate distress but this was not picked up by the member of staff. The person later banged their bowl on the table to get the attention of the member of staff but this was not noticed. People can potentially feel frustrated and that they do not matter when their communication is not acknowledged.

We did not observe any intentional act which would cause harm or distress to people but observed care being delivered in a task orientated manner and sometimes, not in a skilful way. We observed staff spending little time with people unless they were performing a physical care task. One person told us they felt very depressed because of this. One relative said, "Staff are very busy and some seem to rush". A member of staff was very busy during lunchtime and spoke to one person in a frustrated tone saying, "Just listen please. Open your eyes and use the fork".

We observed inconsistent practices when it came to helping people to make simple decisions and choices. For example, some staff asked people what they would like to drink whilst other staff just provided drinks without finding out what the person wanted. Some staff did not understand the difference between telling people what was going to happen and involving them in a decision. For example, a member of staff removed one person's cardigan because they looked too warm. They made little effort to seek the person's preference. One person said staff, "give you an answer when you ask a question" and was happy with the way they were treated.

Two relatives told us they had never been involved or consulted in the planning of their relative's care or asked about their relative's preferences. They had some questions about their relative's care which they told us they had never been given clear answers or explanations about. During the inspection we spoke with the most senior member of staff about this and they organised a care review meeting, with the relatives, so their questions could be answered. Family and friends visited without restrictions and staff greeted them in a friendly way.

We observed one person being moved with the help of a mechanical hoist. Whilst staff carried this out they communicated well with person, offering them reassurance. In doing this staff also considered the person's dignity and they made sure the person's clothing remained in place so as not to inappropriately expose the person. However, at other times, people were left with food on their clothing or body for extended periods of time which did not maintain their dignity. One member of staff removed a person's protective food tabard but did not remove food which had fallen on their skin below their chin. This remained in place until the next meal.

People were not always treated with dignity and respect. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

One person was unable to speak English and although communication was clearly difficult, staff had become used to the person's non-verbal cues. This person predominantly expressed their needs using their hands. One of their visitors translated feedback from this person and told us they said, "Everyone here is very good". Arrangements were in place for a representative of the provider to communicate with the family who also spoke little English. In this person's case, staff had tried to accommodate the person's dietary preferences but they had refused this support.

Inadequate

Is the service responsive?

Our findings

Staff were not responsive to people's needs. There were systemic failings in the way the service operated which meant this shortfall continued despite people and relatives raising concerns and the involvement of external health care professionals.

Opportunities for people to be engaged in social activities and other activities which were meaningful to them were limited. People's records contained very little information about their preferences and particular choices in this area. The service's last satisfaction survey, concluded in April 2015, showed negative feedback regarding the provision of activities. One person had made a comment about not being aware of any activities taking place. The management's response had been, "there had been less than had been planned". The management's response also indicated problems with staff availability to provide activities. Opportunities had remained fairly limited since this although staff had provided some activities when they could from May onwards. This had since reduced again.

On the second day of our inspection one member of staff had allocated time to provide some activities. This member of staff had not received any support to carry out this role and had not completed any training in meaningful activities with people who live with dementia. We observed this person having conversations with some people who clearly enjoyed this but many were not included. Unfortunately, this member of staff was due to go on leave and no further hours had been allocated for activity provision. One member of staff told us a singer had come a few weeks ago and people had really enjoyed this but there was nothing else booked. Another member of staff told us a barbeque had taken place a few weeks ago and people had enjoyed that. We were not made aware of any links with the wider community although the commissioner's review report dated 16 September 2015 stated that a non-denominational service was provided once a month.

We used SOFI to observe how staff interacted with five people sitting in the lounge. The lack of stimulation and meaningful activities were having a negative impact on people. One person shouted out, "It's boring here. Can't do [swear word] nothing" after which staff sat and talked with them for 10 minutes. After staff left, the person was heard to say again, "Nothing to do. I'm bored". This person said to us, "Makes me sad. I feel rotten, I feel low." We observed very little conversation between people living at the home and little interaction with staff. We observed people's mood and the interactions that took place for significant periods of time. People presented as withdrawn and passively watching their surroundings. Several people slept for long periods of time. The television was on all day but few people were actually watching it. A limited number of interactions were initiated by staff and only one was not related to a care task. People's body language reflected boredom and low mood. In the evening, one person was clearly anxious for a period of 50 minutes and this was not addressed by staff. Others, who expressed verbal anxiety, predominantly about wishing to go to bed, were verbally responded to but non-verbal anxiety was not acknowledged or responded to.

The lounge was not arranged in a way which promoted social interaction. Chairs were arranged around the edge of the room and people tended to face each other at a distance. Those sitting next to each other tended to be at an angle which did not help them converse with their neighbour. People received their food on tables in front of their armchairs. The dining area was used very little and staff could not explain why. Most people would have needed staff to help them move from their armchair to the dining room. Staff had only just completed everyone's personal care by midday when lunch was being served. They would not have had time to help people move to the tables before lunch was served.

Other people, who were in their bedrooms, also wanted or required attention which could not always be responded to in a timely manner. One person had been assessed as unable to have a call bell for safety reasons. The risk assessment to support this decision stated that staff should "attend promptly" when the person called out. The assessment also stated there should be an observation chart in place to record the visits staff carried out. The Provider Information Return stated that these observation/ check records would be put in place. There was no observation chart in place and no other record showing when staff had checked this person.

This person called out for 25 minutes but there were no staff nearby to hear them. We intervened at this point and sought staff assistance to address their distress. We raised our concerns about this with one of the nursing staff who explained they normally reminded care staff to check on

this person regularly. They had been on a break and so had not asked staff to check on this person. There was no robust system in place to make sure people were regularly checked and staff did not always use their own initiative.

On the second day of our inspection an observation record had been put in place to record the hourly checks. A member of staff said there was no system to identify who should complete the hourly checks. They said they just "popped up" hourly and if another member of staff had already completed the check they came away. When staff carried out their checks they also did not always identify the person's needs and respond to them. For example, during one check there had been no attempt to alter and improve the person's poor posture. The most senior member of staff agreed that the checks were in place to ensure this kind of need was addressed.

A second person's care plan stated they were unable to use a call bell due to "dementia". We could not see a call bell near to hand. This person's care plan stated they should be "checked 2-3 hourly". At 5:30pm we asked staff who had checked this person since lunch and no one was able to tell us they had. There were no observation charts in place for this person to record these checks. We alerted a member of staff to the fact the person was beginning to slide forward on their pressure relief cushion, had food down their front and had possibly been incontinent. This member of staff repositioned the person and removed their trousers and covered them with a blanket. We were told the person had not been incontinent.

Several people required support to maintain a good sitting posture and staff did not identify this need or respond to it. People's care plans and risk assessments did not refer to their postural needs. We observed one person leaning to one side in their armchair with their hand nearly touching the ground. They were asleep and not about to fall but they were in a very poor position. After the person had been in this position for at least 35 minutes, two staff entered the room one after the other. One member of staff pointed out the person's poor position. Another member of staff said they had been "popping in and out" and had noticed this and then left without further comment. Our observation showed that no staff had entered the room for 35 minutes. The remaining member of staff attempted to move the person but could not do this alone. They also left the room and did not return. This person woke up approximately 40 minutes later and said they felt, "very stiff" and had a "dead arm". Staff were not observing people adequately and also not responding to their needs when they identified them.

Staff did not respond well to people's needs at meal times. During lunch one person was struggling to eat because their food was not placed within their reach. It took over five minutes for staff to notice they were having difficulty and to move the table nearer. The member of staff who served the food seemed unaware of the need to consider whether the person could physically reach their food. A member of staff helping one person to eat was called away three times during the meal to meet other people's urgent needs. Other people found it difficult to eat with the utensils provided and looked as if they needed additional or different utensils/equipment to help them eat their food. When staff noticed they helped people to eat but did not address other practical barriers such as the person's posture. Staff did not always understand that people who live with dementia may not recognise the appropriate tool to eat with and may need a spoon instead of a fork. Two members of staff confirmed they had not received training in supporting people with dementia since starting work at the home.

We were told that not many people had family representatives. The care records for those who did have family representatives showed little sign of their relatives having been involved at appropriate times. Care plans were focussed primarily on what the person could not do but some personal preferences, choices and wishes were recorded. One person's care plan stated they preferred to have their meals sitting at the dining room table. We did not see this happen for this person during our inspection. There was nothing in the person's care records to indicate they would not be able to do this from a health perspective.

Care was not always designed or delivered around people's individual needs. The impact of this had a negative effect on their physical and mental well-being. This was a beach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider told us that information about making a complaint was given to people on admission. Two relatives told us they could not remember receiving this. They told us they had raised several verbal complaints, multiple

Inadequate

Is the service responsive?

times, with the previous registered manager of the home. They had not felt listened to and had remained unsatisfied with both the eventual action taken and the explanations given. Information shared with us by local commissioners showed that another relative had raised their dissatisfaction with the care and services being provided many times with the previous registered manager. The registered manager had been unable to resolve these issues so the relative made a request to commissioners for their relative be moved to another care home. They also raised their issues formally with a representative of the provider. We requested a copy of the complaint response from the provider but this was not forthcoming.

None of these complaints/concerns had been recorded in the complaints file. One issue still required a satisfactory outcome which a representative of the provider told us they would address. The most senior member of staff told us they had received a complaint from a relative the first morning of our inspection. They told us they had acknowledged this and would investigate the issue with the aim of resolving it. They told us they would make a record of the complaint in the complaint file and the actions taken in response.

People's complaints and concerns were not satisfactorily addressed or recorded. The impact of this was people remained dissatisfied when they raised a concern or complaint. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

The service was not well-led and had been left without adequate leadership. The registered manager had left the service at the beginning of September 2015 and the provider had not made adequate arrangements for the service to be appropriately managed since then. The service was being managed by a recently recruited registered nurse without management experience. We were informed by the provider that a new manager would be starting in December 2015. In the meantime, the registered nurse became the most senior member of staff present and was expected to secure people's safety and wellbeing. There were limited resources to do this and inadequate support from the provider.

Problems with retaining staff, poor management of staff contracts and inadequate recruitment action had left the service with limited permanent staff. At times, the service was heavily dependent on agency staff as well as the good will of permanent staff to cover shifts. There was no senior staff structure in place for the senior member of staff to delegate to. Other registered nurses worked no more than one or two shifts per week. This hampered effective communication about people's changing needs and made it difficult for the senior member of staff to delegate tasks to other nurses. A culture existed where staff had not been encouraged to take any further ownership past the shifts they worked. Care staff lacked the support they needed and morale was low.

Important information needed for the smooth running of the service had not been shared with the senior member of staff. The provider had historically relied on information from the registered manager to oversee the service and as a result was unaware of some of the shortfalls highlighted in other areas of this report. The registered manager had completed quality monitoring audits to help her identify shortfalls but these were not always addressed. There was no evidence that the provider was continually looking to improve the service through quality monitoring. There were no action plans developed to give structure to this process. Although the provider informed us that regular meetings were held between one representative of the provider and the registered manager, the provider was unaware of the extent of the problems within the service.

The poor standard of care experienced by people and the number of regulations from the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 not currently met demonstrated that there had been a systemic failure to properly monitor the service and to improve it. After we fed back the initial findings of our inspection, one of the provider's representatives said, "Well, we can't all be perfect". This showed a concerning lack of insight into gravity of the situation and a complete disregard for people's well-being.

The provider had not ensured there were systems in place to assess, monitor and improve the quality and safety of the services provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.