Care Quality Commission

Northfields Care Homes Limited

Sunnyside Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

The inspection of Sunnyside Care Home took place on 3 and 11 June 2015 and was unannounced. We previously inspected the service on 19 November 2013. The service was not in breach of the Health and Social Care Act 2008 regulations at that time.

Sunnyside Care Home is a converted property which is registered to provide accommodation and personal care for up to 30 older people. On the day of our inspection there were 27 people who had been assessed as having nursing needs, many of who were living with dementia, who were resident at Sunnyside Care Home. The home provides accommodation on the ground and first floor, with a dining room and a number of communal lounges on the ground floor.

The service did not have a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008

Summary of findings

and associated Regulations about how the service is run. A new manager had commenced employment at the home three days before our inspection but had not yet commenced their application to register with CQC.

People who lived at the home told us they felt safe, however, staff were not clear about different types of abuse. We saw evidence of a potential safeguarding incident which the team leader had not been made aware of and therefore the incident had not been reported to either the local authority safeguarding team and/or CQC.

We could not evidence that peoples care and support was planned and delivered with the consent of the relevant person. This evidenced a breach of regulations 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff lacked knowledge and understanding of the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005. We saw evidence that people's freedom of movement within the home was restricted by the use of key coded locks. We were told that no applications had been made to the local authority in regard to the restrictions placed on people's freedom. These examples evidenced a failure to comply with the requirements of the Mental Capacity Act 2005.

This evidence demonstrated a breach of regulations 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home was poorly maintained and had not been adapted to support people who were living with dementia to live well. There was no signage to direct people where they were or the locations of the rooms, for example the dining room. There was a lack of sensory stimulation for people. These examples demonstrated a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also noted a number of concerns relating to poor management of infection prevention and control procedures. Two toilets were contaminated with faeces and two commode pans were urine stained. We also saw two easy chairs in people's bedrooms which were not clean. This demonstrated a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staffing level at the home had recently been increased following a request by the local authority.

There was a system in place for the receipt, storage and administration of medicines. However,

Medication Administration Record (MAR) did not detail the time that time critical medicine was administered.

We were not able to evidence staff received induction, regular training or supervision to provide them with the skills to perform their roles safely and effectively. This demonstrated a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People told us the food they received was good. The food served to people on the day of our inspection looked appealing.

People told us they were happy with the care they received and the staff treated them with dignity. During our inspection we saw staff supporting people in a kind, caring and dignified manner. However, we also saw a number of examples where staff did not demonstrate respect towards people's preferences, needs or possessions. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw minimal evidence that people who lived at the home were engaged in meaningful activities. Relatives told us there was little stimulation or activities for people and two people who lived at the home told us they would like to go out more. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Many of the relatives we spoke with told us they thought the service was well led because the care was good and staff felt the management were supportive.

People's records were not an accurate reflection of the care and support they required. There was no evidence that the registered provider had a system in place to monitor and assess the quality of the service provided to people. Peoples records were not always accurate and did not consistently provide enough detail to ensure peoples support needs were met. These examples demonstrated a breach of regulation 17of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Summary of findings

The overall rating for this service is ‘Inadequate’ and the service is therefore in 'special measures'.

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

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

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

People were not adequately protected from the risk of abuse or harm.

People were at risk of injury or harm due to a failure to ensure the premises and equipment were safe, clean, suitable and well maintained.

Staffing had very recently been increased as a result of the local authority expressing serious concerns to the registered provider about inadequate staffing levels at the home.

Medication administration records were difficult to decipher and were unclear as to the time of administration for time critical medicine.

Inadequate

Is the service effective?
The service was not effective.

There was no evidence that staff received appropriate or adequate induction, training or supervision.

No DoLS application had been submitted to the local authority for people whose freedom was being restricted. We could not clearly evidence people's care and support was delivered with relevant consent.

The home had not been adapted to provide appropriate support to people who were living with dementia.

Inadequate

Is the service caring?
The service was not always caring.

People told us staff were kind and caring.

We saw a number of examples where people's dignity was not respected by staff.

People and/or their relatives were not actively involved in the care planning process.

Inadequate

Is the service responsive?
The service was not always responsive.

People were not engaged in meaningful activities.

People and their relatives told us they would raise any concerns they had with a member of staff.

Inadequate

Is the service well-led?
The service was not well led.

There was no evidence that people who lived at the home or, where appropriate their relatives had been asked for feedback about the quality of the service provided.

Inadequate

Summary of findings

Peoples care records were not accurate and fully reflective of their care and support needs.

There were no effective systems in place to monitor the quality of the service.

Sunnyside Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 3 and 11 June 2015 and was unannounced.

The inspection team on 3 June 2015 consisted of four adult social care inspectors, one adult social care inspection manager and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for a person who uses this type of care service. The expert by experience on this occasion had experience in providing care and support to older people. The inspection team on 11 June 2015 consisted of one adult social care inspector. Before the inspection we reviewed all the information we held about the service including notifications. We had also received information of concern from the local authority regarding staffing, care and welfare of people who lived the home and safety and suitability of the premises. We had not sent the provider a 'Provider Information Return' (PIR) form prior to the inspection. This form enables the provider to submit in advance information about their service to inform the inspection.

We used a number of different methods to help us understand the experiences of people who lived in the home. Not all the people who used the service were able to communicate verbally, and as we were not familiar with everyone's way of communicating we were unable to gain their views.

During the inspection we spoke with three people who lived at the home and three visiting relatives and four relatives on the telephone. We also spoke with quality manager, the team leader, a registered nurse, three care assistants, four ancillary staff and a management consultant who was providing support to the new manager.

We spent time looking at five people's care records and a variety of documents which related to the management of the home, including, personnel files, staff training records and maintenance of the home.

Inadequate

Is the service safe?

Our findings

During our visit we asked people whether they felt safe in the home. They each told us they felt safe living at the home and they felt that that their possessions were safe. All of the relatives we spoke with, except one, also thought their family member was safe living at the home.

When we spoke with staff about safeguarding people, feedback was mixed. One staff member said, "Yes, I feel that residents are safe, I have never seen anyone being badly treated and would tell the manager straight away if I was worried." Another staff member we spoke with could not recall having undertaken any safeguarding training, however, they said if they thought anyone was at risk of harm they would report this to a more senior member of staff. Two of the staff we spoke with were not able to describe different types of abuse other than physical abuse. This showed the registered provider had failed in their responsibility to ensure all staff were aware of their responsibilities in relation to safeguarding the people they cared for.

We looked at a random selection of staff handover records. One of the records dated 23 May 2015 detailed a potential safeguarding issue, we asked the team leader if this matter had been reported to the local authority safeguarding team and to CQC. They told us they were not aware of the information which we had seen recorded on the handover sheet. This demonstrated not all staff were aware of their responsibility to report potential safeguarding concerns to their manager. Following the inspection we asked the manager to investigate this matter further.

During a period of observation in one of the lounges we observed a person becoming agitated as they walked towards another person who was sitting in a chair. A staff member intervened but did not effectively de-escalate the situation as the person did not respond to them when the staff member asked them to move away from the person who was sitting down. When the person ignored them, the staff member did not act to protect the person by asking for assistance from another member of staff, therefore we asked another member of staff to intervene.

These examples demonstrate the registered provider failed to ensure people living at the home were protected against the risks of abuse. This is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw one person with a bruise and a slight graze on their face. We asked a member of staff if they knew the cause of the bruising. They told us the person had been found with the injury and the cause was unknown. We asked to look at the accident records for the service and saw there was no record of any accidents or incidents after April 2015. We also saw the analysis of accidents and incidents had not been completed since the departure of the registered manager at the beginning of May 2015. This evidenced accidents were not being recorded and analysed to monitor for patterns and themes. Analysis of accidents and incidents provides opportunity to learn from the incident and implement preventive measures to reduce the potential for a recurrence.

This demonstrated the registered provider failed to maintain accurate, complete and contemporaneous records in respect of each person. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our visit we made an inspection of the premises. This included looking in some people's bedrooms, communal bathrooms and toilets, lounge and dining areas, the laundry and kitchen. On the ground floor we saw a hatch door, when we opened the hatch it revealed a chute to the laundry room located in the cellar. Access to the chute was not restricted and the hatch door was not secured. We spoke to the management consultant and the manager and asked that they take urgent action to ensure people's safety. We received an email the day after the inspection to confirm the hatch door had been secured.

We saw two sets of bed rails which were dangerous and presented a significant risk of entrapment to the people using them. The team leader told us this risk had already been identified and new beds and safety rails had been delivered to the home and were in the process of being fitted that day.

We also saw a number of examples of poor maintenance of the premises. For example, latches on a door gate were loose and poorly fitted, a door handle of an en-suite had

Is the service safe?

broken and was placed on top of the chest of drawers, two wash basins in bedrooms had no plugs and where a radiator cover had been 'cut' to fit around the wood work there were sharp edges.

There was a smoking area, an external area built into the centre of the home. The surface was decking which was uneven and had weeds growing through. There was a table with two large metal food cans which were used as ashtrays, there were also two wooden planters in the corner against the building which were used for cigarette butts and rubbish. This posed a fire risk and was not an aesthetically pleasing environment in which to sit.

A member of staff showed us the garden to the rear of the home. They said this had been a very useful area where people had been able to sit out and meals had been served there in the warmer months. We saw the surface was wooden decking which was warped and uneven, a number of large established weeds had grown through the decking. There was also general rubbish, upturned garden furniture and an open parasol which was upside down. There was damage to some of the fencing with pieces of wood hanging off. The member of staff told us the rear garden was unsafe and dangerous therefore people could no longer access it.

These examples demonstrated a failure of the registered provider to ensure the premises and were properly maintained and fit for purpose. This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw evidence of service and inspection records for a variety of equipment including the passenger and stair lift, gas installation and fire detection system. We also saw evidence that the fire alarm and emergency lights were tested weekly to ensure they were in working order. We saw a document entitled 'Sunnyside fire list', this detailed people's name, bedroom number and the support required in the event they had to be evacuated from the building. This list was dated 17 October 2015, when we checked this against the list of people who were living at the home we saw one person who was not on the list. This meant there was a risk this person may not receive the support required in the event of an emergency. Following the inspection we asked the manager to ensure this information was up to date.

During our inspection of the home we found a number of concerns which evidenced a lack of effective management of infection prevention and control procedures. We found two toilets which were contaminated with faeces, two commode pans which were urine stained and commode seats which were discoloured. We also saw faeces marks on a set of bed rails and a pair of curtains.

We saw liquid soap and paper towels were available in communal toilets and bathrooms. In people's bedrooms, paper towels, liquid soap and gloves were stored in a basket at the bottom of each person's wardrobe, even if the person was not mobile and/or at risk of harm from these items. This meant these items were not accessible for staff to use.

We saw a number of duvets and pillows in the home which were not made of impermeable material. Some of the pillows we saw that were impermeable, the cover was scratched and damaged. The majority of the waste bins in peoples bedrooms did not contain a bin liner which meant the inside of the bin may become soiled and harbour dirt. We saw the easy chair in two of the rooms we looked at contained food debris under the seat cushion. One of the chairs was also visibly soiled under the seat cushion and on the chair base. We saw a build-up of dust on skirting boards, particularly under radiators and in the tracking of the stair lift. This demonstrated a lack of effective cleaning.

There were two white coats hung outside the kitchen door. During the period of our inspection we saw staff put these coats on over their uniforms prior to entering the kitchen. We saw both the coats were visibly soiled and stained. Parts of the material appeared grey in colour rather than white due to lack of cleaning. This showed the coats were not laundered on a regular basis.

These examples demonstrated a failure of the registered provider to maintain appropriate standards of cleanliness and hygiene. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Five of the seven relatives we spoke told us they thought there were enough staff to meet people's needs. One relative said "Whenever I come to visit, whatever time of day, there always seem to be enough staff to do what's needed." Another relative said, "Staffing has been an issue at times, they are doing their best but staff have been little bit lacking in numbers at times."

Inadequate

Is the service safe?

Prior to our inspection a contract compliance officer from the local authority had visited the home. They had expressed serious concerns to the registered provider about inadequate staffing. They had requested the staffing levels at the home be reviewed.

We asked staff if they felt there were enough staff to meet people's needs. They told us staffing had improved since the visit from the local authority. One staff member said, "Until this week there weren't enough staff to care for people properly."

When we spoke with the team leader they told us they wanted to assess people's needs to ensure the 'right number of staff with the right skill mix' were available. They showed us the duty rota for a three week period. They said that since the local authority had told the registered provider to increase staffing levels on some of the shifts, these extra shifts had been covered by staff already employed by the registered provider and other shifts had been covered by agency staff. We saw from the duty rota that prior to the visit by the local authority there were no dedicated kitchen staff to cover the tea time period at the home. This meant a member of care staff had to leave their care duties and go into the kitchen to serve teas and clear away afterwards. We saw that action had since been taken to provide an extra member of staff in the kitchen between 2pm and 5.30pm. This meant care staff were able to prioritise supporting people with their tea time meal.

Throughout our inspection we saw periods when there were no staff available to support people. For example during a period of observation between 9:30am and 10:00am one inspector saw that there were occasions where no staff were present in two of the adjoining lounges to support people's needs. Assistance from staff had to be requested by the inspector. A nurse had been present in this area but they were tasked with administering people's medicines and this took them away from the lounges for significant periods of time.

We looked at the personnel files for three staff. We saw staff members had completed an application form, references had been sought and they had been checked with the Disclosure and Barring Service (DBS) before they started work at the home. The DBS has replaced the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA) checks. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups. However, in two of the files we looked at we saw these checks had last been carried out over nine years ago. We asked the manager and management consultant how often staff should have their DBS rechecked and they told us they did not know. This meant there was no system in place to ensure staff remained suitable to work with vulnerable people.

During our visit we looked at the systems in place for the receipt, storage and administration of medicines. Medicines were supplied in both MDS and bottles and boxes. We saw that the medicines prescribed to be administered at 10 am were still being administered at 12.25pm. The nurse said this was due to them having to carry the telephone and deal with any telephone calls coming into the home. We asked if this was usual practice and the nurse said it was. Having distractions and interruptions when administering people's medicines can increase the risk of an error being made.

We asked if there were any medicines where the administration was time critical for people. The nurse told us they thought all medicines were time critical. We suggested two medical conditions to the nurse where it was important for people to receive their medicine at a specific time. They told us about one person who they said received their medicine at the correct time, however, the Medication Administration Record (MAR) did not detail the time the medicine was administered. This meant we were unable to clearly evidence this person had received their medicine at the correct time.

Where people were prescribed 'as required' or PRN medicines, a stock sheet was in place to enable staff to keep a tally of the amount of medicine available after each administration. We found the stock sheets did not tally with the number of medicines held at the home. For example, we found one person's MAR evidenced they had 56 tablets still available; however there were only 52 tablets available. When we counted the amounts administered we found that 52 was the amount that should be left. We found similar discrepancies with other medicines. This meant that nurses were not accurately counting tablets remaining in stock when recording the on-going balance.

When we looked at people's MAR sheets we found it was difficult to tell if the record of administration was a signature of the nurse or a recording code. For example NR, the code for not required, was very similar to a signature of administration. Other records of administration were also

Inadequate

Is the service safe?

difficult to read. We asked the nurse if they could read the information on the MAR sheets but they also had difficulty in deciphering what were signatures of administration and what were recording codes. This presented problems when staff were tallying the amount of medicine available against the amount received and the amount administered.

We looked at the storage and administration records of a controlled drug (CD). We found storage arrangements to be appropriate and administration records accurate. We also saw that medicines were kept safely and that storage temperatures were recorded daily for the room and the medicine fridge.

Inadequate

Is the service effective?

Our findings

People we spoke with told us they thought staff had the skills to provide the care and support they, or their family member required. However, one relative said they did not think the staff were trained to deal with the behaviour their family member exhibited or in managing the reactions of other people to that behaviour.

We spoke with a member of staff who had recently been employed at the home. They told us they had shadowed another member of staff for their first three shifts, however, when we looked in their personnel file we could not see documented evidence of any formal induction process. We also spoke with another staff member who told us they were employed at one of Sunnyside's sister homes but had begun working at the home a few days earlier. They said they had not looked at any care plans and did not know people. When we asked about this, they said, "I haven't had chance. You just get thrown in there".

We asked the team leader if staff from the registered providers other homes who were helping to cover the extra shifts at Sunnyside had received any induction. They said the staff had been told at handover about the fire procedure and worked with an experienced member of Sunnyside's staff. However, on the day of our inspection we saw a new member of staff trying to support people without the presence of Sunnyside staff to guide them. We asked if these staff had received any formal, recorded induction pertinent to Sunnyside and they told us they had not.

We asked staff if they received regular training, one staff member said, "We have regular training every six months, for example moving and handling training, we also have regular updates on dementia training, the last one was last year, I can't remember exactly when but we all met together it was a mixture of being taught, discussions and written work." Another staff member told us, they had not worked specifically with people living with dementia in their previous roles. They said they had asked for training in this subject when they were recruited but they had not received any.

We looked at the training records for three members of staff. The certificates were filed randomly and some of the training was not current. For example, one had not updated safeguarding training for two years, another had no record of moving and handling training since 2010. We asked the management consultant and the manager if the registered provider had a matrix which detailed all the staff and relevant information regarding the date and subject of training courses they had attended. They told us they had not been able to locate one and did not think one existed. We also looked at how often staff received supervision with their manager. In the three files we looked at, two staff had no recorded supervision since 2012 and one had no record of having received supervision at all. One of the staff we spoke with said "I last had supervision with someone who has since left, that was a good few months ago and I haven't had any supervision since then." Another staff member said they thought they had last had supervision six months ago.

These examples demonstrated the registered provider failed to have suitable arrangements in place to ensure that staff were appropriately supported. This also demonstrated the registered provider failed to ensure staff received effective induction and training in relation to their responsibilities, to enable them to deliver effective care and support to people. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

We observed key code locks on internal doors to corridors, the dining room, a toilet and to a secure garden. Staff could not tell us why these had been put in place. One staff member said the doors were locked to 'keep people safe'. One person who lived at the home required a member of staff to support them constantly from 7am to 9pm each day. We were also told about another person, who was not allowed outside even under supervision as 'they run away'. The team leader told us no applications for a DoLS had been submitted for anyone at the home. This process is carried out if the service needed to make a decision on someone's behalf and ensures the decision involves the relevant professionals and is made in the persons' best interests.

Inadequate

Is the service effective?

These examples evidenced the failure of the registered provider to comply with the requirements of the Mental Capacity Act 2005.This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked three staff about their understanding of the MCA and DoLS in relation to their work. None of them were able to explain the significance of this legislation on their role. One said, "Yes I have heard of that it rings a bell." This showed that staff were not aware of their responsibilities under this legislation.

We found a lack of documentation in peoples care plans to evidence staff had obtained consent from people for the care and support they received or to evidence staff were acting in accordance with people's wishes. For example, a document in one persons care plan recorded 'capacity assessed' but did not detail when the assessment had been completed or by whom.

One person's bedroom was devoid of furniture or soft furnishings and the walls were covered in wipeable shower panels. When we looked in this persons care plan we could not find any evidence to support why this person was being cared for in this environment. Following the inspection we spoke with the registered provider on the telephone about this. They told us the previous registered manager, a member of the care staff and themselves had made the decision to support this person in this bedroom. We asked if they had requested guidance from any other health care professional prior to making this decision and they told us they had not. We also asked if they had taken any steps to ensure they were acting in the persons best interests and they told us they had not.

These examples evidence a failure of the registered provider to people's care and support was delivered with the consent of the relevant person. The registered provider had failed to act in accordance with the requirements of the Mental Capacity Act 2005. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was no indication the home provided a suitable environment for people who were living with dementia. The home was difficult to navigate as there was no colour coding of doors or signage, for example to the dining room or lounges. Toilets did not have any signs of identification on the door, for example, we opened an unmarked door in a communal area to see a toilet and wash basin. We heard a person tell staff they needed the toilet, they asked staff to take them as they said they would 'get lost'. This demonstrated the environment was not conducive to promoting peoples independence.

There were four lounges in the home, in one there was classical music playing and one lounge with a TV playing which no-one was watching. The TV was mounted high on the wall above the fireplace and was difficult to see. There were two other lounges with no resources or stimulation visible.

Throughout the home there were no areas for people who were walking with purpose to enjoy as they moved around the home and no items for people to engage with such as rummage boxes, sensory or tactile displays, magazines or craft equipment. Chairs in the lounges were arranged around the walls and were not conducive to people engaging with each other.

These examples demonstrated a failure of the registered provider to ensure that premises and equipment were suitable for the purpose for which they were being used. This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with all told us that the food was good and that they looked forward to their meals. One person said "I get a good breakfast in the morning and then two cooked meals later. There's always plenty of food and its good stuff." Three of the relatives also told us they were pleased because their relatives had put on weight since living at the home.

Catering staff told us they were made aware of people's dietary needs and we saw records were kept in the kitchen of people's individual preferences and requirements. Catering staff were clear on different types of consistencies of food, such as for liquidised or soft diets for example and we saw these were noted on people's diet sheets. Staff told us there were no people in the home who chose a vegetarian diet, although each day a meat option and vegetarian option was offered.

The white board in the dining area detailed the lunch and tea menu. We saw lunch comprised of a choice of two main course and three puddings, including fresh fruit. For tea there was a choice of three savoury options and four puddings, again including fresh fruit.

Inadequate

Is the service effective?

We saw that the lunch served on the day of our inspection looked appetising and there was a choice of two meals for lunch and tea. We observed staff asking people for their choice of meal as the lunch was being served. We observed two people did not eat either of the meals on offer and they were given an alternative. The pureed meals were well presented with each food being separately blended. In the dining room at lunchtime we saw that some people were provided with adapted cutlery and plate guards to enable independent eating.

We saw care staff prompting people to eat or finish their meal and we saw care staff supporting some people fully with their meal in a kind and patient manner. We also observed care workers support two people who ate their lunch in their bedrooms. The support was offered in a patient and sensitive manner.

We heard staff ask people in the dining room if they had finished their meal and ask if they wanted anything else. People were offered choices of juice, fizzy pop or hot drinks with their meals.

We observed warm drinks being served mid-morning and mid-afternoon. We also noted that people who were able to communicate their wish for further drinks during the day had their requests met. Other people who were not able to verbally communicate were not offered the extra drinks. We also noted that some people who were asleep when staff served warm drinks did not receive a mid-morning or mid-afternoon drink.

We saw documented evidence where people had received the input of external healthcare professionals. For example, GP, dietician and optician. People we spoke with told us that GPs were called if they, or their family member, needed medical attention. One relative said “The staff always contact me if (relative) needs a doctor and that’s good because I know they’re on top of things.” Another relative said, “The staff phoned me to let me know that (relative) had started leaning to the left and they said that they had phoned the GP. The GP had visited and the staff let me know that there wasn’t anything to be concerned about.” This showed people who lived at the home received additional support when required for meeting their care and support needs.

Inadequate

Is the service caring?

Our findings

All the people and relatives we spoke with were complimentary about the staff and the standard of care they received. Comments included, "I like living here. The people are nice."; "The carers here are just wonderful. I'm treated very well." and "They're fantastic, every single one, just fantastic."

One person told us they were very happy with their care, "They (staff) do things the way I like. Sometimes I don't want a shave and they let me be. Other days I do". Two people told us they could get up and go to bed when they liked and could go to their bedrooms if they wanted to spend time on their own.

People told us that they, or their family members, were treated with dignity and respect. We saw staff knocking on bedroom doors and we heard respectful and polite communications, using people's names. We observed a person being transferred from their chair to a wheelchair, with the use of a hoist, staff ensured that the clothing of the person was covering the person appropriately. We also observed another member of staff ask a person if they would like assistance to go to the toilet and this was done in a discreet and appropriate manner.

However, we also noted a number of examples where people's dignity was not respected. We saw a member of staff asking people at lunchtime if they wanted a "pinny". One person appeared embarrassed by this reference and said they did not want it. We heard the staff member say, "I think you'll need it." and put the apron on them anyway." We also observed a staff member supporting a person with their lunch in the lounge. They told the person the meal was steak pie but did not inform them of any other components to the meal. They placed the plate where the person could not see it. When we asked why, they said the person would 'grab it'. During our observation the person made no attempt to grab the plate. We saw another member of staff supporting someone with their lunch who did not speak to the person while they were supporting them, but who spoke loudly across the room to the other staff member.

We saw one person's bedroom was devoid of any soft furnishings or furniture other than a bed. The wall coverings were wipeable showerwall panels and the floor was hard, non-slip material, the window was too high to enable the person to see out of it. We saw staff enter the person's bedroom, however, at the time of our observation the person was seen to be laying on their bed without any bedclothes for comfort. We spoke about this with the management consultant who told us they had noted this already, they assured us they would review this person's bedroom to ensure it was appropriate.

When we looked in peoples bedrooms we found a number of items of underwear which had been placed in the wrong drawers. We also found a hairbrush with a person's name clearly written on it, in a communal bathroom. In one of the bedrooms we looked at the person had brought in a large piece of furniture. The furniture had not been used to display their personal effects, instead miscellaneous bits and pieces including wipes, shoes, old care records and a dirty hair brush had been randomly put in the unit. This demonstrated a lack of respect for this person's personal belongings and a lack of awareness of how personalising a bedroom can help to create a sense of familiarity and make a person feel more comfortable.

These examples evidenced people's dignity was not respected by staff. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with did not know about their care plan, but told us they did not wish to know anything more about it. One person said "I'm happy getting the care I need. That's all I need to know." Relatives we spoke with told us they had some knowledge of the care planning system. One relative said, "I have seen (family member)'s care plans, I always have a look but they do keep me updated on what's happening. I met with them initially and helped draw up the plans for their care when they first came here but haven't been asked to a meeting since then." However, another relative whose family member exhibited behaviours which challenged others told us they had not been involved in any conversations about strategies staff could employ with their family member. This demonstrated that people and/or their relatives had not been consulted about the care and support provided for them.

We observed one person who was not independently mobile did not get supported with their continence needs all day. Another person's care plan detailed they required support with elimination needs every two hours, we observed this person for at least three hours and their continence needs were not checked by staff. Some people's

Inadequate

Is the service caring?

fingernails were soiled and we saw a number of people whose hair was unkempt. This indicated staff had not taken the time to support people with their personal care in a way which would promote their dignity.

These examples evidenced people's care and support was not appropriate to their individual assessed needs. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Throughout our visit we observed many staff interactions with people which were kind, caring and patient. We heard staff greeting people kindly by their names and speaking sensitively with people who appeared distressed. We also observed staff accompanying people who were walking in the corridors, speaking reassuringly with them.

Staff offered people basic lifestyle choices, for example, what they would like to eat and drink and we observed staff wait patiently for appropriate responses from people. We heard care workers patiently answer a person who repeated the same questions throughout the day.

Some of the staff we spoke with and observed demonstrated knowledge and understanding of the people they supported. For example, one staff member told us about the employment history of one person who lived at the home, they said, "One of the clients (person) I know used to work in a mill, so we sometimes talk about that with them. We often bring things in for people that we think they will like, one person likes hair slides and things like that, so we bring things in that we think she will like – it's great to see her face light up – she really appreciates this and we like to do this for her."

Inadequate

Is the service responsive?

Our findings

Relatives we spoke with told us there was little stimulation or activities for people who lived at the home, although there were musical entertainers at times. One relative said "I think there should be some colouring books or board games available for (family member). They would enjoy that." Another relative said they visited daily, they said staff would arrange a table and two chairs for them in the entrance area, "(Family member) doesn't like noise and there are some very noisy people in the lounges, so we always sit here, out of the way."

Two people who lived at the home told us they would like to go out more, one said, "It's nice to go out on a sunny day." They also said they did not like sitting in the lounge areas. One person said "Everyone's asleep in the lounges or there are some noisy people. I like a bit of life so I have a chat with the staff." Both of these people told us they preferred to spend their time in the corridors where they could see and speak to staff, or in their bedrooms where they could watch their preferred TV programmes.

A staff member told us, "We do have a carer who is interested in providing activities for people, we do reminiscing. We have a set of reminiscence cards of old film stars which we bring out and have an informal quiz with people. We used to bake buns with people when they were more able. One of the residents helps out in the kitchen sometimes as they like to be busy doing things to help us. We don't go out with people though. I can't remember going out on a trip since I have been here in the last four years." They also told us staff brought in books for one person who liked to read, however, they were unable to tell us how other people's specific interests or hobbies were supported by the home.

Another member of staff told us the activities were currently organised by different staff on different days. They said they had not had any training in providing activities for people for about nine years. They said there had been no money allocated to the activity programme and staff had to run a jumble sale and tea and cake stall to raise funds. They said they hoped to use the money they had raised to purchase a greenhouse to grow plants. We asked them how the outside environment limited their ability to do activities with people, they said that it had a big impact as they thought only 10 people could access the garden at the front of the property, and the area at the rear was shut to people as it was unsafe and dangerous. They also told us they ran a 'not for profit' tuck shop trolley to allow people to buy themselves treats of their own choosing. They said they had also arranged for an ice cream van to visit the home which had been very popular with people. We asked what other activities people took part in, they said, baking, painting, watching DVD's, reminiscence and games. They told us they had asked if sensory equipment could be purchased for the home and they said they had chosen this with the previous manager, but they were unsure if it had ever been ordered.

During our inspection we did not see people engaged in any form of meaningful activity. Music was played in one lounge and the television was on in another lounge. We saw people were either seated in chairs or walking about the home. We looked at the record of activities for four people. We found the entries were irregular, for example, one person's record detailed, 13 February 2015 'Valentine party with singer, enjoyed listening to music', there was no other entry recorded for this person. Another person's record noted, 'hand massage', 31 March 2015.

In one of the care records we looked at, the only reference to the person's activity preference was visits from the person's spouse.

These examples demonstrate that people who lived at the home were not engaged in regular, meaningful and person centred activity. Enabling people with dementia to take part in meaningful and enjoyable activities is a key part of 'living well with dementia'.

These examples evidenced people's care and support was not appropriate to their individual needs and was not reflective of their personal preferences. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Each of the relatives we spoke with told us they felt they could talk to a member of staff if they had a concern and they felt the staff members would deal with their issues appropriately. One relative said, "I did ring the owner because of some concerns that I had that I wanted reassurance about and they did speak to me directly as I was worried about this particular issue I shared with them." When we looked at the complaints file there was no record of any complaints or concerns having been logged. The

Inadequate

Is the service responsive?

manager and management consultant were not aware of any current formal complaints that were on-going. We were not able to see any information on display about how people could raise a concern or complaint with staff.

Inadequate

Is the service well-led?

Our findings

Most of the relatives we spoke with told us they thought the service was well led because the care was good. Comments included, "You can't run a good service without good leaders, can you?", and "I think there's a limit to what you can do with people who need so much help. And I think they do a great job here." and "There is a new manager – she has said hello to people briefly – but not introduced herself formally to me yet."

Five of the staff we spoke with told us they felt morale in the home was good and the management were supportive. They said the team worked really hard to keep the service going, they said they did this by working as a team One staff member said, "They are good to us as an employer. When the owner comes to the home they say hello but they don't always talk to me specifically." Another staff member said the registered provider usually visited the home on a weekly basis.

The home had been without a registered manager for about a month prior to our inspection. The manager, present on the day of our inspection had only commenced employment on Monday 1June 2015. They were being supported by a management consultant who was also present on the day of the inspection.

The manager told us they were a registered mental health nurse with previous experience of care home management. They told us the first two days of employment had been spent with the registered provider and developing an action plan to tackle the contractual failings identified by the recent local authority inspection. During the day of our inspection the manager spent a significant amount of time in the office and was not a visible presence in the home. However, they told us they were a 'hands on' manager.

We asked two staff about staff meetings; one said they could not remember the last time that there was a staff meeting. Another member of staff they told us a meeting had been arranged for the following week with the management consultant and all the maintenance team. The last recorded staff meeting minutes were dated October 2014 and January 2015. Staff meetings are an important part of the registered provider's responsibility in monitoring the service and coming to an informed view as to the standard of care and support for people living at the home.

We saw the registered provider did not have a system in place for gaining the views of people who used the service and people involved in the service. We asked one of the relatives if the registered provider had asked for their opinion about the care provided by the home. They said, "I have not been asked to fill in a questionnaire to give feedback on how things have been from our perspective of the care here, (person) has been here for 18months now." We could not see any documented evidence of meetings with relatives or people who lived at the home. The management consultant told us they had a relatives' meeting planned in the coming few days and they intended to gain feedback from people who lived at the home about the food and meal service at the home.

We asked the management consultant and the manager if we could review the management systems to monitor and assess the quality of the service provided to people. They told us they were not aware any existed and were unable to provide any documented evidence of audits or management oversight.

We also found evidence of poor record keeping. For example, we saw a discrepancy in the catering staff's records relating to one person. The entry dated 9 January 2015 and indicated that the person was not diabetic, however, the care plan, dated 6 November 2013 recorded the person was diabetic. This was brought to the attention of the team leader who immediately updated the information.

People's care records were also lacking in detail. For example, we observed one person who was seen exhibiting distressed behaviour, crying loudly, on a number of occasions. When we looked at the care plan for this person we found no record of this behaviour and no care plan in place to tell staff how to support the person to ease their distress. Two of the care plans we looked were poorly organised and had documents which recorded incorrect information. For example, an infection control assessment, completed on admission, stated no history of urine infections, however other information referred to a long history of urine infections.

This meant the registered provider had failed to establish or effectively operate systems and processes to assess and monitor the quality and safety of the service. The registered provider had further failed to make sure accurate records

Inadequate

Is the service well-led?

relating to the care of the people living at the home and the management of the service. This is a breach of regulation 17of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The registered provider had failed to ensure people's care and support was not appropriate to their individual needs and was not reflective of their personal preferences.** Regulation 9 (1) (2) (3)

The enforcement action we took:
Notification of Proposal to cancel the registration to be issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The registered provider had failed to ensure people were treated with dignity and respect.** Regulation 10 (1) (2) (b)

The enforcement action we took:
Notice of proposal to vary condition of registration to remove a location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The registered provider had failed to ensure people's care and support was delivered with the consent of the relevant person.** **The registered provider had failed to act in accordance with the requirements of the Mental Capacity Act 2005.** Regulation 11 (1) (2) (3)

The enforcement action we took:
Notice of proposal to vary condition of registration to remove a location

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered provider had failed to maintain appropriate standards of cleanliness and hygiene.** Regulation 12 (2) (h)

The enforcement action we took:
Notice of proposal to vary condition of registration to remove a location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered provider had failed to ensure people who were living at the home were protected against the risks of abuse.** **The registered provider had failed to act in accordance with the requirements of the Mental Capacity Act 2005.** Regulation 13 (1) (2) (3) (5)

The enforcement action we took:
Notice of proposal to vary condition of registration to remove a location

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

The enforcement action we took:
Notice of proposal to vary condition of registration to remove a location

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered provider had failed to establish or effectively operate systems and processes to assess and monitor the quality and safety of the service. The registered provider had further failed to make sure accurate records relating to the care of the people living at the home were maintained. Regulation 17 (1) (2) (a) (b) (c) (e) (f)

The enforcement action we took:
Notice of proposal to vary condition of registration to remove a location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered provider had failed to have suitable arrangements in place to ensure that staff were appropriately supported. The registered provider had also failed to ensure staff received effective training in relation to their responsibilities, to enable them to deliver effective care and support to people. Regulation 18 (2) (a) (b)

The enforcement action we took:
Notice of proposal to vary condition of registration to remove a location