Yorkshire Parkcare Co Limited

Meadow View

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?	Good
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

This inspection took place on 24 and 25 November 2014 and was unannounced. The home was previously inspected in March 2014 in response to concerns and we found breaches of regulations 9 and 14 of The Health and Social Care Act 2008. Care and welfare of people who used the service and nutritional needs were not being met. Following that inspection the provider sent us an action plan to tell us what improvements they were going to make. We did a follow up inspection in May 2014 where we found some improvements had been made but we still found breaches in regulation 9. This was a repeated breach and people's care and welfare needs were still not always being met.

Meadow View is a care home providing accommodation for older people who require personal care and nursing care. It also accommodates people who have a diagnosis

Summary of findings

of dementia. It can accommodate up to 48 people over two floors, which is divided into three units. The floors are accessed by a passenger lift. The service is situated in Kilnhurst near Rotherham.

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

The provider had appointed a new manager on 1 September 2014. At the time of our inspection they informed us Disclosure and Barring Service check (DBS) had been applied for to help determine their fitness to work with vulnerable people. Once returned they could submit an application to CQC to be considered for registration.

While most people said they were very happy with the service and praised the staff very highly, some also raised a number of concerns. Our observations and the records we looked at did not always match the positive descriptions some people gave us. We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including balancing autonomy and protection in relation to consent or refusal of care or treatment.

The Mental Capacity Act Deprivation of Liberty Safeguards (DoLS) requires providers to submit applications to a 'Supervisory Body' for authority to deprive people of, or restrict their liberty. The manager had a good understanding of the Deprivation of Liberty Safeguards. However, during our inspection we identified that an urgent application was required for one person and this had not been considered by the service. The standard of the applications submitted to the local authority by the manager needed to be improved.

Although people's needs had been reviewed the care plans were not up to date, so they did not detail people's changing needs. Staff were in the process of updating all people's plans of care to ensure all of people's needs were identified. Although we did not see a completed one we were shown the documentation being introduced, which would improve the plans of care.

The manager had monitored the quality of the service, but this had not been completed fully. Therefore, they had not effectively checked the care and welfare of people using the service.

Most staff were recruited safely and all staff had completed an induction. However we found two staff who had recently been recruited did not have references form their last employer. Staff had received formal supervision including clinical supervision for qualified nursing staff. Staff also had an up to date annual appraisal. Although the induction of new staff was poor and staff told us they had to learn as they went along. There was not always enough staff to provide people with individual support. This was predominantly at night, between 7pm and 7am. There were only three care staff and one nurse on shift to care for up to 47 people. From speaking with relatives, people who used the service and staff we found this sometimes left the service with inadequate staff to meet people's needs. The regional manager was at the service during our inspection and agreed to increase the numbers to four care staff from 26 November 2014.

We found best practice guidance was not always followed for people living with dementia in respect of the environment. Although this had been recently redecorated the colour scheme was very neutral with walls and doors very similar colours. This is not conducive for people living with dementia.

The manager told us they had not received any complaints since they had been in post. However, we found a number of concerns and issues requiring attention had been raised by relatives. We found these were not documented to show any action taken. There was no evidence to show people were listened to and issues resolved.

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?

Inadequate

The service was not safe.

People were not protected against the risks associated with the unsafe use and management of medicines. Appropriate arrangements were not in place for the recording, safe keeping and safe administration of medicines.

There was not always enough staff to provide people with individual support at night. Relatives told us the numbers decreased form 7pm and staff struggled to ensure people's wishes were followed.

Staff were knowledgeable on safeguarding procedures and procedures had been followed.

Is the service effective?

Requires Improvement

The service was not effective.

Most staff were recruited safely and all staff had completed an induction. However we found two staff who had recently been recruited did not have references form their last employer. A number of staff told us their induction was of very poor quality. One staff member said, "I was just thrown in and had to learn as I went along."

Care plans had not been updated. In some cases this had not been done in two years and did not detail people's changing needs. Staff were reviewing plans, but the support plans did not reflect people's current needs. Mental capacity assessments and best interests meetings did not take place in line with The Mental Capacity Act 2005.

A well balanced diet that met people's nutritional needs was provided. However people were not always supported by staff to enable them to eat and drink sufficient amounts for their needs. We observed people sat for up to an hour before their food was served. We also observed people's needs in relation to type of food required were not followed.

Best practice guidance was not always followed for people living with dementia in respect of the environment.

Is the service caring?

Good

The service was caring.

People praised the staff and we found they were kind, caring, showed compassion and had an understanding of how to communicate with people who had complex needs.

Summary of findings

We observed positive interactions between people and staff laughing and joking and using positive verbal and non-verbal communication. Every person who used the service and their relatives we spoke with said that the staff were 'marvellous'.

Is the service responsive?

Inadequate

The service was not responsive

People's health, care and support needs were assessed and reviewed. However, we found the support plans did not always reflect the person's changing needs. This meant staff were not always aware of people's needs and how to meet them. Some people and their relatives told us they were not always happy with the care provided. This was mostly regarding lack of stimulation and activities leading to isolation.

The manager told us they had not received any complaints since they had been in post. However, we found a number of concerns and issues had been raised by relatives. We found these were not documented to show any action taken. There was no evidence to show people were listened to and issues resolved.

Satisfaction surveys were used to obtain people's views on the service and the support they received. 'Residents' and relatives' meeting' had recommenced since the manager had come into post. People told us the new manager listened and was improving the service.

Is the service well-led?

Inadequate

The service was not well-led.

There was no registered manager in post. There had been five different managers overseeing the service since January 2014. Relatives told us there had been no consistency in management. However all relatives we spoke with told us the home had improved considerably since the new manager had been in post.

People were put at risk because systems for monitoring quality were not effective. For example, audits to monitor the safety and quality of medication administration were not effective.

Accidents and incidents were monitored by the manager. However we identified this was not always effective.

Staff and 'residents' meetings' had been reintroduced and regular staff meetings were held to ensure good communication of any changes or new systems; they also gave staff opportunity to raise any issues. However, staff we spoke with felt they raised issues and they had not always been dealt with appropriately. For example, they had not been informed of last minutes changes to staff rotas.

Meadow View

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.

This inspection took place on 24 and 25 November 2014 and was unannounced. The inspection team was made up of a, two adult social care inspectors 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.

As part of this inspection we undertook a Short Observation Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us

Before our inspection we reviewed all the information we held about the service. Prior to our visit we had received a provider information return (PIR) from the provider which helped us to focus on the areas of the inspection we wished to look at in detail. The PIR document is the provider's own assessment of how they meet the five key questions and how they plan to improve their service.

We spoke with the local authority, commissioners, safeguarding and Rotherham Clinical Commissioning Group. The local authority contracts officer also visited the service on the second day of our inspection.

At the time of our inspection there were 43 people living in the home. The service consisted of two floors. The downstairs unit provided care and support for people living with dementia.

We spent some time observing care in the lounge and dining room areas on both floors to help us understand the experience of people who used the service. We looked at all other areas of the home including some people's bedrooms, communal bathrooms and lounge areas. We looked at documents and records that related to people's care. We looked at five people's support plans. We spoke with 16 people who used the service and 14 relatives.

During our inspection we also spoke with 11 members of care staff, two nurses, the deputy manager, the head of care, the new manager and the regional manager. We also looked at records relating to staff, medicines management and the management of the service.

We also spoke with visiting professionals, including a speech and language therapist who told us the service had improved since the new management team had been in post.

Inadequate

Is the service safe?

Our findings

People who used the service who we spoke with said that they felt safe in their accommodation at Meadow View. One person said, "I feel completely safe. I have no worries, everyone here is alright with one another, everything is OK."

This view was echoed by relatives and friends visiting the home that we spoke with. One relative of a person who had been in the home for two years said, "I feel they are safe here and that there is no prospect of the staff being abusive towards them." They also said, "Yes, we have had our ups and downs – mainly through changes of management – but I would not leave my relative here if I had any doubts."

Most people we spoke with said they felt comfortable talking with the staff and one person told us, "They (The staff) are really smashing lasses." Another said "I know what to do if something isn't right, I tell the senior carer and if she can't do anything I will tell the manager."

We looked at the systems in place for managing medicines in the home. This included the storage, handling and stock of medicines and medication administration records (MARs) for three people.

The medicines were administered by qualified nursing staff and care staff, who were trained to administer medication. Staff had also received competency assessments in medication administration. However, we found staff who administered medication had not followed procedures. This put people at risk of not receiving medication as prescribed.

We found staff did not always administer people's medication as prescribed. For example we found a number of errors in the records we looked at, one person was prescribed paracetamol to be given when required. Staff had signed to say there were 64 tablets on 19/11/14 and 22 were signed for as given, this would leave 42 in stock. However, 38 were left in stock. This meant tablets were missing and unaccounted for. We also found the balance sheets did not always tally with the amount of medication left in stock. This made it difficult to account for medicines received and administered, and difficult to ensure stock levels were correct.

We looked at the protocols for 'as required' medication and saw these did not give sufficient detail for staff to be able to determine when the medication was required. The protocols stated; 'give as directed'. The protocols should provide guidance for staff to follow when to give PRN medicines. For example, there was no guidance for staff to determine how people showed they were in pain and needed medicine for pain relief. Two of the people's care we looked at in detail did not have the capacity to be able to verbally communicate to staff when they were in pain. This meant the people could be in pain and not have pain relief medication administered as staff did not know what signs to determine if pain relief was required.

We were shown medication audits. The audits had identified errors and picked up issues of concern, but these had not been addressed formally with staff. We spoke with the manager and regional manager regarding this and they told us this would be addressed to ensure staff did follow procedures or if not, appropriate action taken.

This is a breach of Regulation13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

With regard to the number of staff on duty, most people who used the service and relatives we spoke with said there were sufficient staff on duty in the daytime. However, they had concerns about the numbers of staff on duty at night. One relative said, "I don't come to visit at night, but my relative has told me that there is only one carer on the top floor at night." Another said, "There are not enough staff to see to everybody. Some are in bed, and others need quite a bit of assistance, but they all do their best."

We looked at the staffing rotas and saw that there were insufficient staff on duty at night. We discussed this with the manager and regional manager. They told us they had identified the need for more staff to meet people's needs at night and allocated an additional care worker, and told us two care staff were on each unit from 25 November 2014.

One person we spoke with, who required two staff to help them into bed said, "When it is time for bed, I often have to wait until quite late because there is only one member of staff up here (by this they meant the first floor) and two downstairs. I have to wait until someone can come up to help with me." We asked what time this usually was, they said, "Usually after 11 o'clock, or once it was nearly midnight." Another person we spoke with told us, "My husband has to stay and help me to bed otherwise I would have to wait until very late and I like to be in bed by 10 o'clock."

Inadequate

Is the service safe?

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

One person we spoke with told us they liked to leave their bedroom door open at night to go to the toilet without making a lot of noise. When we checked this, the person propped their door open with a table, which does not comply with fire safety regulations. We spoke with the provider and manager about this and they told us they would look to address this immediately.

We spoke with 10 staff about their understanding of protecting vulnerable adults and they told us they had undertaken safeguarding training and would know what to do if they witnessed poor practice. We looked at their training records to confirm this. Staff we spoke with had a good understanding about the whistle blowing procedures and they said they would report anything straight away. We saw that staff had followed procedures and referrals had been made to the local authority safeguarding team. This meant people were safeguarded from further harm and abuse, because abuse was recognised and plans put in place to protect people from further harm.

We found the provider had recruitment procedures in place which included the required employment checks to be carried out for new staff. The manager told us that staff did not commence working with people who used the service until references had been received and they had obtained clearance to work from the Disclosure and Barring Service (DBS). The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. We looked at the recruitment files of three staff and spoke with staff who were on duty on the day of this inspection. Evidence in the recruitment files confirmed the majority of the required checks had been carried out prior to commencement of employment at the service. However, the references from last employers had not always been obtained. For example, for two staff we saw their references had been obtained from a regional manager who had worked for the employee's previous company. However, the references were sent from a personal email and did not detail in what capacity they knew the person. This meant the provider could not be confident the reference had been written by a previous employer. We discussed this with the manager who agreed to obtain references form the last employers and told us this would always be completed in future.

Before our inspection, we asked the local authority commissioners for their opinion of the service. They told us they had some concerns regarding care needs being met and records not being kept up to date. They told us they were regularly monitoring the service.

Requires Improvement

Is the service effective?

Our findings

We looked at seven care files and found they had assessed and identified people's individual needs with care plans in place detailing what care and support was required to meet their needs. However, we found these did not always reflect peoples current needs as we saw some that had not been reviewed or updated for two years in response to peoples changing needs. We also saw the care and support plans in place to meet people's needs were not always followed. For example, one person had been assessed at high risk of malnutrition and the care plan stated staff should monitor the food the person had eaten and to record this on a food chart. When we checked, there was no food monitoring chart in place for this person.

Most care staff we spoke with were aware of people's needs and had an understanding of how to meet them, despite care plans not having been reviewed to reflect people's changing needs. For example, most staff were aware of people's dietary needs. They could describe who had fortified meals, who were regularly weighed to monitor the risk of weight loss and people on special diets. We also saw speech and language therapist, dieticians and the local authority's care home liaison team had been contacted when required. However if peoples care plans are not up to date there is a risk they may not always receive the care they require to meet their individual needs.

People who used the service and their visitors we spoke with all told us should a GP be required, one would be summoned. Relatives told us that if their family member had a fall or some other untoward occurrence, staff from the home telephoned them immediately.

Two visitors we spoke with told us that their family member had recently had their eyes tested and had been given new glasses. We were told the optician had visited and tested people's eyes and where required, new glasses had been provided.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We used SOFI during lunch on two units. We observed on the unit upstairs on 24 November and the downstairs unit on 25 November 2014. We found the service of food was very slow. People in the upstairs unit had to wait an hour for their food to arrive and to be served. Staff told us the cook went with the heated trolley to each unit and served the meal. This meant there was a long wait for the last unit to get served. People also told us the meal should be have been served from around 12.15 to12.30, but it never arrived on time.

Five people sat at the tables in the small dining area upstairs at 12.15. They were chatting and enjoying each other's company. One person's relative joined them for lunch. A staff member came in to the dining room at 12.40 and said they did not know how long it would be before the food arrived. One person said, "On Sunday I got fed up with waiting so I went back to my room."

The lunch eventually arrived at 1.15 pm. One person said they did not want any food now, as they were no longer hungry. The other people at the table encouraged the person to have a meal and once all the people were served they talked together and gave encouragement to each other to eat the meal. Everyone had a pleasant experience once the meal had arrived. The care worker in the dining room also chatted to the people and helped with meals when required. The interactions we observed were very positive.

We observed again people waited for long periods for their food to be served in the downstairs unit. This unit accommodated people living with dementia. People got up from the table while waiting for food to be served. Two people waited for so long for a pudding, when this was offered they said no, as they were up from the table and leaving the dining room.

Staff on both units tried to assist people who required help to eat and also served people who were in their bedrooms. This meant staff were not always present in the dining room to help people. We observed a lack of organisation during meal times to ensure it was a pleasant experience for people.

The interactions we observed between staff and people who used the service were very positive and if the meal time had been better organised it would have meant people could have had a pleasant experience.

When we asked people what was for lunch no one knew what it was, as there was no menu available. One care worker said, "We take a menu round the day before and ask what they want, but they forget what they have ordered and if they see someone sitting near them with something else, they ask for that."

Requires Improvement

Is the service effective?

People told us the home did not have a permanent cook and a care worker was covering. They told us the food they cooked was very good. We did not observe anyone being asked what they wanted for lunch. The cook made the choices and gave people their meals. The cook told us they knew what people liked.

Some people we spoke with said the teatime meal was not as good as it used to be. They said it was mostly sandwiches. One person told us, "We used to get a hot choice, but not very often. It gets very boring, sandwiches all the time."

Others we spoke with said the food was good. Comments such as, "You can always ask for what you want." One visitor said, "My relative had been losing weight, but now that the staff are keeping an eye on what they eat this is improving and they have gained a few pounds. They always were a poor eater."

During our observations we saw no consideration had been given to the people who lived with dementia. All crockery was traditional white rather than coloured. The environment was not conducive to people living with dementia. Pastel colours were used and the doors along the corridors were also light in colour, which meant they were hard to distinguish.

Best practice guidance in the 'Environmental Assessment Tool' from the Kings fund 2014, suggests that if food and drinks should be presented on coloured plates it is appears more appealing to people living with dementia. Also that having different colours on walls and doors makes it easier for people living with dementia to locate their bedrooms, toilets and bathrooms.

The flooring on the corridors was a pale, shiny wood pattern. People living with dementia may interpret shiny floors as being wet or slippery. 'Memory boards' were mounted at the side of people's bedrooms to help people who were living with dementia locate their bedrooms. However, some were left blank. The Kings fund guidance also details the use of memory boards as good practice for people living with dementia.

Staff said they had received training that had helped them to understand their role and responsibilities. We looked at training records which showed staff had completed a range of training sessions. The training records we saw showed staff were up to date with the mandatory training required by the provider. We saw evidence of staff one to one supervision meetings with their manager had recommenced when the new manager came into post. All staff had an up to date annual appraisal of their work performance.

The manager told us they were in the process of delivering Mental Capacity Act and Deprivation of Liberty Safeguards training. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves. It also ensures that any decisions are made in people's best interests.

We found best interest discussions had not taken place, or had not been documented for some people who lacked the capacity to make decisions. This meant important decisions had been made on their behalf without following the MCA to ensure their rights were protected. For example, people who lacked capacity had been given vaccinations without staff assessing their ability to consent.

The Mental Capacity Act 2005 includes decisions about depriving people of their liberty so that where a person lacks capacity they get the care and treatment they need, where there is no less restrictive way of achieving this. The Mental Capacity Act Deprivation of Liberty Safeguards (DoLS) requires providers to submit applications to a 'Supervisory Body' for authority to do so. As Meadow View is registered as a care home, CQC is required by law to monitor the operation of the DoLS, and to report on what we find.

During our inspection we identified a person who was under continuous supervision and control by staff to ensure they did not get out of the building. The person continually went to doors and tried to get out. They also left the building when there was a fire alarm check during our inspection and staff had to go outside to encourage the person back. The manager or staff had not considered that they may be depriving this person of their liberty and that a DoLS application may be required to be made.

We spoke with the local authority safeguarding team who told us a number of DoLS applications they had received from Meadow View recently had been returned as they had not been completed correctly.

This was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Good

Is the service caring?

Our findings

People we spoke with gave nothing but praise regarding care staff. We observed care staff had good relationship with the people they were caring for. However, none of the people we spoke with were involved in their care and the decisions they did make were confined to what they wore, what they ate and, when available, whether or not to join in with activities. We found decision making was at a perfunctory level as there was a general perception that the staff knew what they were doing and were there to help people. This meant people were not always actively involved in making decisions about their care.

We observed a positive interaction in one lounge with people and staff laughing and joking and using positive verbal and non-verbal communication. Every person who used the service and their relatives we spoke with said that the staff were 'marvellous'. One person said, "She (care worker) is a good lass, and I love her to bits." Another said (naming the staff member), "She is so lovely and will do anything for us. This particular member of staff often comes in on her day off simply to see us."

The care workers we observed asked the people if it was alright to assist them before they completed the task For example, we saw staff ask people before they helped with their meal and we also observed staff knock on people's bedroom doors before entering. Staff also knew what they were doing to meet people's needs at a basic level and treated them with significant affection and patience.

One person said, "I get on with staff." When we asked them what they would do if they had a problem with anything they said, "I would call one of them as they go past the door and tell them." People also told us if they had any issues that staff could not resolve they would speak with the manager or deputy. Visitors we spoke with all told us that concerns had been dealt with immediately and resolved since the new manager had been in post.

A visitor we spoke with said, "The staff are lovely and work very hard. On occasion there are not enough of them." She went on to say, "Since the new manager and deputy manager came everything had been so much better."

Family members said they were welcome at the home at any time during the day or evening. Relatives we spoke with said they were able to stay until their relative when to bed and spend time with them once they were in bed if they wished. No one we spoke with said there were any restrictions on when they could visit.

We spoke with staff who demonstrated that they understood how to maintain people's privacy and dignity. For example, staff said they would always ensure that they covered the person as much as possible when undertaking personal care.

We asked the manager if the service had dignity champions to ensure people were respected and had their rights and wishes considered. They told us there were champions but more work was required and some training as they felt staff did not fully understand the role.

We saw people had chosen what they wanted to bring into the home to furnish their bedrooms. They had brought their ornaments and photographs of family and friends or other pictures for their walls. This personalised their space and supported people to orientate themselves.

Inadequate

Is the service responsive?

Our findings

Some relatives had visited the home prior to the admission of their family member. One relative said, "We picked this home for its location. All the family can easily get to visit here, and it was recommended." Another relative said, "We wanted my relative to come into here as she is from this locality and has a relative already in here."

We found relatives who visited regularly got some opportunity to talk about and influence what care their family member received. One relative said, "There have been many ups and downs here, mainly through changes in management and if you want anything doing, even now, you have to push for it."

One person who used the service told us, "If there is anything wrong they fetch the doctor to you." A visitor said "When my relative had a fall, they rang me straight away and I went to the hospital with them." They also added, "I did not feel there was any negligence on the part of the staff associated with the fall."

Other relatives we spoke with said they could see the improvements the new management were making. They said they had responded to concerns and issues and were working hard to improve the service.

One other relative praised the staff, saying, "The staff have really persevered with her using her frame as she was at grave risk of falling and wanted to use just a stick. She now is much steadier with the frame and has got accustomed to using it."

When we spoke with people we found a large number struggled to hear us, as they were hard of hearing. We identified these people were not wearing hearing aids. Voices were therefore raised when talking with them, giving an overall impression that they were being 'shouted at'. Staff we questioned were unable to tell us if these people had a hearing aid or if they had been assessed for one.

Relatives we spoke with told us, "My relative really needs their ears syringing or something, they can't hear a thing." Another relative of a different person said, "My relative needs a hearing aid but the staff don't seem to get around to getting anything done about it."

We looked at seven people's care plans. Each person's care plan outlined the areas where they needed support. However, we found these were out of date and did not always reflect people's changing needs. We also identified the care and support delivered did not always follow the care plan as the plans required updating. The manager was aware of this. For example, we saw one care plan that detailed the person's moving and handling plan. This included, what was required and how to meet their needs when out of bed. However, this was not followed, as the person was cared for in bed.

We saw care plans were reviewed. However, the reviews were not responsive to people's needs, as staff had stated people's care plans remained the same, when we found the person's needs had changed. For example, one person's care plan stated they should sit in a specialist chair when out of bed, for their safety. Staff told us the person did not get out of bed. We spoke with the occupational therapist (OT) they told us they person had received an assessment in October 2014 and the manager had been informed that a specialist chair was required to meet their needs. This had not been ordered when we spoke with the OT on 4 December 2014.

Other care plans we looked at also showed that the monitoring of people's food and fluid lacked detail. For example, care plans had identified when people were at risk of poor nutritional intake and had stated people needed food and fluid monitoring charts to be completed, to monitor what they were eating and drinking. We found these were not completed or reviewed to be able to determine people's needs were met. People's records showed they had not received sufficient fluids to prevent dehydration and on a large number of days, the records showed people had not eaten sufficient to ensure they received adequate nutrition.

We identified that one person should have been prescribed a thickener for their food and drinks as they had been assessed by the speech and language therapist (SALT) as at a risk of choking. We found the entry had been made in the care plan in the section under health professionals. However, we could not find any reference to this in the person's care plan for nutrition. No medication administration records (MAR) sheet was available for this prescription. Staff we spoke with said they had been using the thickener in the person's food and drinks for a week, yet there was no clear guidance for staff on the quantity of thickener to use to prevent the person from choking. The nurse we spoke with told us this had not been prescribed by the person's GP.

Inadequate

Is the service responsive?

One person we saw during our inspection continually asked for the toilet. The person was very distressed. When we asked staff about this they said it was probably due to the person's dementia. When we questioned further if they had ruled out or checked any other underlying factors they said they had not. When we looked at their care plan it showed that they had only been using the service for a month. There was no evidence their continence needs had been assessed to determine if there was an underlying cause of the continued requests to go to the toilet.

We looked at peoples care files to see if they were individualised. We found they did not always reflect people's choices, wishes or decisions and did not show involvement of the person. However, the manager had identified this and was aware the plans required reviewing and updating to reflect this.

This is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This is the third continued breach of regulation 9 and CQC have issued two previous compliance actions. We are taking further action and will report on this when it is concluded.

The manager was aware that people's care plans were out of date and needed to be reviewed. They said this was in progress, since they had been in post.

The activity coordinator was on leave on the day of the inspection**.** The television was on in the lounge, although no one seemed to be watching it. Televisions were on in most of the bedrooms where people were sitting, although most people were asleep. Channels were not changed. Throughout the day staff talked with people who were awake, but apart from at mealtimes several people remained in their rooms without any interaction from staff. When we asked staff, they explained this was their choice. There was very little sign of stimulation or activities provide to these particular people. We saw there was an activity programme; however this was mostly for people who were able join in group activities.

We asked staff whether they thought there were enough activities. Care workers we spoke with said that it was not always possible to do things with people, especially on the ground floor. They said it was easier upstairs. The suggestion was that staff did not understand how to engage people living with dementia in activities. Relatives we spoke with also told us there was a lack of activities and stimulation. One relative said, "They do have some outings and entertainers come into the home but not everyone is able to join in, we need more stimulation for people who are in bed."

The manager and regional manager were aware there was not enough activities provided and told us they were in the process of recruiting staff to provide additional hours for activities.

We identified that there had been two relatives meetings since the new manager came into post on 1 September 2014. This meant communication was being considered and improved to seek the views of people and their relatives.

A complaints process was in place. However, we found that not all concerns had been recorded. The manager had dealt with a number of minor concerns and relatives told us they had raised issues that had been dealt with, but no record had been kept of the concerns, or of any action taken and outcomes.

We spoke with visiting health care professions during our inspection. They all commented on the improvements since the new management team had been in post. The speech and language therapist said, "Seems better recently they've passed things on, been more responsive and approachable."

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Our findings

At the time of our inspection the manager had not yet been registered with the Care Quality Commission. There was a newly appointed manager in post who had commenced on 1 September 2014. We were told they had submitted a disclosure and barring service check and once this was returned they would submit an application to CQC to consider their registration. There was also a new deputy manager and head of care in post.

There were systems in place to monitor and improve the quality of the service provided. We saw copies of reports produced by the manager and the deputy manager. The reports included some actions required and these were checked to determine progress. However, the systems were not always effective. For example, they had not adequately monitored medication administration and we found the issues they had previously identified had continued to occur. Staff had not followed the correct procedures to ensure people received medication safely. This had not been addressed with the staff concerned. We also identified that assessments and recommendations by healthcare professions were not always followed.

Accidents and incidents were monitored by the manager. However, we identified this was not effective as they did not pick up issues we identified. For instance, we found that out of 23 incidents recorded, 20 of these occurred between the hours of 7pm until 7am in October 2014. This was when the staffing numbers were considerably reduced for the night shift. The times of the incidents had not been monitored to determine any triggers or themes which could be addressed.

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

Overall, every visitor with whom we spoke said that the quality of the care provision in the home had improved since the new management team had been in post. The relatives we spoke with told us the changes in management had been very frustrating. They said the service had gone downhill without a consistent manager. It had become dirty and care was not being delivered to a good standard. They told us the new manager had improved this considerably. They said their only concerns were the high staff turnover. They told us that on a number of occasions, due to last minute sickness some shifts were not adequately covered to meet people's needs.

One relative we spoke with said that a number of improvements have been made since the current manager has been in the home. They said, "He has made a terrific difference to the place in more ways than one. He has made sure that everything is clean and there has been some repairs competed that were required." Another visitor said, "I didn't recognise the place when we came in, he certainly has made a difference."

A number of relatives we spoke with were concerned about the high level of staff sickness, which meant that on some days there were not enough staff on duty. We discussed this with the manager, who was clearly dealing with this issue. We saw evidence that they monitored staff sickness and used a scoring system to determine when staff were met with formally to discuss their sickness.

The manager and deputy manager when we spoke with them told us that they has a number of plans in place to change working practices in the service to ensure care practices improved. They also said they were looking to improve things for people living with dementia. For example, new crockery. However, they said there main concern was, "The people who live here."

Satisfaction surveys were provided to obtain people's views on the service and the support they received. However these had not been sent out for over a year. We identified there had been significant decoration and improvements recently at the home. However, by talking with people who used the service and their visitors, we found that no consultation had been carried out with them regarding this, although they all appreciated the results. We also identified that some of the improvements were not conducive to meeting the needs of people living with dementia. The manager and deputy had identified this and had plans to change the environment.

We spoke with the local authority contracts officer. They told us they had concerns regarding the service, but they had more confidence since the new manager had been in post and had seen improvements.

The staff told us it had been difficult as there had been five different managers in the last year. They said each manager

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had different ideas, which meant things kept changing. However, some staff said they felt the new manager listened to them and tried to resolve issues, but it was not always possible as they were very short staffed.

We received conflicting views from staff about whether they felt they were listened to. Staff meetings had been reintroduced and regular staff meetings were held to ensure good communication of any changes or new systems; they also gave staff the opportunity to raise any issues. However, some staff we spoke with felt they raised issues and they had not always been dealt with appropriately. For example, they had not been informed of last minutes changes to staff rotas.

One staff member said, "The ways of doing things are clearer, before we were working on our own." Another said, "Since (the manager) come in it's a lot calmer, you can go to him and he'll sort it if he can, he's firm but fair."

Staff we spoke with told us that they could talk with the manager if they had any concerns. A number of staff told us that they thought that it was right that some staff had left the home since the new manager was in post. They also said, "If you don't want to improve things by working with the manager you need to go." Staff were positive about the changes which would ensure standards improved for people who used the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **People were not protected against the risks associated with the unsafe use and management of medicines. There were not appropriate arrangements for obtaining, recording, handling, dispensing and disposal of medicines.**

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 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **People did not receive care or treatment in accordance with their wishes. People were not always asked for their consent before treatment was given. The Mental capacity Act 2005 was not always followed.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **The provider did not ensure at all times that there were sufficient numbers of suitably qualified and experienced staff to meet people's needs.**

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **People were not protected against the risks of receiving care or treatment that was inappropriate or unsafe.**

The enforcement action we took:
We have issued a Warning Notice which we have asked the provider to comply with by 31 January 2015

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **The provider did not have an effective system to regularly assess and monitor the quality of the service provided.**

The enforcement action we took:
We have issued a Warning Notice which we have asked the provider to comply with by 31 January 2015.