Handsale Limited

Handsale Limited - Shakespeare Court Care Home

Inspection report

1 Shakespeare Close
Butler Street East
Bradford
BD3 9ES

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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

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 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

Summary of findings

We inspected Shakespeare Court on 13 August 2014 and 21 August 2014 and the visits were unannounced. Our last inspection took place in February 2014 and at that time we found the home was meeting the regulations we looked at.

Handsale Limited – Shakespeare Court is registered to provide accommodation and nursing care for up to 80 people accommodated over four units. This includes two residential units and two nursing units. Two units of the home cater for people living with dementia.

A registered manager was in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

Cleanliness and hygiene standards in the home were not being met and we saw some poor infection control practices. This put people at risk of transferring and acquiring infections. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staffing levels were not adequate to keep people safe. People told us there were not enough staff. People were not adequately supervised and had to wait for support and assistance. Staff did not have the time to provide meaningful interaction with people. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were not protected from abuse. There was a lack of evidence of action taken following incidents to keep people safe. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People's care needs were not always assessed and people did not receive care in line with the requirements set out in their care plans. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The manager had sought and acted on advice where they thought people's freedom was being restricted. This helped to ensure people's rights were protected.

Most people said staff treated them with dignity and respect. However, we saw staff did not always treat people with dignity and respect or respect their privacy. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Most people spoke positively about the quality of food at the home. However, we found the mealtime experience required improvement with unnecessary delays in serving food. People were not always appropriately supported at mealtimes and appropriate action not always taken following the identification of the risk of malnutrition. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Quality assurance processes were inadequate; the issues we found had not been identified by the provider's own monitoring and audit processes. Risks to people's health, safety and welfare were not appropriately assessed and managed. This was a breach of Regulation 10, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Accurate records were not always maintained in respect of each person who used the service. For example a lack of information on people's life histories and preferences. This was a breach of Regulation 20, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider is required by law to notify the Commission of any allegation or instance of abuse. We found seven notifiable incidents which should have been reported and were not. This was a breach of Regulation 18, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Systems were in place to ensure medicines were managed safely. We found that medicines were ordered in a timely way and recorded, stored, administered and disposed of safely.

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 who used the service were put at risk because cleanliness and hygiene standards were not maintained. We observed poor infection control practices which put people at risk.

Staffing levels were inadequate and people were left waiting for assistance. Staff did not have time to engage in activities or provide companionship for people. We found people were not protected from the risk of abuse as appropriate action had not been taken following incidents.

CQC monitors the Deprivation of Liberty Safeguards (DoLS). The manager had sought and acted on advice where they thought people's freedom was being restricted. This helped to ensure people's rights were protected. However, we found some overly restrictive practices which could have been avoided, such as locking dining room doors. This amounted to unnecessary restrictions of people's movement around the home. Staff said they had received training in Mental Capacity Act (MCA) but were unable to confidently describe the requirements of the Act. This risked that the correct steps were not followed to assist people with limited capacity to make decisions.

Is the service effective?

Inadequate

The service was not effective. People's healthcare needs were not always met, for example around pressure area care. We received mixed feedback from health professionals, with both of those we spoke with raising concerns over some aspects of care.

The mealtime experience required improvement. People were left waiting for unnecessary periods of time and were not given appropriate support. There was not always evidence that appropriate monitoring and action had been taken to protect those who were identified as being at risk of malnutrition. People's feedback about the food was mixed. People said they had a choice of food but some people said they were bored of the lunchtime options.

A range of training was provided to staff. Staff said it gave them the skills and knowledge required to undertake their role effectively

Is the service caring?

Requires Improvement

The service was not always caring. Most people said staff were kind and caring and treated them with respect. However, two people alluded to less positive relationships with staff.

Although we saw some good interactions between staff and people, we saw instances of people not being treated with dignity and respect. For example, staff broke off from supporting people at mealtimes to attend to other tasks. Staff did not have time to interact in a meaningful way with people.

Summary of findings

An appropriate level of privacy was not offered during doctors consultations and staff openly discussed people's medical issues with the doctor in the lounge which resulted in confidential information being discussed within earshot of others.

Is the service responsive?

Inadequate

The service was not responsive. We found people's care needs were not always assessed to enable staff to deliver appropriate care. The service failed to respond to people's changing needs by ensuring amended plans of care were put in place.

We found appropriate care was not delivered. This included lack of assistance with personal care and staff not following care plans.

People reported there was not enough to do in the home and said they were bored. We saw staff did not have time to engage in activities or conversation with people.

Is the service well-led?

Inadequate

The service was not well led. We found a number of concerns during our inspection which had not been identified by the provider or manager. This showed a lack of a robust quality assurance systems. Where issues had been identified by external agencies, robust action had not been taken to resolve issues.

Accidents and incidents were not properly analysed and there was a lack of action taken to prevent re-occurances. We found seven notifiable incidents which had not been reported to CQC as required by the regulations.

Staff spoke positively about the management at the home and said they were supportive of them.

Handsale Limited - Shakespeare Court Care Home

Detailed findings

Background to this inspection

We visited the home on 13 August 2014 and 21 August 2014. We used a number of different methods to help us understand the experiences of people who used the service. We spoke with 13 people who used the service, two relatives, seven members of staff and the deputy manager. We spent time observing care and support being delivered. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not express their views to us. We looked at seven people's care records and other records which related to the management of the service such as training records and policies and procedures.

The inspection team consisted of two inspectors, a pharmacy inspector and an Expert 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. A specialist advisor in nutrition also accompanied us on the inspection.

Before our inspection, we reviewed the information we held about the service. This included notifications and the provider information return (PIR), a document sent to us by the provider with information about the performance of the service. We contacted the local authority safeguarding team to ask them for their views on the service and if they had any concerns. As part of the inspection we also spoke with two health professionals who regularly visited the service.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Inadequate

Is the service safe?

Our findings

We found significant problems with cleanliness and hygiene in the home. The home and equipment was not clean, hygienic or well maintained and we observed poor infection control practices that put people at risk. Before the inspection we received a complaint from a relative concerned that areas of the home were "filthy" and their relative's room was particularly unhygienic. On the day of the inspection, a visiting health professional also raised concerns with us about the cleanliness of some areas of the home. During the inspection our observations confirmed some people's rooms were dirty and had not been cleaned properly. For example, in one person's room we found faeces and other dirt on the walls and chairs which put the person at risk of infection. Some people's mattresses were stained and some bedding was stained and ripped. There was a strong odour in the dementia units of the home. Chairs throughout the home were stained with food such as in communal dining areas and a number were sticky to the touch and ripped. In one lounge area, we found food was splashed on walls and dried food was observed embedded in the carpet. In another person's room we found a meal left on a side table from the previous night. When we asked the carer who was spending 1-1 time with the person about this, they said they had found it on the floor in the morning, had removed it and placed in on the side table. This indicated proper cleaning and checks of people's rooms were not taking place, as the food was left on the floor all night. Some areas were poorly maintained which meant they could not be effectively cleaned such as bathroom and toilet floors. Some furniture was also in a poor state of repair and required replacing so that it could be effectively cleaned to keep it hygienic.

We observed some poor infection prevention practices. For example, we noticed faeces was on the knob of one bedroom door. We saw a staff member touched the door knob and then went to handle food for someone else without washing their hands. This posed a risk of infections were passed between people. The faeces was only cleaned from the bedroom door when a member of the inspection team prompted staff and even then it was not cleaned properly. In some toilets in the dementia nursing unit there were no bins to dispose of waste and instead black bags were tied to the toilet rail. This was not a hygienic way to manage and dispose of waste. Personal Protective Equipment (PPE) was not always available. For example, gloves were locked in the linen cupboard and staff were not able to easily access them. One agency member of staff confirmed this by telling us they did not know where the gloves were kept. We observed open packs of incontinence pads were left by the side of a toilet which had the potential to increase the risk of infection.

The deputy manager told us daily room checks were undertaken, however these were not documented. This meant there was no evidence that the checks took place and there was no accountability for maintaining the standard of each room.

These issues put people who used the service, staff and other people at significant risk of acquiring or transferring infections. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Through our observations and discussions with people and staff, we found that there were not enough staff to meet the needs of the people who used the service. People told us there were not always enough staff. For example, one person told us, "They are always so busy." Another told us, "It all seems to have fallen apart a bit over the holiday season. I think they are a bit short staffed at the moment." People said staff did not always attend when they needed them. For example, one person talked about staff availability in a lounge said, "It depends: – If there's someone here in the room it's easy, otherwise I have to shout or just wait." One relative also told us that their family member was always complaining about staff not coming back in a timely fashion to assist them. Another visitor raised concerns stating, "I've come more than once at lunchtime and found my relatives' breakfast still sitting beside them because they had been asleep. It's still there, cup of tea and everything," This indicated there were not enough staff to ensure meals were promptly cleared away.

Agency staff were used to cover absences, but staff said sometimes it was not always possible to get them at short notice. Staff confirmed they were struggling with staff over the holiday season and there were times when they did not meet their target staffing levels due to difficulty obtaining agency staff. Staff also told us that the cleaners had not been available the last two weekends as they had to do the

Inadequate

Is the service safe?

laundry instead. This had put a strain on cleaning and meant the standard of cleaning had suffered. This showed there were not always sufficient staffing levels to keep people safe.

We looked at the care of a person whose care plan stated they required constant supervision and found this person was left unsupervised putting them at risk. Staff confirmed there were not enough staff to ensure that all people's care needs were met, such as providing the required supervision for this person. When we looked at people's care plans and the care they had actually received there was evidence there were not enough staff to meet people's needs. For example, people had not received regular pressure area relief as stated in their plans, nor were people's personal hygiene needs being met such as the frequency of showers or baths as stated in their care plans. This showed there were not enough staff to meet people's needs and keep them safe.

We observed a number of occasions where people had waited in excess of 10 minutes for staff assistance after calling out. There were periods of 10-15 minutes when communal areas were not supervised and staff were not visible. This included areas where people displayed behaviour that challenged, putting people at risk. Reviewing incident data from June and July 2014 there were incidents which happened when staff had not supervised communal areas. These could have been avoided if sufficient staff had been available. For example instances of one person throwing cups of tea at other people.

Staff did not have time to provide any meaningful interactions with people other than carrying out basic tasks. For example, they had no time to undertake activities. People reported there were a lack of activities and staff busy in routine care tasks was partially responsible for this. We saw people were left walking about the corridors with little interaction and staff did not have the time to comfort people who needed it. We saw a number of incidents occurred which indicated there were not enough staff. On the dementia unit, we observed faeces had been smeared on three people's door handles. From speaking to staff it was evident that this was due to one person and that the behaviour had been occurring for several weeks. However, staffing levels were such that staff were unable to supervise this person appropriately and prevent them from doing this. Bathroom and toilets in the Cedar Unit did not contain bins or toilet roll; staff said this was because one person misused them. However this meant other people had to rely on staff to provide these items on an individual basis. This practice indicated that there were not enough staff to offer support to that individual.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found safeguarding incidents were not always reported to the Local Authority Safeguarding unit. For example we found one incident in July 2014 which stated 'person has been quite aggressive, smacking residents.' Another incident in July 2014 where someone's face had been marked by another person who used the service had not been reported. If safeguarding referrals were not being made this meant external agencies were unable to consider the issues raised in order to decide if a plan to keep people safe was required

Through observations and speaking with staff we found people were not receiving care in line with their care plans, for example in relation to pressure area care, personal hygiene or meeting their emotional needs. This indicated a neglect of people who used the service. We found following incidents of aggression, appropriate preventative measures were not always taken to keep people safe from abuse. For example, behavioural care plans were not updated with strategies to reduce the risk of abuse and incident forms did not always contain clear preventative measures to keep people safe.

Care plan documentation showed some people required constant supervision to ensure they and others were kept safe. However, we saw this was not always possible and we saw an argument break out between two people, when one person who was supposed to be supervised was not. This put them and others at risk of abuse. Following the inspection we made a safeguarding referral to the Local Authority, in regards to the dementia units of the home because we found people were at risk of abuse due to neglect and failure to control risks to people.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This is because the provider was not taking appropriate steps to protect people from abuse.

People did not report any restrictions and said they could go to their rooms, bedroom and gardens when they

Inadequate

Is the service safe?

wanted. We found the deputy manager had a good understanding of Deprivation of Liberty Safeguards (DoLS). They were aware of the recent supreme court judgement, had risk assessed the restrictions on each resident, and sent a number of recent DoLS applications based upon risk. This indicated that the service was taking action to ensure that its practices were assessed to determine whether there were any unlawful restrictions. However, we observed some overly restrictive practices which could have been avoided. For example, the dining room door in the Cedar unit was kept locked. This was an unnecessary restriction on people's movement. Staff said they had received training in mental capacity act but were unable to confidently describe the requirements of the Act. We saw capacity assessments had been completed for some people, but not others indicating an inconsistent approach to the assessment of capacity.

People said they felt safe in the home for example one person said, "I had started to feel nervous at home, especially when it got dark. I feel much better knowing that there are other people around all the time." People who lived at the home told us they felt able to raise concerns with staff for example one person said, "I can talk to them no problem".

Appropriate arrangements were in place for obtaining medicines. People's regular medicines were ordered in good time and a record of medicines received from the pharmacy was kept. This meant that people always had the medicines they needed. We saw that senior staff carried out daily checks (audits) to see if medicines were given safely. Appropriate arrangements were in place for recording medicines. We counted some tablets and found that the stock records were accurate. We saw that administration records were completed in the right way when medicines were administered. This meant that people received the medicines they needed. Medicines were given to people appropriately. Any change to the dose of a person's medicine was confirmed in writing by the doctor or health professional. Medicines were safely administered. We watched medicines being administered in all four areas of the home. Members of staff gave medicines in a safe and friendly way, and stayed with each person until they had taken their medicines. This meant that people were supported appropriately to take their medicines. However there were no written guidelines (protocols) to help staff decide when to administer medicines prescribed 'when required' which meant these medicines might not be administered in the right way to each person.

Medicines that were controlled drugs (CDs) were kept in cupboards that complied with the law. Medicines were disposed of appropriately. Medicines to be disposed of were recorded and collected by the pharmacy that supplied them or a licensed waste carrier (as required by law). This helped prevent mishandling and medicine errors.

We saw safe recruitment procedures were in place to ensure staff were suitable for the role. This included ensuring a Disclosure and Barring Service (DBS) check and two written references were obtained before staff started work.

Inadequate

Is the service effective?

Our findings

Staff were not effectively meeting people's healthcare needs, for example around pressure area care. A health professional we spoke with said they had some concerns over pressure area care in the home as they thought that some pressure ulcers had developed because people were left in an unhygienic state and their continence needs not always met in a timely fashion. One person's care records stated they required two hourly pressure relief, their legs to be elevated and to be sat on a pressure cushion. We observed they were left for at least four hours without a position change, their legs were not elevated throughout this time period and they were not sat on a pressure relieving cushion. This showed staff were not meeting their healthcare needs and the person was at increased risk of developing pressure ulcers. This person also had a pressure relieving mattress on their bed but there were no details recorded on the setting which it needed to be on. This meant staff did not have complete information to meet their pressure area needs. We found pressure area care plans were not detailed enough to enable staff to deliver appropriate care. For example, one person's care plan who was highlighted as being at risk of pressure ulcers stated, 'ensure pressure relief given' but did not describe the details of this or what staff needed to do. This person's records showed the District Nurse had visited in May 2014 following the development of a pressure ulcer but the care plan had not been updated with any new advice following their visit. This meant there was insufficient assessment of people's healthcare needs in order for staff to provide appropriate care.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People said they had access to healthcare professionals and that staff would enable them to access those services. For example, one person said "The staff would sort it out. They would probably know if I needed a doctor." A GP was present for part of the visit and we saw them speaking with people. There was evidence other health professionals were involved in people's care such as GP's and district nurses. Feedback from health professionals was mixed about the effectiveness of care. For example, one health professional told us that overall the care was good, but they had some concerns over people's continence needs being met in a timely way. Another health professional told us they were concerned about the standard of care and said, "If I could move [the person] I would."

We spoke to people who used the service and relatives about the food. Feedback was mixed. One person told us, "The food is okay. I get what I'm given and it's ok." Another person commented, "I am sick to death of soup and sandwiches." People indicated they got choice at mealtimes. One person told us, "I think you do get to choose. I know that if it's something I don't like I can ask them to boil me an egg or something instead." People said they were given plenty to eat and drink. For example one person told us, "We get drinks with our meals and they bring them round in between as well."

We observed people were given some choices, such as a cooked breakfast tailored to their request. However, the menu provided did not demonstrate that people had a balanced diet that promoted healthy eating, for example we observed very little in the way of fresh vegetables on the menu. The choices each evening meal appeared very similar, for example meat or vegetable lasagne, fish or cottage pie. Halal meat was available, however, the cooks told us that all meat used was Halal as this was perceived to be of better quality. However, people who used the service were not given a choice as to whether they wanted Halal meat or not.

We found the mealtime experience required improvement. When we arrived at 8am, people who were up and sat in the lounges. However, breakfast was served late and people were restless whilst waiting for the food service to commence. On the Willow unit, the breakfast service commenced at 09:15, but some people did not receive their breakfast until 10.00am meaning they were waiting for three quarters of an hour at the table, with a number of people complaining about the delay. We saw this experience was repeated in the Aspen unit at breakfast and at lunchtime. Lunch began to be served at 12.30 which meant some people did not receive an appropriate time period between breakfast and lunch. The organisation of the meal service was not conducive in providing a pleasurable meal-time experience for people. We found people were not always given a required level of support with eating. For example, one person kept getting up and walking about during the lunchtime meal service, their soup was left untouched but none of the staff encouraged

this person to eat their soup. We also saw in the Rowan Unit one person in the lounge was seated with their legs over the arms of the chair and a carer sat on a coffee table in front of the resident to assist them. There was no attempt made to help this person sit up properly before they were assisted. People having their meal in the lounge had their trays placed on low height coffee tables, which made it difficult for them to eat without spilling the food. We saw people were offered hot drinks of tea but no saucers were used increasing the risk of spilling.

People's food preferences were recorded on admission and the support required identified. People were weighed on admission and regularly throughout their stay so staff could monitor their risk of malnutrition. People were assessed using nutritional risk assessment tools to determine whether they were at risk of malnutrition. There were a variety of nutritional risk assessments in care plan documentation, some risk scores were inaccurately calculated, which meant that the risk score was not always correct. This increased the risk that malnutrition may go unrecognised. We found where people were highlighted at risk of malnutrition, they were not always referred to the dietician or speech and language therapist:, the stated action on the risk assessment form. Some people were referred to their GP and/or community matron and a food suppliment prescribed, but there was an inconsistent approach, with no evidence that any action had been taken for a number of other people assessed as at risk.

Kitchen staff reported that they were informed verbally by care staff of any special dietary requirements including soft and pureed diets but there was no written confirmation. Given that the home cooked for up to 80 people, this risked that information on people nutritional needs may be missed as nothing was recorded for kitchen staff.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found fluid and food charts were inconsistently completed. Two people's care plans stated their food and fluid input was to be monitored because they were at risk, however their records showed no monitoring of nutritional or fluid intake. This meant no checks could be made to see if they were eating and drinking enough. Two staff members when questioned were unsure why the fluid intake and output chart had not been completed.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because a lack of proper information was recorded about people's food and fluid intake.

We asked people who used the service whether they felt that the staff had the correct skills and knowledge to care for them. Most said that they felt they did. However, one -person told us "There are one or two who could do with more training I think. I'm not always sure that they lift me properly." We raised this issue with the deputy manager for them to investigate. Staff had received a range of training which included moving and handling, fire safety, safeguarding and dementia awareness and challenging behaviour. Training compliance was analysed. Staff were up-to-date with most training and compliance was analysed by the manager so they could monitor this. However, only 13% of staff had received nutrition training which meant they may not have the required skills to ensure people received good nutrition. Induction training was provided which was a mixture of competency based workbook and videos. Staff reported training was timely and effective in enabling them to carry out their role effectively. They said they received regular supervision and appraisal and felt well supported.

Requires Improvement

Is the service caring?

Our findings

Feedback from people about the attitude and nature of staff was mixed. Some people spoke positively about the care provided by staff. One person told us, "I think that I am very well looked after." Another person said, "They know when I'm a bit down and upset and they know just how to talk to me to help me feel better." Two people alluded to less positive relationships with staff. One person told us, "It can depend; one or two can be a bit less friendly." Another person told us about one member of staff that they felt spoke to them in an unpleasant way. They said, "They told me that I was nothing, and that's how they treat me." A visitor told us about concerns that their relative was often left in soiled bedding. They told us "I have arrived to find [the relative] lying in a soiled bed, with their carer seemingly unaware. I've been told that it had only just happened but even their socks were wet – [the relative] must have been like that for some time." This indicated that people were not always treated in a dignified manner.

We saw some good interactions, for example, we observed a person who used the service telling a member of staff that they felt uncomfortable. The member of staff appeared to understand immediately what the person was indicating and adjusted their clothing appropriately ensuring their dignity was respected. We observed several instances of staff speaking to people with patience, warmth and affection. However, staff did not always treat people with dignity and respect. Some interactions appeared entirely task-focused and staff did not engage in chat with people and occasionally undertook tasks without speaking to the person. For example, in one lounge, two members of staff were using a hoist to transfer a person from their chair to a wheelchair. They did not speak to the person as they put them into the sling. They did not offer any reassurance or commentary whilst they were hanging in the hoist waiting to be lowered into the wheelchair. The only time that the staff members spoke was to each other. Another member of staff was assisting a person to drink. They simply told the person, "Here's a drink for you" and broke off giving the person a drink midway through to attend to something else without telling the person why they were leaving. We saw this experience repeated at lunchtime on the Cedar Unit with a staff member breaking away from assisting a person to eat twice to attend to other matters. During the lunchtime meal we observed one member of staff spoke very loudly throughout the meal service to another member of staff, which was not a pleasant environment for people to be eating their lunch in. We also saw some people wearing clothing with food stains on them, and they were not offered the opportunity to change their clothing by staff. In people's bedrooms we observed examples of stained clothing that had been put away in people's drawers. This indicated a lack of dignity and respect towards people.

We observed the television and radio were turned on by staff with no consultation with people as to what they wanted to watch or listen to. When we asked a person whether they had input into the choice of programme they said, "The staff do it, they put it on and that's that." Another said, "I know that there's a remote control but we're not allowed to have it." We saw staff walk past one person who wanted attention and they were ignored. Another person appeared very distressed all day, calling out and shouting but they were not offered any comfort. Other than when engaging in a task with the person, for example being assisted to eat, staff did not speak to the person or otherwise reassure them.

During the inspection we observed a GP conducting patient consultations in the busy lounge area. This included the doctor and nurse on duty discussing people's health issues. This meant confidential issues were being discussed in full earshot of other people. No consideration had been given by staff to ensuring people had privacy during their consultation or to ensure discussions were done in a confidential manner.

This was a breach of Regulation 7 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because people were not always treated in a dignified manner and their privacy was not always respected.

Care plans did not always contain sufficient detail to ensure dignified and personalised care. For example, one person's care plan stated they could communicate in their own language but did not specify which language this was. Another person's care plan stated they were unable to have a basic conversation, however, during the inspection we were able to have a conversation with them about football. A number of care plans were missing life histories and there was only limited information about people's preferences. This indicated staff had not taken the time to obtain and record proper information on people's likes, dislikes and preferences so individualised care could be provided.

Requires Improvement

Is the service caring?

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People reported that they there were not any restrictions placed on visitors. One person told us, "I get quite a few phone calls." Relatives told us they could visit when they wanted.

We asked people whether they felt that the staff listened to them. Most told us they did, using phrases like "I'm always talking to them," and "You can just chat to them." Periodic surgeries were held where management would engage with people to hear about any issues or problems they had. Feedback had also been obtained from surveys and resident meetings indicating there were mechanisms in place to listen to people.

Inadequate

Is the service responsive?

Our findings

Care plans did not contain enough information about people's needs for staff to deliver responsive care. For example, medical histories were brief, one care plan stated "bowel cancer" but did not provide any further details, and others said "dementia" but did not record the type of dementia. Care plans often did not offer solutions or strategies for staff to follow. For example, one care plan highlighted the risk of a person parking their wheelchair in inappropriate places such as the corridor, but the monthly care plan updates just confirmed this was still a problem rather than offering any strategies for re-solving the problem. During the inspection we saw this person was sat in their wheelchair blocking the corridor unaware of any potential risks of this behaviour. This indicated staff had not effectively controlled the risk they had identified.

Assessments were not responsive to people's needs. For example one person no longer had their urinary catheter in situ but there was no interim plan in place for managing their continence needs. Another person, we observed had smeared faeces around the home. On speaking to staff this was clearly a problem that had been occurring for a number of weeks. However, there was no care plan responding to this problem guiding staff on how to manage the person and meet their needs. Behavioural care plans were not responsive following incidents. For example one person was frequently aggressive towards staff and people who used the service. However, their behavioural care plan had not been updated with new care strategies to reduce the likelihood of further incidents.

Care was not always delivered in line with care plans. We found people's personal care needs were not being met. For example, one person's care plan stated they should receive support to use the toilet every two hour, but records showed three to four hours between support. The person's records also stated they should be supported to shower daily but there were only 15 showers recorded since 14 January 2014. Another person's care plan stated they should be supported to shower two to three times a week; however, their last documented shower was 12th July 2014. This person looked visibly unclean, their care plan said nails should be kept clean, they were dirty. Another person's care plan stated they should be wearing glasses, we observed they were not wearing them until 15.00hrs when we raised this issue with a member of staff, who went to get this person's glasses. Another person's care plan stated that staff should assist them to wear appropriate footwear. The slippers looked too large and the person confirmed to us they were too big and uncomfortable. People were observed wearing clothing with food spills/stains on it and were not assisted to change. We observed some people who required assistance from staff had not had their hair brushed or combed. This indicated people were not receiving appropriate care.

We observed one person who was in discomfort; this person was putting their fingers in their mouth and rubbing their gums. They were visibly distressed. When we asked staff, they said their teeth were falling out and they had been seen by the dentist. However when we looked in their care plan, there was no evidence of any dental input or advice for staff to follow. Our observations concluded that staff did not know how to comfort this person or meet their needs as they were left in a distressed state with no contact from staff for long periods of time.

Some entries in care plan documentation were illegible. This meant staff could not review whether people were receiving appropriate care. In August 2014, we received a complaint from another healthcare organisation, part of which stated they were concerned that they were unable to review care records in an emergency situation due to illegible handwriting. We showed records to the deputy manager who confirmed the records were illegible and said they could not read them. They told us they were aware that some staff had poor record keeping and would ensure their record keeping improved. This risked inappropriate care and treatment as legible information on people's care was not always recorded.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People provided mixed responses about the standard of care. One person told us, "I picked here based on the atmosphere when I came for a look round. I thought it suited me, it was nice and quiet." Another said that they had picked the home based on experience of it. They told us "I used to come here and visit a friend of mine, and I thought it seemed alright. It took me a while but I feel quite settled now." However, we did receive some negative comments. One person told us that they did not really like where they lived. They said, "I want to move somewhere else, and I think my family are looking into it. One or two

Inadequate

Is the service responsive?

things have happened that have put me off. Some of the staff are unfriendly sometimes and it's hard to get help sometimes. I'm not incontinent but I've had a couple of accidents because no one came to help me. It upset me."

People reported there was not enough to do in the home. Most were critical about the activities on offer, using phrases such as "boring" and "not much apart from the television." Our observations confirmed this. People were mainly left sitting in the lounges with little interaction between them. People had no access to any stimulus other than the television and they looked bored. The atmosphere in all the living rooms was very flat. One person told us, "There's never much to do. I like to sit and do a crossword sometimes." An activities programme was displayed on the wall, however the activities co-ordinator and our observations confirmed this was not followed. For example baking was advertised but we did not see this going on and one person told us they had never done baking at the service even though it was a hobby of theirs.

People said they would speak with staff if they had any concerns. There were notices in the reception area giving information as to how to raise concerns either with management or statutory bodies. Several 'thank you' cards were also displayed. We looked at recorded complaints and saw that written complaints had been appropriately responded to within the given timescales. However, given comments passed to us by relatives, it was evident that not all verbal complaints were recorded. The deputy manager told us they did not record some verbal complaints such as missing laundry. However, this was a missed opportunity to demonstrate they did listen to people and acted on information received.

Inadequate

Is the service well-led?

Our findings

A registered manager was in place on the date of the inspection. We found seven notifications of abuse which should have been submitted to the Care Quality Commission (CQC) had not been. This is a breach of Regulation 18 Health and Social Care Act 2008 (Registration Regulations) 2010. We are currently considering our regulatory response to this breach.

Inadequate systems were in place to ensure the delivery of high quality care. During the inspection we identified failings in a number of areas. These included dignity and respect, nutrition, care and welfare, managing risks to people and staffing levels. These issues had not been identified by the provider prior to our visit, which showed there was a lack of robust quality assurance systems in place. The registered manager confirmed there was no improvement plan in place or action plan to improve the service and they were waiting for CQC's findings to action improvement. As part of a robust quality assurance system the manager should actively identify improvements on a regular basis and put plans in place to achieve these and not wait for CQC to identify shortfalls.

With regards to Infection Prevention, some issues had been identified by the local authority infection control team, who conducted an audit at the home in April 2014. They had identified issues such as dried faeces on commodes and toilets, unhygienic flooring, and stains on chairs. We found these issues were also present during our inspection, which demonstrated the provider and manager had not taken satisfactory action following the audit. There was no evidence of any more recent infection control audits/ environmental audits to monitor cleanliness and hygiene in the home on an ongoing basis.

The provider did not have a formal system to assess and monitor the quality of care provided to people or to manage risks of unsafe or inappropriate treatment. There was no evidence of recent quality monitoring of care documents at the home. We saw care plan audits had been undertaken in 2013 but there were no more recent audits. We found some care plans lacked detail and others did not contain appropriate advice for staff to follow. Other care plans were missing information about people's preferences, life histories and mental capacity assessments. We found various instances of care not being delivered in line with people's care plans. These issues could have been identified through a formal system to assess and monitor the quality of care. Nutrition audits were undertaken in 2013 but there were no more recent audits looking at whether the quality of food or mealtime experience was suitable.

There was no formal system in place to assess and monitor staffing levels. Although each person had a dependency tool within their care plan to determine the level of support they required, there was no evidence this was used to calculate staffing levels within the home. We found staffing levels were inadequate which could have been identified and rectified through observations and/or the use of a formal staffing level tool.

Given the provider was registered to provide care for up to 80 people spread over four units the presence of a structured and effective quality assurance system was essential in order for management to receive assurance regarding the performance of different areas of the home.

Where issues or improvements had been identified, we saw appropriate action had not always been taken to address. For example, the resident and relative surveys' completed in late 2013 had identified that lack of activities for people was an issue. During this inspection, feedback from people was that there was not enough to do and we observed there was inadequate stimulation for people. This showed that the organisation had failed to make appropriate improvements based on people's feedback.

We saw that a complaint had been received from a health professional on the 7 August 2014, concerned that people who used the service were wandering around and one person had been crying continuously. Although this complaint had been responded to by the manager, during the inspection we also found this was an ongoing issue. We were particularly concerned about the welfare of this person and the lack of comfort given to them by staff. This indicated that once an issue had been raised with the home, insufficient action had been taken to respond to it.

Risks to people's health, safety and welfare were not appropriately reported, managed and analysed. For example, we found numerous incidents of violence or aggression against staff or people who used the service which were recorded in people's care plans but not reported on the provider's incident form. This meant there was no evidence these issues had been reported to management for action. Where incidents had been

Inadequate

Is the service well-led?

reported, the incident form was not fit for purpose, there was often insufficient space on the incident form to detail preventative measures taken to drive improvement. Staff were having to write details of the incident on the blank reverse of the form. We saw actions were not detailed enough to assure us that strong action had been taken to learn lessons from incidents. We found incidents such as people throwing tea, were re-occurant, indicating incidents were not managed appropriately to ensure a positive outcome for people who used the service.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We observed a poor atmosphere in the home, with most of the communal areas populated by people and staff who seldom interacted with each other. We did not observe many examples of staff trying to engage with people who used the service or lift the atmosphere. There was no evidence of good leadership on the units by senior staff to improve the experiences for the people who lived there. Whilst people did demonstrate that they recognised and knew the staff none were able to tell us about the registered manager of the home which indicated they were not always visible and known to the people who used the service.

Staff spoke positively about the registered manager and said they were able to raise concerns with them and were confident action would be taken to address. Staff meetings took place periodically and there was evidence that issues were discussed with staff such as complaints, and care issues, indicating that management had identified some incidents of poor care practice and raised with staff to make improvements.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services Regulation 17 (1) (a), The registered person must, so far as reasonably practicable make suitable arrangements to ensure the dignity, privacy and independence of service users. Regulation 17 (2) (a) The registered person must treat service users with consideration and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 (1) (a) Where food and hydration are provided to service users as a component of carrying out the regulated activity, the registered person must ensure that service users are protected from the risks of inadequate nutrition and dehydration, by means of the provision of a choice of suitably nutritious food and hydration in sufficient quantities to meet service users needs. Regulation 14 (1) (c) Support where necessary, for the purposes of enabling service users to eat and drink sufficient amounts for their needs

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 (1) (a) The registered person must make suitable arrangements to ensure that service users are safeguarded against the risk of abuse by means of – Taking reasonable steps to identify the possibility of abuse and prevent it before it occurs.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing Regulation 22 – In order to safeguard the health, safety and welfare of service users, the registered person must take appropriate steps to ensure that, at all times there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purpose of carrying on the regulated activity

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records Regulation 20 (1) (a) The registered person must ensure that service users are protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of an accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided to each service user.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 (2) - People were not protected against the risks of acquiring an infection as the maintenance of appropriate standards of cleanliness and hygiene were not met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 (1) - People were not protected against the risks of receiving care or treatment that was inappropriate as an assessment of people's needs was not carried out and care was not planned and delivered to meet people's individual needs.

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 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers Regulation 10 (1) – People were not protected against the risk of inappropriate care and treatment as the quality of the service was not regularly assessed and monitored. Risks to people's health and welfare were not identified, assessed and managed.