Care UK Community Partnerships Ltd

Charlotte House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The inspection took place on 3 November 2015 and was unannounced.

The last inspection of the service was on 29 September 2014 when we found no breaches of Regulation.

Charlotte House is a nursing home for up to 56 older people, some people are receiving support at the end of their lives and some people are living with the experience of dementia. At the time of our inspection 49 people were living at the home. The home is managed by Care UK, a national organisation who provide care and support.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

People were at risk because the staff followed practices which were not safe and put them at risk of choking.

There were not enough staff deployed to keep people safe and meet their needs.

There were risks to people's wellbeing because the environment was not well maintained or clean.

People could not always access call bells and were unable to alert staff when they needed support.

People were not asked for their consent and there was limited evidence that people had consented to their care and treatment.

The staff had the training they needed but did not always feel supported.

The staff did not always respect the people who they were caring for.

People's privacy and dignity was not maintained.

The staff tended to focus on the task they were performing rather than the person they were supporting.

People's individual needs were not always being met and sometimes they were put at risk because the staff failed to notice and act on their needs.

People's social needs were not being met and they were not being cared for in a person centred way.

The provider had not responded appropriately to complaints and people could not be confident that complaints would be acted upon.

The provider had failed to assess, monitor and mitigate the risks of inappropriate and unsafe care and treatment.

People using the service, their relatives and the staff felt that their opinions were not listened to and improvements to the service were not being made as a result of their feedback.

Records relating to care and the management of the service were not always clear and accessible.

People had received their medicines as prescribed.

People's nutritional needs were assessed, monitored and met.

People's health was monitored and they had access to external health care services.

The record of care needs and the plans to meet these were detailed and regularly updated.
We observed some interactions that were kind and caring. People told us that the regular staff were kind.

We found breaches of the Health and Social Care Act 2008 and associated Regulations. We are taking action against the provider for the breach of the Regulations in relation to the safe care and treatment of people using the service (Regulation 12) and the good governance of the service (Regulation 17). We will report on it when our action is completed.

CQC is considering the appropriate regulatory response to resolve the problems we found.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's

registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were at risk because the staff followed practices which were not safe and put them at risk of choking.

There were not enough staff deployed to keep people safe and meet their needs.

There were risks to people's wellbeing because the environment was not well maintained or clean.

People could not always access call bells and were unable to alert staff when they needed support.

People had their medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not asked for their consent and there was limited evidence that people had consented to their care and treatment.

The environment did not always meet the needs of people who had dementia.

The staff had the training they needed but did not always feel supported.

People's nutritional needs were assessed, monitored and met.

People's health was monitored and they had access to external health care services.

Is the service caring?

Requires Improvement

The service was not always caring.

The staff did not always respect the people who they were caring for.

People's privacy and dignity was not maintained.

The staff tended to focus on the task they were performing rather than the person they were supporting.

We observed some interactions that were kind and caring. People told us that the regular staff were kind.

Is the service responsive?

Inadequate

The service was not responsive.

People's individual needs were not always being met and sometimes they were put at risk because the staff failed to notice and act on their needs. People were not always being supported to have regular baths and showers.

People's social needs were not being met and they were not being cared for in a person centred way.

The provider had not responded appropriately to complaints and people could not be confident that complaints would be acted upon.

The record of care needs and the plans to meet these were detailed and regularly updated.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had failed to assess, monitor and mitigate the risks of inappropriate and unsafe care and treatment.

People using the service, their relatives and the staff felt that their opinions were not listened to and improvements to the service were not being made as a result of their feedback.

Records relating to care and the management of the service were not always clear and accessible.

Charlotte House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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.

The inspection took place on 3 November 2015 and was unannounced.

The inspection team consisted of three inspectors, a pharmacy inspector, a nurse special advisor 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. The expert at this inspection had personal experience of using health and social care services. They had also taken part in voluntary work, chairing a safeguarding group and advising local authorities about health and social care.

Before the inspection we looked at all the information we held on the provider, including notifications of significant events and safeguarding alerts.

During the inspection we spoke with ten people living at the home, 14 visitors (relatives and friends), two visiting nurses, a visiting physiotherapist, the GP and staff on duty who included the manager, team leaders, nurses, care assistants, activity coordinators, the chef and domestic staff.

We observed how people were being cared for and treated. We looked at the care records for 15 people who lived at the home, the recruitment, training and support records for seven members of staff, the provider's audits, records of accidents, incidents and safeguarding alerts. We looked at medicines storage, administration and the medicines records for 31 people.

Inadequate

Is the service safe?

Our findings

People living at the home were at risk because some of the practices staff followed were not safe or suitable. We observed two members of staff standing to support two different people to eat their lunch. This meant that they may not have been at the correct position to safely support people who were at risk of choking. One person sat behind the person they were supporting to eat. Therefore they could not see the person clearly and they were reaching around them to place food in their mouth. We observed two incidents where two different members of staff attempted to force someone's mouth open with a spoon by pushing the spoon hard between their lips. The person was chewing food at the time and had indicated by shaking their head that they did not want more food at the time. We observed other staff holding forkfuls of food to other people's mouths whilst they were still chewing. In one case the person put their hand up to stop the member of staff. The member of staff then held their hand so they could not raise it. These practices put people at risk of choking. The staff appeared unaware and unconcerned that their actions were dangerous and inappropriate, because they continued with this practice and showed no reaction to the response of the people who they were supporting.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People living at the home were at risk because there were not enough staff deployed to keep them safe and meet their needs. One person told us, ''Most of the time I call for help and there is no one to help me. One day I had an accident because no one came to help when I buzzed. I can never have a tea to drink when I want one unless it is time for the tea round.'' Another person said, ''The staff are very good but there is a shortage. I have asked many times but there is no response.'' People and their relatives told us there were not enough staff. They said their needs were not always met and they sometimes had to wait for care and treatment. One relative told us, "the home needs more staff to offer better and quicker personal care, otherwise (my relative) needs to wait for a long time to be changed and as staff is very busy it feels like a burden to ask for help sometimes." Another relative told us that they and other visitors helped out for example by supporting people (not just their own relatives) to eat their lunch. The relatives also raised concerns about the high turnover of staff and the use of agency (temporary) staff. They said that people found this distressing and the staff did not get to know individual needs.

We observed that people's needs were not met during our inspection. Many people living at the home required support to move safely, including the support of two staff to transfer them from a bed to a chair and to the toilet. There were not enough staff to support people so they were left in a chair or their bed without support. Some people required regular attention because they were agitated and confused but were in bed and unable to move independently. We observed people pulling at their clothes or bedclothes and one person frequently swung their legs over the bedrails causing possible risk of injury. The staff told us they checked on people as they walked past their rooms, but they did not spend time with these people. The staff told us they did not have time to do this.

On the day of the inspection people were not given the support they needed at mealtimes. People were not supported to have baths and showers regularly and people were not supported to take part in social activities. The staff did not spend time engaging with people and they were left in communal areas or their bedrooms without support. The medicines round took the nursing staff all morning so they were unable to support people in other ways. One visitor told us that sometimes the medicine round took so long people did not get their medicines when they needed. They said that the medicine their relative was prescribed had to be administered an hour before the person ate, but that on two occasions in the previous month this did not happen. We observed people calling for help and not being supported. These included people who were left in communal areas who raised their hands beckoning for attention or help and people who were alone in their bedrooms calling out. We observed one person calling for staff for over ten minutes.

The provider was not maintaining the staffing levels which they had considered appropriate. For example, on the day of our inspection one person who had been assessed as requiring individual staff support had not been given this. They presented a risk to themselves and others. The individual staff support was made available by lunchtime, however, this member of staff supported a number of people and was not solely supporting the person they were assigned to.

The permanent staff told us they were concerned about staffing levels and felt they could not meet people's needs. They told us the lack of familiar and permanent staff had an impact on care and they were often working with temporary staff who had never worked at the home before. One member of staff told us, ''we are under a lot of pressure, there is not enough staff.'' Another member of staff said, ''we just do not have time to care for people, there is not enough of us.'' One of the activities coordinator told us, : "it would be much better if there was more staff as there could be more one to one attention and we could spend more quality time with residents".

Relatives and the staff told us they had raised concerns about staffing levels and the impact of this to the manager and provider. They said that they were dissatisfied with the response as they had not been reassured but had been told that the home had ''better staffing ratios than the industry standard.'' The manager also told us this was the response of the provider when we spoke about the concerns relating to staffing levels.

The manager told us that the staffing levels were four carers and two nurses on each floor during the day with two people receiving additional individual support from one member of staff. They said that the staff prioritised people's needs and some people had to wait for care if their need was not as great as someone else's.

One of the recent complaints received at the service related to the neglect of a person. After investing the complaint, the provider's response to this complaint was that the staff had to attend to another's person's need which was more urgent than the person's and there was not enough staff to meet both their needs. The person had been escorted to their room in order to use the toilet. They had been left without receiving this support and in a position where they were at risk.

The manager told us that the recruitment and retention of staff at the service had been difficult. They confirmed that there had been a high turnover of staff. They said that at the time of the inspection the provider was in the process of recruiting new permanent staff. They told us that the provider was using approximately 400 hours of agency (temporary) staff employed each week. The manager said that they tried to use the same familiar agency staff, however the care assistants and nurses told us this was not the case. They said that the agency staff were usually different and new to the home. They said that they did not have time to get to know the people who lived at the home or the routines and practices, making it harder to

meet people's needs. One member of staff told us that an agency worker who had been employed the previous week could not speak English and they considered this a risk as the person could not understand what they needed to do. We spoke with agency staff employed on the day of our inspection. The majority of them had not worked at the home before or had only done so a small number of times.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People were at risk because the provider had failed to mitigate against the risks of unsuitable and unsafe premises. For example, the electrical socket in one bedroom, which was live and being used, was covered in masking tape with a notice stating, ''Danger, broken socket'' written on it. The socket was close to a person who was restless, confused and at times distressed. The en-suite toilet in one bedroom had a broken wall panel which exposed a soil pipe from a toilet on the floor above.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The call bells used for people to contact staff in an emergency were not always working or accessible. People told us that they did not always have access to call bells. One person told us they had to wait for up to 10 minutes for call bells to be answered. Other people told us they had to call for help. One person said the call bell in their room was not working. We found that this was the case when we tried it. One person told us they were frightened to use the call bell because they would ''get into trouble.'' Another person said, ''I ring for someone to help me to the toilet but no-one comes.''

The emergency pull cords were not within reach of some toilets and showers and had been tied up. Some of the bathrooms on the first floor did not an emergency pull cord. The pull cords in many of the bedrooms had been hung on the wall holder out of reach of the person in the room.

We observed one person calling for assistance to use the toilet for over ten minutes. The staff only attended to this person when we alerted them to this.

We observed one person in their bedroom who was unable to communicate verbally or to mobilise. Their call bell had been placed out of reach. We asked the staff how this person would alert the staff if they needed attention. The member of staff told us they did not know.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

However some people told us that call bells were answered promptly and they felt safe at the home. One person said, ''Yes, I feel safe, my room feels safe. When I walk sometimes the staff walk with me.'' Another person told us, ''If I want to go downstairs, a nurse comes with me. Staff answer the call bell and I usually get help quickly.''

People living at the home were at risk because the provider had not taken sufficient action to minimise the risk of cross infection and contamination. Throughout the day there was a malodour in some communal corridors and rooms. The furniture in some rooms also had a malodour. We observed a cleaner using the mop and bucket dedicated for bathroom and toilet use to clean a bedroom floor. They told us they were aware this equipment was for use in toilets and bathrooms only and could not explain why they were using this in a bedroom. The manager told us that there had been an infestation of mice but that the premises had

been rodent proofed by the time of the inspection. However, we saw a mouse running from one bedroom to another during the morning of the inspection.

Some of the relatives we spoke with told us that they were concerned about cleanliness at the home. The minutes for the most recent relative meeting showed that relatives were concerned about mice at the home.

Some of the walls around the building were marked and stained. There were cracked and damaged tiles in one of the shower rooms.

People living at the home were not offered the opportunity to wash or wipe their hands before eating.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014

People received their medicines as prescribed and in a safe way. However some practices around the handling of medicines were not as safe as they could be and this presented a risk. For example, the clinic rooms were cramped and some areas appeared disorganised such as the storage of dressings. The oxygen cylinders in one clinical room were not secured. Containers for medicines and sharps needing disposal were piled up in the clinical rooms. The kits used to destroy controlled drugs had not been used appropriately, were stored in a disorganised way and had not been collected regularly. Some medicated creams were stored in communal bathrooms and in one case the prescription label had been removed.

We observed the nurses administering medicines in a safe and caring manner, taking people's individual preferences into account. However we noted that the medicine rounds took a long time and one morning round was not completed until 11:30am. The nurses took account of people who needed medicines at dosage intervals and this was not seen to be a risk. One person told us that they had to wait a long time for their medicines particularly at night. They told us that sometimes it was past 10pm which was too late for them.

Medicine administration records (MAR) were clearly printed and written additions were signed and checked by two nurses or the prescribing GP. These were completed at the time of administration with a signature to denote the administration or a code to show why a medicine had been omitted. Reasons for omissions were recorded on the MAR and any frequent refusals were discussed with the GP. Changes in dose of medicines, blood tests and changes to medicines on discharge from hospital were clearly recorded and acted on. Each person had a record sheet that had a photograph of the person, their allergies, medical conditions and preferences for taking medicines recorded with the MAR. Agency nurses told us that this was particularly useful when they were administering medicines.

The nurses told us they had received training in administration of medicines via e-learning. We saw evidence of recent competency assessments for the nurses employed at the home. Agency nurses told us that they had a good induction and the medicines processes were set up in a way that they were able to follow safely. They knew what to do if medicines needed to be ordered.
The provider undertook audits of medicines management. We saw the most recent audit had taken place in September 2015. This was comprehensive and action plans were produced where concerns were identified. We noted that the staff had taken the required action since the last audit.
Medicines were stored securely. The temperature of the medicines storage areas was regularly monitored. All medicines were in stock and available and no expired medicines were seen. Oxygen was stored behind appropriate signage.

The staff had assessed the risks to people's wellbeing and safety. These included risks of malnutrition, risks

associated with skin conditions, and risks relating to the care and treatment they received. There were also assessments regarding how people could safely move around the house and whether they needed additional equipment to support them to move. Where additional equipment was used, for example bed rails and hoists, the use of these had been assessed. There were clear management plans to tell the staff how to care for people safely. Risk assessments had been regularly reviewed and updated.

The provider had a procedure for safeguarding vulnerable adults. This was clear and had been regularly reviewed. The staff received training in safeguarding and had opportunities to discuss this with the manager at individual and group meetings. The staff we spoke with were familiar with the safeguarding procedure and knew what to do if they suspected abuse. The manager had a good knowledge of safeguarding alerts that had been made and had worked with the local safeguarding authority to investigate and respond to these. The provider had notified the Care Quality Commission of safeguarding alerts and how they had responded to these.

The provider had suitable procedures for recruiting new staff. These included checks on their suitability to work with vulnerable people. The provider requested references from previous employers, criminal record checks and checks on their identity and eligibility to work in the United Kingdom. The staff completed an application form with an employment history. There were records of staff interviews which were comprehensive and included questions about scenarios they might experience.

We Recommend the provider follows recommended practice and guidelines for the storage of medicines and related equipment; and the disposal of unused medicines and equipment.

Requires Improvement

Is the service effective?

Our findings

People who lived at the home and their relatives told us that they had not been asked to consent to care and treatment. The staff told us they were not aware of any records of consent. There was no evidence of recorded consent to care and treatment, photographs being taken, the use of bedrails or administration of medicines.

The manager told us that people were asked to consent to their care and treatment when this was given. However, our observations were that the majority of staff did not ask people for consent, they carried out tasks without interacting with people or observing their reaction. We observed the staff ignoring non-verbal indicators from people that they were refusing treatment, for example when they were supporting people to eat.

One person was receiving their medicines covertly (without their knowledge). This had been agreed in a multidisciplinary best interest meeting and supported with a care plan. However, the provider had not carried out a Mental Capacity Assessment for this decision. Therefore the person's ability to consent to this had not been assessed in accordance with the Mental Capacity Act 2005.

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

The staff told us that they had regular team meetings. There was a record to show that the majority of staff had received individual supervision. However, the manager could not locate the actual records of these meetings for all the staff. Some of the staff told us they had individual supervision meetings but other staff did not understand what we meant when we asked about individual meetings. They told us they could not remember having a meeting to discuss their work with their line manager. The staff told us they had not had annual appraisals of their work and there was no evidence of these. The staff told us they did not always feel supported particularly when they raised concerns.

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

The environment was not always designed and used in a way which reflected people's preferences and took account of their needs. For example, the bathrooms on both floors were used for storing hoists and slings making them inaccessible. At the time of the inspection some of the shower rooms were being refurbished. None of the shower rooms or bathrooms on the first floor were accessible or could be used at the time of our inspection. A chair used for weighing people was situated in a communal lounge. Areas of the building were in need of redecoration and repair. Some of the paint and woodwork was marked and damaged. Some of the blankets and sheets used on people's beds were worn. There was insufficient signage and way finding clues for people who had dementia. For example, the lighting, colour schemes and textures of the environment did not reflect good practice guidance for environments for people who are living with

dementia. Bedrooms doors were distinguished by numbers and small name plates. Information on notice boards was not always clear, and was sometimes located high on the wall. For example, a photographic board of staff was small, positioned high on the wall and did not include photographs of the majority of the staff.

The National Institute of Care Excellence (NICE) guidance about environments for people with dementia states, '' Good practice regarding the design of environments for people with dementia includes incorporating features that support special orientation and minimise confusion, frustration and anxiety.'' The guidance also refers to the use of ''tactile way finding cues.'' The government guidance on creating ''Dementia friendly health and social care environments'' recommends providers ''enhance positive stimulation to enable people living with dementia to see, touch, hear and smell things (such as sensory and tactile surfaces and walls, attractive artwork, soothing music, and planting) that give them cues about where they are and what they can do.''

There were a number of small communal rooms designed for people to spend time relaxing in. These were equipped with games and books. However, we did not see people using these rooms and the majority of people needed support to access them.

We looked at five care plans which included Do Not Attempt Resuscitation documents. These meant that it had been considered in the person's best interest that if they stopped breathing the staff should not attempt to resuscitate them. However, only three care plans contained the correct legal document for this, and only one of these had been correctly signed and authorised. In one case the form indicated that the person had capacity but had appointed a power of attorney to make decisions on their behalf. There was no additional supporting evidence of this. There was evidence that end of life care and decisions not to resuscitate had been discussed with the person or their representatives and care plans clearly recorded people's wishes. However, the provider had not ensured that the documents and records met legal requirements relating to these decisions.

The law requires the Care Quality Commission (CQC) to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS provides a process to make sure that providers only deprive people of their liberty in a safe and correct way, when it is in their best interests and there is no other way to look after them. The manager was aware of his responsibilities under this legislation. The staff had carried out assessments of people's capacity and these were recorded, with the exception of one assessment relating to the covert administration of medicines. Where people were unable to consent and their liberty had been restricted the provider had ensured this decision had been made by a group of their representatives in their best interest. For example, some people were restricted from leaving the home without support because they were considered at risk. There were clear assessments and DoLS authorisations for this.

The staff demonstrated a good understanding of DoLS and the Mental Capacity Act 2005. They told us they had received training and information about these and their responsibilities under this legislation.

All the staff received an induction into the home and training in areas the provider considered mandatory. The training included health and safety, dementia awareness, food hygiene, manual handling and infection control. The staff told us training was regularly updated and they could access training via a computer system as well as face to face training. The provider had systems to monitor when training was due to be renewed. The staff told us the content of the training was good and they were able to tell us about the things they had learnt and how this was relevant to their role. One member of staff told us, ''They did very good induction.'' Another member of staff said, ''They are very good with training. We have opportunities to train.''

The home employed nursing staff 24 hours a day. The nursing staff assessed, monitored and met specific health needs. The staff told us they had good access to other health care professionals and there were regular visits from the GP. Care records indicated that people had access to the healthcare professionals they needed and had regular appointments as required. However, we found that a referral to a psychiatrist for one person had been made in July 2015 but the person had not yet had a response from the relevant healthcare team. The staff had not followed this up and therefore the person was not receiving the support they needed. There were records to show that health was monitored and where people had specific health conditions there was clear information about this.

People's nutritional needs had been assessed and recorded. These assessments were regularly reviewed. People were weighed regularly and there was evidence the staff had responded to changes in weight and in most cases they had referred people to other professionals as needed. However, we noted that the staff had sought advice from a Speech and Language Therapist regarding one person's risk of choking but they had not included the guidance from this professional in the person's care plan. The person had also lost weight but the staff had not made an additional referral to a dietitian to see if they could offer support to the person.

People's care plans included information on special dietary needs, for health and cultural reasons. The chef was aware of these and had a record of each person's needs and preferences.

There was a choice of different meals and these were advertised on menus in the dining rooms. People told us they generally liked the food, although some people with restricted diets told us that there was not always a lot of variety for them.

The chef told us that hot and cold food was available throughout the day for people if they requested this. However people told us that because the staff were not available and did not always answer call bells this did not happen in reality as they were not offered food outside of set mealtimes.

The chef attended meetings for people who lived at the home and relatives to obtain feedback on the food, they also visited people in their rooms and the dining rooms at mealtimes to get feedback on each meal.

We Recommend the provider consult recognised good practice guidance for improving the environment to help orientate and support people living with the experience of dementia.

Requires Improvement

Is the service caring?

Our findings

Some people and their relatives told us that the permanent staff were kind and caring, however they said these staff were often rushed and did not spend time with people. People told us there was a reliance on agency (temporary) staff and these staff did not take time to get to know people or their needs. One person told us, "I don't know any of the staff's names. There is not enough staff and no-one is caring here, it's not good. There's no one in charge – I haven't seen the boss at all. No one pays any attention most of the time…. It is even worse at night." Some people told us the staff were not helpful or were ''defensive'' if they were asked to do something. One person said, ''Nothing is done properly and they are nasty.'' Another person told us, ''People walk past my door but they never stop and talk to me.''

Throughout our inspection we observed that the staff supported people by focusing on the task they were performing and not the individual needs and preferences of the person. We saw the staff approaching people to support them without speaking with the person. They did not ask people about their choices or preferences. They did not offer comfort to people or reassurance.

One of the nurses escorted a visiting GP around the home whilst people were eating their lunch. The GP was carrying out examinations and administering the flu vaccination. The GP administered the vaccination to some people whilst they were eating their lunch. The staff supported him to do this and this did not show consideration or respect to the needs and wishes of the people living at the home. We spoke with the nurse on duty at the time and they confirmed that this practice was not appropriate however they had allowed it to take place. During the afternoon we observed the GP administering vaccinations to people in communal areas, including to one person who was seated in the main entrance hall to the first floor. There were four other people, including a visitor present in this area. The GP then carried out an examination of someone in a communal lounge. The staff did not challenge this or make a request that these interventions were carried out in private.

During lunch time on the ground floor three members of staff were seated supporting people to eat their meal. The staff had limited, and in some cases, no interactions with the people they were supporting. One member of staff was supporting two people at the same time. The staff repeatedly left their seats and attended to other duties whilst they were supporting people without telling the person what they were doing. We observed all of the staff holding forkfuls of food to people's mouths whilst they were still chewing their previous mouthful. The staff spoke with each other but not the people who they were caring for. One member of staff scraped left over food from two different people's plates in front of them and then handed the spoon used to scrape the food back to a person to eat their dessert with. Twice the staff supporting people left the person to be replaced by another staff member without telling the person what they were doing. Two members of staff stood to support people rather than sitting with them. The staff served the dessert (of crumble and custard) in bowls which were left in front of people who were eating their main course. The desserts were then left to go cold before people had the opportunity to eat them. We saw that three people who were eating alone in their bedrooms had been served soup, the main course and dessert at the same time. One person also had two cold cups of coffee and two cold drinks on the table in front of

them. They had no room to manoeuvre their cutlery so they could eat their meal comfortably. One person who was eating in their bedroom told us the GP had just come into their room, accompanied by a member of staff, and mixed up all the food on their plate so the individual elements of the meal were all mixed together. They told us the staff had not stopped the GP from doing this and they did not understand why he had done it. People were not offered a choice of cold drink with their meals and no condiments were available on the tables. People were not offered an opportunity to clean their hands before they ate. We observed the staff using napkins which were protecting people's clothes to wipe their faces, without warning them. They were not gentle or caring when they did this. We also observed the staff scraping food from people's chins with a spoon and then placing this in the person's mouth. The staff treated the mealtime as a task to be completed and showed no consideration to the needs and wishes of the people they were supporting.

We witnessed an incident where a person had become distressed and was asking about the welfare of their children. The staff supporting this person ignored their distress and instead of reassuring the person they repeatedly told them that Charlotte House was ''their home.'' The person stated that they did not feel that it was their home.

The majority of staff did not wear name badges and they did not introduce themselves to the people who they were caring for.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We saw some interactions which showed respect towards people. For example, the activities coordinators greeted people by name and took time to listen to people and respond to their requests. Some of the other staff were polite. For example we heard the staff greeting people when they approached them, apologising for keeping people waiting and explaining what they were about to do. However, even the polite interactions with people were task focussed and there were very limited sustained conversations.

The staff had recorded people's individual cultural and religious needs in care plans. There were regular visits and services from the local churches. The chef was aware of individual cultural needs and catered for these.

The manager told us that the service had a high proportion of people who were receiving care at the end of their lives. The staff worked closely with the palliative care teams and other professionals to meet people's needs. There were detailed care plans describing how people should be cared for when they were dying, including their preferences and those of their families.

Inadequate

Is the service responsive?

Our findings

People's individual needs were not always met. Some relatives told us that they were concerned that people did not have regular baths or showers. One visitor told us that their relative's toothpaste and shower gel were never used and this led them to believe the staff did not support the person to wash or brush their teeth. Another visitor said that they thought their relative's teeth were never cleaned. On the day of the inspection none of the bathrooms were accessible because they were used for storing hoist and other equipment. Three shower rooms were being refurbished. No one was supported to have a bath or shower during our inspection. The records of baths and showers did not clearly indicate how often people had these. There was no record for some people. The record for two people indicated they had one bath in October 2015, one person had had three recorded showers and the record for another person stated bed baths. We asked three different members of staff about this. Two members of staff were unable to give us an answer about whether people had regular baths or showers. One member of staff told us they did but then described the bath as a person sitting on a chair with their feet in a bucket of water being cleaned with a sponge. They told us this was recorded as the person having had a bath.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We noted that five people had developed pressure sores whilst living at the home. Whilst this is a risk for people with high needs, such as those living at the home, this is also associated with poor skin care, failure to reposition people who are unable to move themselves and nutritional needs. People at the home were not receiving baths and showers regularly, there were risks associated with poor infection control practices and rodent infestations. Some of the charts to evidence that people were being repositioned were incomplete. One visitor told us that their relative's skin care was not properly documented and the person developed a grade 3 pressure sore (a wound which had started to developing into the tissue beneath the skin). They told us that records up to the day before this wound was identified stated the person's skin was in-tact (no obvious wound).

One relative told us that they did not think the staff gave the proper care and attention to people's skin and wounds. They told us that on one occasion the staff had removed the dressing from their relative's wound, covered this with a napkin and left the person for over an hour. They told us the wound was properly dressed again only because they had alerted the manager to the situation.

One visitor told us that their relative had recently attended a hospital appointment with staff from the home. They said that the hospital had not been given information about their relative's needs by the staff so they were unable to treat the person. They also said that the staff did not support the person during the hospital visit to change a soiled pad. So the person remained in this pad until they returned home.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People did not receive the support they needed to meet their social, emotional and leisure needs. The provider employed two activity coordinators who organised some group and individual activities. However, outside of these activities the provider did not support people to meet these needs. Some of the things people told us were, '' I used to go out and shop for people, and mix in the community but I do not anymore'' and ''I'd like someone to talk to.''

On the day of the inspection one of the activities officers was offering individual support to a person who was upset and anxious for most of the morning. Seven people were seated in the dining room on the ground floor for the duration of the morning with no activities and limited engagement. One person was reading a magazine, the other people were not taking part in any activity or conversation. The staff entering the room did not engage with people. There was the noise of a dripping tap which was left unattended for half an hour. When the activities coordinator entered the room they engaged positively with individuals and the group but this was for a limited time only, when they left people remained seated with nothing to do. People remained in the same seats until lunch was served. People in the dining room on the first floor were also left with no activities and nothing to do. Two people had visitors, however the rest of the people in the room were not given anything to do and the staff did not interact with them. At one point the activities coordinator started a group activity but this lasted less than five minutes. The notice board advertised a craft activity to take place on the morning of the inspection. This did not take place. Many of the people living at the home were in their bedrooms or in bed. The staff did not routinely visit these people and they were left alone. We observed one person reaching down from their bed and when we asked them if they needed anything they wanted their newspaper which the staff had placed on a table on the other side of the room. The person was unable to get this without support.

People and their relatives told us there was not enough variety of activities and their individual needs were not being met. Some families told us they had completed life stories to help the staff understand about their relative's needs. However, these were not available in people's bedrooms and the agency (temporary) staff told us they had not seen these. The staff told us they did not have time or opportunities to read these life stories.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People living at the home and their representatives could not be confident that complaints would be investigated and acted upon. Some of the people who we spoke with and their visitors told us they were not happy with the way in which complaints were responded to. One person told us it had taken two months for the provider to acknowledge and respond to a formal complaint they had made. Another person told us they had made a formal complaint a month before the inspection but this had still not been investigated.

We asked the manager for information on complaints made to the service. We were shown the original complaint and response for one complaint. However, there was only the copy of a different letter of complaint without any information about the response. We also saw the response to a third complaint but not the original complaint. There was no record of investigations or evidence relating to these complaints. The manager told us he received some complaints from relatives at the relatives' meeting. However, there was no record of these, apart from the minutes of the meeting, no evidence of the investigation into these and no response to the complainants. There was no central analysis of complaints to identify themes of concerns. There was no log of complaints to show when these had been received, investigated and responded to.

Some of the areas of concern raised by complainants had not been addressed. For example, one complaint

identified that someone had been left in an inappropriate, unsafe and uncomfortable positon by the staff who had attended to another person, whose needs they had considered more important. The response to the complaint indicated that the staffing deployment did not allow for both people's needs to be met at the same time. The staffing deployment at the home at the time of the inspection had not changed and people's needs were still going unmet. Therefore there was no evidence of learning from complaints to improve practice.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) 2014

The staff had created care plans for each person which reflected their assessed needs. These included different areas of their needs and gave clear information about how the staff should support people. The care plans were regularly reviewed and updated. Where people had a change in need this was reflected. The nurses recorded clear information about how to care for specific health needs. For example, where people had wounds and pressure sores. The progress of the wound and the care received to manage this was clearly recorded.

The relatives of people who used the service told us that they were able to be involved with planning the care of their next of kin. One person told us, ''They look after me nicely so I expect I have got a care plan.'' A relative said, ''I know (our relative) had a care plan when she first came but I don't remember a review. We are regularly in touch with the manager and staff so we get an update frequently.''

The activities coordinators told us about some of the positive work they had done. They told us they had planned activities taking into account people's likes and dislikes. One activity coordinator told us about the support of one individual which reflected their interests and needs and valued the person giving them a sense of personal achievement.

Inadequate

Is the service well-led?

Our findings

The provider had failed to identify, assess and mitigate the risks of unsafe care and treatment for people who lived at the home. The staffing deployment at the home meant that people's needs were not being met. Some of the practices at the home put people at risk, for example the way in which staff supported people to eat their meals. People were at risk of developing pressure sores. The environment was not clean or well maintained. People's privacy and dignity were not always respected.

People living at the home, their representatives and staff felt their opinions were not sought or acted upon. For example, relatives told us they had raised concerns and these had not been addressed. The staff told us they had expressed concerns about people's safety because there were not enough staff deployed. They told us they had not received a satisfactory response to their concerns.

Records were not always easily accessible or well organised. For example, the minutes to a relatives meeting were located in a file entitled ''nutrition''. The staff did not maintain accurate and up to date records to show when people had taken a bath or shower and when people at risk of developing pressure areas were repositioned. The care plans and risk assessments for people were recorded on a computerised system. However, only permanent staff had access to this information. Paper copies of care plans did not contain the same level of detail or information. The majority of staff working on the day of our inspection were agency (temporary) staff. They were unable to tell us what people's needs were and how they should meet individual needs. Daily care notes showing how people's needs had been met varied in detail and quality. The staff told us they were supposed to log these on the computer system but that this was sometimes temperamental and therefore difficult to use. During the inspection we found that the computer system repeatedly closed down whilst we were trying to read care plans, making it very difficult to see the information we needed. The staff told us this was a regular occurrence. Therefore the staff caring for people did not have access to the information they needed to understand and meet individual needs.

We asked to see the staff supervision and meeting minutes for seven members of staff. The manager had difficulty in locating these and they were not stored within the staff member's individual files. There was no log of complaints, or analysis of complaints and the response to these.

The staff told us they did not feel there was a positive culture at the service. They said that this was due to the low staffing levels, high staff turnover and reliance on agency staff. They said they were not motivated. One member of staff told us, ''it is so hard working with different agency staff all the time, we have to do all the work, they do not know what they are doing.'' Some of the staff felt supported by their colleagues but their comments included, ''there is no visible leadership'', ''the deputy manager and clinical lead sometimes help when we are short staffed but we never see the manager'', ''we are not valued or appreciated'', "The level of care here is good but numbers needs to increase – especially at weekends", "There's a high turnover of staff here which is bad for relatives and residents", "There's a lack of recognition of staff hard work" and ''I have been very unhappy and stressed in recent months.''

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The provider undertook a number of different checks and audits on the environment, records, care and treatment. The audits included actions which needed to be taken where concerns were identified. The manager told us the provider's senior managers were supportive and visited the home regularly. However, the provider's audits had failed to identify and mitigate the risks that were identified at this inspection.

There was a registered manager in post and he was supported by a deputy manager and clinical lead nurse.

There were regular meetings for relatives of people who lived at the home. The provider asked people to complete annual satisfaction surveys.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The registered person did not ensure that service users received care that was appropriate, met their needs and reflected their preferences. Regulation 9

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	The registered person did not always ensure that service users were treated with respect and dignity or ensure their privacy was respected. Regulation 10(1) and (2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person did not always ensure service users had consented to their care and treatment. Regulation 11

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints
Treatment of disease, disorder or injury	The registered person did not always operate an effective system for identifying, receiving,

recording and handling complaints.
Regulation 16(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person had not deployed sufficient numbers of suitably qualified staff. Regulation 18(1) The registered person did not provide the staff with appropriate support, supervision and appraisal. Regulation 18(2)(a)

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 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The registered person did not provide care and treatment in a safe way for service users because they had not mitigated the risks of unsafe care and treatment or the risks associated with the preventing, detecting and controlling the spread of infections. Regulation 12 (1) and (2)(b) and (h)

The enforcement action we took:

We have issued a warning notice telling the provider they must make the required improvements by 18 December 2015

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The registered person did not operate an effective system to assess, monitor and mitigate risks to the health, safety and wellbeing of service users. Regulation 17(2)(a) The registered person did not maintain accurate, complete and contemporaneous records in respect of each service user. Regulation 17(2)(c)

The enforcement action we took:

We have issued a warning notice telling the provider they must make the required improvements by 18 December 2015