Care Quality Commission

Churchgate Healthcare (Maples) Limited

Maples Care Home

Inspection report

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Ratings

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

Overall summary

This inspection took place on the 7, 8 and 9 April 2015 and was unannounced.

Maples Care Home is a large residential home which provides long term residential care and support, nursing care, dementia care and respite services for up to 75 older people. There are three units in the home, one providing nursing care, a dementia unit and a unit that provides support for people with behaviour that can be challenging. The home is situated within a residential area of the London borough of Bexley. At the time of our visit there were 48 people using the service.

At the time of the inspection the home did not have a registered manager. 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 2008 and associated Regulations about how the service is run.

There were not enough staff to meet people's needs on all the units and the provider had not followed their own recruitment policy in all cases. We found soiled

Summary of findings

equipment and a lack of hand washing facilities for staff which presented a risk of cross infection. People we spoke with told us they felt safe in the home and the provider had policies and procedures in place to respond to any concerns raised relating to the care provided. The majority of staff had completed training on safeguarding adults and records were kept of any safeguarding concerns.

People's care needs were assessed when they initially moved into the home and we saw their care plans and risk assessments were regularly reviewed but the information in the care plans was task focused and did not reflect the person's wishes in relation to how their care was provided. There was no evidence that the person using the service or their relatives had been involved in the development and review of the care plans.

We saw that most people were supported to maintain good health with access to GP's and other healthcare professionals and each person's individual healthcare needs were identified in their care plans.

People told us they liked the activities that were organised at the home and we saw people enjoying different types of activity during our inspection.

The recruitment procedures used by the home were not robust and there was no formal process for assessment during the induction period, an annual appraisal and staff had not completed a range of refresher training courses which were relevant to their work.

Medicines were handled and administered safely but staff did not complete records relating to medicine use as required by the home's own systems. The provider had systems in place for the recording of incidents and accidents as well as complaints but did not identify learning from these reports to reduce possible risk.

We found the service was not meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act 2005 (MCA) in the way assessment of capacity were carried out.

There was mixed feedback relating to the quality and type of food. We saw that people were given food that met their nutritional need or they found difficult to eat and they were not appropriately supported by staff. People did not have access to suitable cutlery and equipment to enable them, to maintain their independence when eating.

The provider had system in place to monitor the quality of the care provided but these did not provide appropriate information to identify issues with the quality of the service

We found a number of breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to emergency evacuation plans, infection control, recording incidents and accidents, staffing levels, recruitment practices, staff training and support, Mental Capacity Act, food, staff interaction, person centred care plans, complaints and monitoring the quality of the service. You can see what action we told the provider to take at the back of the full version of this report.

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

Summary of findings

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.

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 using the service were put at risk as standards of cleanliness were not maintained. There were not always enough staff to meet people's care needs appropriately and safely.

The provider had systems to record but not identify learning from incidents and accidents to minimise possible risk and keep people safe. There were procedures in place for the safe management of medicines but staff did not complete records relating to medicine use as required by the home's own systems.

The service did not have an effective recruitment process in place.

People using the service felt safe and the provider had effective policies and procedures in place to deal with any concerns that were raised about the care provided.

Is the service effective?

Inadequate 

The service was not effective. Procedures were not in place in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) to ensure the service only deprived a person of their liberty in a safe and correct way.

Staff had not received the necessary training and support they required to deliver care safely and to an appropriate standard.

People gave mixed feedback regarding the choice of food available. People did not always receive appropriate support to eat and drink.

Is the service caring?

Requires improvement 

Some aspects of the service were not caring. Some of the staff did not interact with people using the service in a supportive and encouraging way.

Staff spoke to people on a respectful way and addressed them by their preferred name. Staff also treated people with dignity and respect when providing care but some staff did not act in a respectful manner at other times.

Preference forms had been completed for most people using the service identifying their wishes in relation to the care they received.

Is the service responsive?

Inadequate 

The service was not responsive. People using the service were not supported to contribute to planning their own care.

The provider had systems to record but not identify learning from complaints they received to minimise possible risk and keep people safe.

Summary of findings

Activities provided by the home were meaningful and engaging for people using the service.

Is the service well-led?

Inadequate 

The service was not well-led. The provider had various audits in place to monitor the quality of the care provided. We saw some of these did not provide the appropriate information relating to quality to identify aspects of the service requiring improvement and action had not always been taken to address issues.

People using the service and their relatives completed a questionnaire to feedback their views on the care and support provided.

Maples Care Home

Detailed findings

Background to this inspection

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

This inspection took place on the 7, 8 and 9 April 2015 and was unannounced. The inspection was carried out by an inspector, a specialist advisor in dementia care, an expert by experience and a pharmacy inspector. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the notifications we had received from the service, records of safeguarding alerts and previous inspection reports.

During the inspection we spoke with 26 people using the service, 10 relatives and visitors and 11 staff members. We also spoke with the deputy manager, head of operations and a director of the service. Following the inspection five relatives contacted us via email with comments.

We reviewed the care plans and risk assessments for 17 people using the service, the daily records for eight people, emergency evacuation plans for 30 people and the Medicine Administration Record (MAR) charts for 30 people. We looked at the employment records for 10 staff members. Other records we looked at included 13 accident and incident reporting forms and various audits. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also carried out general observations around the home during breakfast, lunch and throughout the day in the lounge areas.

Inadequate

Is the service safe?

Our findings

People we spoke with told us they felt safe in the home and when they received care from the staff. They said "It's not so bad here. I feel safe." and "Yes I feel safe here. When I arrived they said to me where you would like your room to be and I chose the first floor as I like to be up. I feel safer." However our findings at this inspection did not support people's views.

People using the service and relatives we spoke with told us felt there were not enough staff on the units to provide the care required to meet people's support needs. One person said "I don't think there are enough staff and I don't think they have the right training." A relative told us "They have not got enough of the right type of staff and they do not have the relevant training." On one unit where people with behaviour that challenged were cared for, A relative said "They won't take my relative to the toilet at mealtimes; staff say she needs to go in her pad as they are too busy."

The nursing and care staff worked 12 hour shifts on one of three units. The deputy manager explained that staffing levels were decided based upon the results of dependency assessments that had been sent to head office each week to assess the number of staff required. We saw that the dependency assessments were not completed weekly but monthly which meant there could be a delay of up to a month in ensuring the right number of staff were available to support people.

Our observation showed that staff were very task focused with the amount of time they could spend with individuals to help promote their independence and support their emotional needs being limited as staff were often busy with other tasks, including preparing food, clearing up and with administration work and updating care records.

There was one nurse and two healthcare assistants (HCA) providing seven people with support during the day with one nurse and one HCA at night. The deputy manager explained that all the people receiving support on this unit each required support from two staff for personal care and at other times during the day. This was also confirmed by the staff on the unit. Staff we spoke with told us they felt there was not enough staff to provide appropriate care for people with higher levels of support needs. Staff also said that people were unable to access the garden as it had been identified from previous occasions that some people on the unit would require the support of two staff if they went outside. This would result in only one member of staff being left on the unit which would not meet the identified support needs of the people remaining on the unit.

Another unit had 25 people receiving support including nursing care and some of them also living with dementia. There was one nurse and five HCA's providing care during the day with a nurse and two HCA's at night. The deputy manager confirmed there were ten people who required the support of two staff for personal care and five of them also needed two staff to use a hoist to help move them. People told us they had to wait for support from staff during busy times such as breakfast. Two visitors told us "Sometimes our friend is not dressed until 11.00am. The staff had to spend more time with other people who are not so able." We observed that the staffing levels on this unit resulted in people not receiving appropriate care in a timely manner. We saw people who were waiting for personal care and food and drink for up to 30 minutes as staff were busy elsewhere on the unit. One person who was in their bedroom told us they were still waiting for a cup of tea and their breakfast at 10am and staff had not been back to their bedroom since providing personal care over an hour before.

The above paragraphs demonstrate a breach of Regulation 18 (1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were not managed safely at all times. Although systems were in place to manage medicines safely, staff did not follow these systems and processes and did not complete records appropriately. For example, records related to medicines were incomplete and did not record the action taken when an anomaly was noted. We found that when a fridge temperature was recorded as outside the recommended range there was no record of the action taken to rectify the fridge temperature. These meant medicines may not be safely stored.

There were record sheets in place to record the number of tablets in boxed medicines so that there was awareness of stock left and an audit trail. However these were only completed intermittently which meant that additional medicines may not have been requested before they ran out to ensure people received their medicines as prescribed. Care plans were available for medicines

prescribed to be taken only if needed, however some of these were not individualised to people's needs and, gave no extra information or did not give clear guidance to staff to allow for a person centred, consistent usage.

When a new medicine was hand written on the MAR chart another person did not check the information for accuracy before commencing treatment. We saw three MAR charts with duplicate entries where medicines had been recorded when administered in both entry. Medicine could not be given twice as medicines were received in a medicine dosage system (MDS) format however there was a risk that medicines could have been given twice if they were boxed and not included in the MDS.

All of the above recoding shortfalls showed that the care staff were not following the systems of the service at all times.

The above issues demonstrate a breach of Regulation 12 (2) (g) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the day of our visit the morning medicine round on one unit took over two hours as an agency nurse was administering medicines for the whole unit was not used to each person's prescribed medicines. The lunch time medicine round was therefore delayed to allow sufficient time between doses. We saw regular staff took less time to complete the medicines round on other units.

Risks to people were identified but records to reduce risk were not always maintained. The provider had a process in place for the recording and investigation of any incidents and accidents but not all the information relating to the action taken was recorded on the forms. We saw staff had recorded information about the incident as well as action that had been taken at the time. There was a section on the form asking if the care plan had been updated following the incident and if not the reason why. We saw where staff had indicated that the care plans had not been updated no reason was given for this on the form. The completed forms should be passed to the manager for review and investigation if required. We saw some forms had not been reviewed by the manager. Where the manager had reviewed the form they made general comments but did not identify actions that should be taken to reduce possible risk of reoccurrence. There was a section on the form asking staff to record what action they feel could prevent the incident or accident happening again but the section was not always completed and we could not see what had been done to reduce the risks to people. For example, following an unwitnessed fall a staff member had suggested the use of a sensor mat in the person's room. The manager had stated on the form staff were advised to use a sensor mat but there was no record of this being implemented on the incident and accident report form.

The above paragraph demonstrates a breach of Regulation 17 (2) (b) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home was not always clean and people were not protected from the risk of cross infection. The provider had procedures in place in relation to infection control and the cleaning of the home but these were not being followed by staff and did not meet the needs of the home. During the inspection we looked in 11 ensuite bathrooms in one unit. We found the shower chairs and commodes in 5 of the bathrooms had not been cleaned appropriately and there was faecal matter on the equipment. We also saw that wheelchairs were being stored in the bathrooms next to the commodes and shower equipment. This increased the risk of cross contamination between equipment and the person using the equipment developing an infection. In one bathroom we saw a bed pan contained urine and had been left balanced on the commode. We saw used gloves had been left next to the toilet and had not been disposed of appropriately in another bathroom. This increased the risk of cross infection.

Staff did not have access to separate hand washing facilities and equipment. We saw staff had to use the sink in each person's bathroom to wash their hands after they provided care as there was no hand washing facilities outside the bathrooms. We did not see any disposable hand towels or hand wash for staff in the bathrooms. We saw that staff had access to alcohol hand gel but staff also needed to be able to wash their hands regularly when providing care. This meant staff could not maintain appropriate levels of hand hygiene.

Staff were not clear about the infection control procedure in place at the home. The head of housekeeping explained that each unit had a bucket which contained appropriate cleaning solution and equipment but in one unit the bucket had not been cleaned and this meant the equipment could be contaminated before use. On another unit there were a number of people experiencing continence issues which impacted on the cleaning of the

unit and resulted in a slight residual odour being present. Staff explained that the housekeeping staff cleaned each unit once a day and any further cleaning was carried out by the care staff when required however staff we spoke with said it would be helpful if the housekeeping staff could clean the units twice a day to help maintain cleanliness standards.

The above paragraphs demonstrate a breach of Regulation 12 (2) (h) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not safe. Personal evacuation plans were available but these did not provided adequate information on the support required for people during an emergency. The standard evacuation plan format included information about the mobility, behavioural and health issues of the person with their photograph and a list of their medication. These information sheets were kept in a folder in the emergency box in the reception area. The deputy manager explained that this information would be given to the fire brigade if the home had to be evacuated. We saw emergency evacuation equipment was stored in the stairwell and the deputy manager explained that as there was a sprinkler system installed at the home any evacuation of people using the service would be carried out by the fire brigade. We looked at the personal evacuation plans for 30 people and saw each person's mobility and medical issues had been identified. There was no information provided on how people should be assisted during an evacuation and what equipment should be used in relation to moving and handling especially for people with mobility issues on the first and second floors. For example, one evacuation plan identified that the person's behaviour may become challenging due to the loud fire alarm but did not explained how to provide appropriate support for the person to prevent them becoming agitated to aid safe evacuation. This information was not kept in the units so staff could not see the overview of each person's support needs in case of an emergency.

The above paragraph demonstrates a breach of Regulation 12 (2) (b) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service did not have safe recruitment processes in place. We looked at the recruitment folders for six people and saw applications had not been processed in line with the provider's recruitment process. Appropriate police and identity checks had been made. However we saw one person had an 18 month gap in their employment history but the applicant had indicated there had not been any gaps in employment on their form. The interview notes we saw did not indicate that this had been discussed at the interview. The applicant also provided two personal references but did not indicate their relationship with the people providing the reference to ensure these provided an accurate view of the person's suitability for the role. An application form for another person had the details of two references which had been requested but only one reference had been received and the person had started employment. The deputy manager told us new staff should not have started at the home without two appropriate references and any discrepancies or missing information in their application should have been checked before any offer of employment was made.

Applicants had to complete a literacy and numeracy test as part of the recruitment procedure to ensure they had the appropriate skill level to record information clearly and accurately. We saw in three of the recruitment folders that applicants had been assessed with a low score on both the literacy and numeracy tests with some people failing to complete all the questions. The deputy manager explained that, as part of the recruitment process, if an applicant had not reached an acceptable level with their literacy and numeracy tests they were identified as requiring additional support and a development plan would be created. This would identify suitable training and support to develop the person's skills to the required level so they delivered safe and appropriate care. During the inspection we did not see that any development plans had been created following interviews for people with low scores. Notes of interviews that had been carried out were not completed in full to ensure a complete record of the discussion was kept. During our inspection we found examples of people's weight and dependency scores being miscalculated by staff.

The activity coordinator explained there were six volunteers that helped with activities and during meal times at the home. There was no policy and procedure in place at the home for the recruitment of volunteers. The activity coordinator told us they discussed with the volunteer what they would like to do around the home but they did not complete an application form and references

Inadequate

Is the service safe?

were not requested. Therefore, staff could not check that volunteers had the appropriate experience and skills required for their role. All volunteers had completed a criminal record check before starting at the home.

The above paragraphs demonstrate a breach of Regulation 19 (1) (b) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that risk assessments were in place in the care folders we looked at. A general risk assessment was initially carried out when a person moved into the home. More specific risk assessments were then developed covering such areas as mobility, continence, nutrition and pressure ulcers. The risk assessments were reviewed monthly or sooner if a change in support needs was identified. The risk assessments we looked at were up to date but we saw this information was not integrated into the care plans and clearly explained the possible risks and actions to be taken by staff to reduce the risk to the person. We also found there were some errors in calculations of assessments.

We saw the service had effective policies and procedures in place to deal with any concerns that were raised about the care provided. Staff completed safeguarding training and records we saw showed that the majority of the 44 care staff were up to date with their training but four staff had not completed the training and eight people had not attended the annual refresher course.

Staff we spoke with were aware of the principles of safeguarding and how they would protect people using the service from abuse. We saw records of safeguarding concerns that had been identified which included information on the incident, the outcome of any investigation and any required action. The records we saw showed that the provider had dealt with these appropriately.

The service had a whistleblowing policy and procedure in place and information on how to report any concerns was included in the employee handbook that staff received when they started working at the home.

Inadequate

Is the service effective?

Our findings

A person's relative told us "We feel we have to come here every day. We don't have the confidence. You can't blame the carers as a lot of them haven't had proper training. A new carer did not know how to strap a catheter bag to my relative's leg. I strapped the bag on correctly and took photos of it to show the staff how the bag should be fitted."

Staff did not receive the necessary training and support when they began working at the home. The deputy manager explained that during their first week of employment new staff completed the training identified as mandatory by the provider. We looked at the training records for ten staff who had started working at the home since 1 January 2015 and saw only one person had completed all the identified mandatory training courses and one person had not completed any of the required training. The remaining new staff members had not completed up to three courses.

As part of the induction programme new staff observed an experienced staff member during their first week. We asked to see what assessments were carried out to ensure the new staff member had reached the required level of competency to carry out their role. The deputy manager told us that at the end of the first week new staff were given a competency assessment form and told to ask an experienced staff member to review their skills and complete the form during the six month probationary period. It was the responsibility of the staff member to return the completed form and these were not monitored. However there were no completed competency assessment forms in the files we looked at of care staff who had completed their six month probation. This meant that the competency of new staff members was not assessed before they provided care which increased the risk of people receiving inappropriate and unsafe care.

Existing staff had not completed the required training to support them in their role. The provider had identified a number of training courses as mandatory which included fire awareness, safeguarding, moving and handling, medicines, infection control and first aid. Staff were required to complete a refresher training either annually, every two years or after three years depending on the course. We looked at the training records for clinical care coordinators (CCC), health care assistants (HCA) and shift coordinators. We saw that 29 staff had not completed first aid training and 15 staff had not completed food hygiene course. There were 10 staff members that had not completed the fire awareness course and five had not attended the health and safety training.

Staff were unclear about the supervision provided to support them in their role. We saw records showing that staff had a supervision session with their manager but when we spoke with staff members they told us they had not had any supervision with their manager and had not seen any records of supervision. The deputy manager informed us that the role of supervision sessions would be discussed with staff and they would be provided with notes following each meeting.

Staff appraisals were not carried out. The deputy manager told us that staff did not have an annual appraisal which was confirmed by staff we spoke with. This meant training and development needs may not be identified to ensure staff had the appropriate skills to provide safe care.

The six volunteers providing support around the home did not receive induction training or mandatory training. There was no system in place for assessment or supervision of volunteers to ensure they had appropriate training and support.

The above paragraphs demonstrate a breach of Regulation 18 (2) (a) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had not taken appropriate action to ensure the requirements were followed for the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA and DoLS is law protecting people who are unable to make decisions for themselves and provides a process to make sure that people are only deprived of their liberty in a safe and correct way, when it was in their best interests and there was no less restrictive option by which to provide support.

During our inspection we asked the deputy manager how many DoLS applications to the local authority had been made. We were given a list that identified 22 DoLS applications that had been made since June 2014 and included the date of submission. We asked the deputy manager to show us the outcomes of these applications and they were unable to provide any documents. We asked the acting head of care to check the progress of these applications with the local authority who confirmed they had received 10 applications, two of which were not

recorded on the list provided to us by the home. The records kept by the home indicated that DoLS applications had been made in relation to 14 other people but the local authority had no record of these applications being made. The home had no record of applications being made in relation to two people identified by the local authority. The staff had recorded three of these as being applied for in August 2014. Senior staff told us they believed these applications had been authorised by the local authority. This meant that safeguards were not in place for these people and this increased the risk of their rights not being protected.

When asked, the deputy manager was unaware of the latest Supreme Court judgement in relation to DoLS and the impact on people receiving care.

Ten staff had not completed their training on MCA at the time of the inspection. The training had to be repeated every five years as part of the mandatory training identified by the provider. Therefore there was a risk that staff would not understand their responsibilities under the MCA and we found that assessments were not all conducted in line with the MCA.

We saw that the staff used a number of different forms to assess if the person using the service had the capacity to make decisions. Staff completed a resident assessment which related to different issues related to a person's care. These forms were used to review a person's mental capacity to make decisions relating to their accommodation, medicines and care and treatment. The assessments did not identify specific decisions, as the MCA requires, in relation to the person's care but were used to assess capacity to make decisions in relation to all care and treatment received. We saw that where the person had been identified as having capacity they had not signed the form as indicated to confirm they agreed with the outcome of the assessment. Where a person had been assessed as not having capacity there was no information recorded as to any actions to be taken such as involving family members or advocates in making decisions in the person's best interests.

During the inspection we looked at Do Not Attempt Cardiopulmonary Resuscitation (DNAR) forms which had been completed for a number of people. We saw one person had been assessed as having the mental capacity to make this decision but only their relative had been consulted about the person's end of life wishes.

The above paragraphs demonstrate a breach of Regulation 11(3) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had mixed feedback in relation to the food provided. One person said "We had stewed chicken the other day. There was no meat. A piece of chicken the size of a peanut. Dessert is very bad. Lots of custard and a piece of cake." When asked if they could have fruit the person told us "Yes, but we had to complain to get it. They give us the cheapest food money can buy." Another person said "The staff are very obliging when you ask for something different to eat. It's good we get a choice." A visitor who visited regularly to help someone eat their meal told us "The food is excellent."

Staff would ask people for their choice for meals for the following day but we saw that staff did not remind the person what food they had chosen when serving the meal so some people were confused or thought they had requested something different.

People were given food which did not meet their nutritional needs or was difficult for them to eat. During our visit people were given melon for desert and we saw that people were unable to cut the fruit as it was hard. Staff did not help them cut the food into manageable pieces so they did not eat it and they were not offered an alternative. We saw one person, who required a soft diet, was given a plate of food which had not been prepared appropriately so a relative had to go to the kitchen to make it suitable to eat. The food for this person was not prepared in advance so they had to wait before eating. Both the relative and staff confirmed that this person was on a soft diet and appropriate food should have been provided.

On one unit a volunteer helped the staff serve the food to people in the dining room. They told us "My relative was in here and I picked up that they needed more help at mealtimes. So I told them I would come back after my relative died and here I am Monday to Friday." We saw the staff on that unit did not serve food in the dining room with the volunteer both serving and clearing away the meals. This meant that the staff were dependant on the volunteer to provide appropriate support and encouragement to people who were eating in the dining room. It was also difficult for staff to monitor food intake as they did not see what food was left on the plates after the person had eaten as the volunteer cleared them.

Inadequate

Is the service effective?

We saw people did not have appropriate cutlery and equipment to support them to maintain their independence when eating their food. On one unit there were no non slip placemats available so people were unable to control their plate as it moved when they tried to eat. Staff told us they preferred to serve food in bowls as it was "a better option as it was more stable". We saw that some people had difficulty holding the cutlery due to the shape of the handle. One person told us they found it difficult to hold the cutlery because they did not have a good grip. We asked if they had been offered any other type of cutlery which would be easier to grip and they told us they no and they did not know it existed but it sounded like a good idea. We did not see any assessments in place in relation to the use of suitable cutlery.

Food was not always served to people while it was hot. A heated trolley was used during meal times to keep food hot during meals in two units but on the third unit food was left on a counter top and there was no system in place to keep the food hot while being served so food was served at a lower temperature than on other units. People told us the food was not always hot. We were told by staff that they no longer used a heated trolley as a result of the identification of the possible risk of a person burning themselves on the equipment. The director confirmed that the use of the heated trolley would be reinstated on the unit in a secure area for storage during use to reduce possible risks. We also saw one person had to wait 20 minutes for their toast at breakfast when they were in their bedroom. The staff member arrived with cold toast and told the person the delay was due to a slow toaster but did not offer to replace the cold toast.

People's food preferences were not always met. The menus provided in the dining rooms were not easy to read for people with visual or cognitive impairments. The list of the food was in a decorative font which was not easy to read and there was no description or pictures of the food to help people chose.

During the inspection we observed people eating their breakfast in a dining room. One person asked staff for toast and marmalade and a staff member told them they had run out of marmalade, which was on order, so the person would have to have jam. The person using the service explained to us that there had not been any marmalade for a week and they did not want jam. Another person in the dining room also asked for marmalade and toast. We saw staff give them toast and jam even though they did not want it. The person asked why the staff could not get some marmalade from the local shop but they did not answer. On the second day of the inspection the person we spoke with told us they had been given marmalade on toast for breakfast and they were very happy.

The above paragraphs demonstrate a breach of Regulation 14 (1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that most people were supported to maintain good health and the care plans identified each person's individual healthcare needs. A person said "I have been out twice on hospital visits since I got here; to the dentist and the doctor. I now have an NHS physiotherapist who visits but I had to wait a year or eighteen months. I find the visits helpful." We saw visits from the GP and other health professional was recorded in the care folder. During our visit we saw people using the service were visited in their rooms by chiropodists. However not all relatives believed that health issues were dealt with in a timely manner. Following our visit four relatives told us they had concerns relating to delays in arranging visits from the General Practitioner (GP) when they informed staff that their relative required medical assessment.

Requires improvement

Is the service caring?

Our findings

There were mixed views about how caring the staff were. One person said "My carer helps when she feels good. A third of them are good, a third don't care except when there is someone watching and a third are not good. Last night I asked them to pull a blanket over me. I was cold. They told me to do it myself." This person told us they felt this was not said to encourage their independence. A relative told us "It's fine here. I've got no complaints. The carers are absolutely marvellous."

During our inspection we carried out observations during lunch on two different units and we saw that staff did not interact and communicate with people in a positive way. On one unit we saw that staff did not speak to people in the dining room during lunch for 40 minutes and the only interaction people had was with a volunteer who was serving the meals. In the other dining room the atmosphere was quiet with limited interaction between people and staff apart from when the staff member was placing the meal in front of the person.

Staff did not always treat people with dignity and respect. We saw that a group of staff were sitting in a lounge writing the daily records of the care provided and there were 10 people sat near them in the lounge. The staff were asking each other questions to enable them to complete the daily records for example "Who changed the incontinence pad in room X?", "So who have you changed?" and "Who did the change on (person's name)?" These discussions continued for ten minutes and did not respect people's privacy and dignity. We then observed two members of staff in a lounge laughing and joking with other staff and not involving people using the service that were seated in the lounge. A visitor told us "They don't know how to respect a person. I have heard a carer say too my friend who complained 'Now you listen to me!' and they tell my friend not to ring the bell too often at night as it wakes everybody up. My friend has to ring the bell as they need help going to the toilet at night."

Staff did not always have information about the people they supported to help them understand their life experiences and interests and encourage communication. We saw that some care folders had partially completed forms so information was not available to staff. The completed forms included information on their family, childhood memories, where they lived and where they liked to go on holiday.

The above paragraphs demonstrate a breach of Regulation 10 (1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that some of the staff communicated face to face with people, spoke to them in a respectful way and addressed people by their preferred name. The activity coordinators related positively with people and had developed an understanding of people's interests and support needs. Some staff we observed treated people with dignity and respect at times when providing care.

We saw preference forms had been completed for most people using the service. These identified each person's preferences relating to where they wanted to eat, if they preferred blankets or duvets and what they liked to drink. They also identified if they had a preference for a male or female staff member to provide care and if they wanted their bedroom door open or closed at night.

Inadequate

Is the service responsive?

Our findings

Care was not planned appropriately to meet people's needs and did not reflect their preferences. We spoke with one person who told us they had lived at the home for four weeks and wanted a shower but were unable to stand safely. They had asked the staff for a shower chair so they could sit down while washing but the staff told them it was on order and they had to have strip washes until the chair was available. We raised this with the deputy manager who located a shower chair from a store room and took it to the person's room. The person was very happy to now be able to use the shower. One person said "The staff are not standard with the regulations. They do as they feel like at the time. I wanted to go out for a walk in a wheelchair with my sister last month. They said I needed assessment to go out and the person to do the assessment was not here." This person was unable to go out with his relative. We asked one person if they could get up in the morning when they wanted to. They told us "I am supposed to have free choice about the time I get up but they have to complete their work. Officially I get up at 8am but I have to sit by my bed from 6am." People we spoke with told us they felt that staff were not always aware of what was in the care plans. One person said "They do not seem to stick rigidly to care plans. I think some staff don't understand them."

People's preferences were not recorded. We saw that each person had multiple care plans for example social care, personal hygiene, communication, eating and drinking and mental cognition plans. The deputy manager explained that care plans were reviewed monthly or sooner if there was any change in the person's care needs. The care plans we looked at were up to date but were task orientated. The actions identified in the care plans focused on what staff had to do and not how the person wished their care to be provided.

People's care planning was not done in a person centred way to take account of their experiences and preferences. A relative told us "I asked for my relatives care plan to be available but I was told it was confidential and could not be left in the room." We asked if they had been offered regular sight of their relatives care plan and notes and they told me they had not. Another relative said "My relative is due for a review of their care plan but it was cancelled." We saw people's views and experiences were not taken into account in the way the service was provided as people using the service or their relatives were not consulted in the development and review of care plans we looked at.. One relative told us that the contents of the care plan had changed during the month without any notification. We saw that the section on the care plan for the person using the service or their relative to sign to indicate that had been consulted in its development had not been completed. The care plans had only been signed by the staff member who developed it. The monthly review form had a section for the date, comments and the name of the person carrying out the review but not to record if a relative had been involved.

The care plans were not in a format which was accessible to everyone using the service. Some people had visual and cognitive impairments which made it difficult to read a standard document. There were no alternative formats available for example using large print or pictures to help the person using the service to be fully involved in the development and review of their care plan.

The above paragraphs demonstrate a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records relating to care and people using the service were not completed accurately. During the inspection we found examples of numeracy errors occurring. For example a staff member had miscalculated a dependency assessment as 111for three months but the maximum figure assessment possible was 100. The records of another person's weight indicated a weight gain of 18.3kg over four weeks and this error had not been identified through any regular checks. The numeracy errors could result in a person not receiving the correct level of care they need or being identified as requiring professional support in relation to weight loss or gain.

Staff completed a diary sheet to record of the care and support received by people using the service during each shift. We looked at the daily records for ten people and saw that they were up to date but most of the records were task focused with similar information recorded on different days. We saw staff recorded if the person's incontinence pad had been changed but no information relating the person's experiences and how they felt during the day. There was also a section on the form for staff to record if the person had a bath, shower, bed bath or strip wash as well if the person had their nails trimmed or hair washed. We saw that staff recorded in the diary sheet that personal

care had been provided but did not identify what type of care it was. We also saw that staff had noted that one person had been feeling unwell for more than three days but staff did not record of any action taken. The information recorded through the diary records did not provide a current picture of the person's care and wellbeing.

The above paragraphs demonstrate a breach of Regulation 17 (2) (c) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with knew what to do if they had any concerns or complaints regarding the care provided. We saw that the service had a complaints policy and procedure in place. Information on how to make a complaint was also displayed in the reception area and was included in the resident's guide. A complaints log was completed showing the date the concern was raised, who it related to, the subject of complaint and if it was upheld or not. However complaints were not always investigated and responded to in line with the provider's policy. We looked at the complaints folder and the complaints received during January and February 2015. The deputy manager explained that complaints were initially processed by head office and passed to the home to investigate. The policy indicated that complaints should be investigated and a response sent to the complainant within 28 days of receipt. At the time of the inspection the complaints received at the beginning of March 2015 were still being processed by head office and had not been investigated yet. One relative told us they had not received an acknowledgement of a complaint made three weeks before the inspection. Other relatives told us they had not had their complaints dealt with to their satisfaction.

The provider's policy also stated that a complaints form should be completed with the details of the concerns raised and any actions taken. We saw that the complaints forms were not completed in full with some forms missing details. For example a complaint form referred to an attached email for details of the complaint and the rest of the form was left blank. Other forms had brief details of the complaint but did not record any actions taken, the conclusion and the complainant's view of the outcome of the investigation. This meant that staff could not monitor the progress of the investigation, ensure identified actions had been completed and the complainant was happy with the outcome of the investigation.

The above paragraphs demonstrate a breach of Regulation 16 (2) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessments were carried out before a person moved into the home to identify if appropriate care and support could be provided. We saw the completed assessments reviewed the person's individual support needs including mobility, social and health issues and were used to develop the care plans and risk assessments.

People's need for stimulation and social interaction were recognised. A person we spoke with said "The activity man is very good. If I want to go to any of the activities he will organise things for me. Generally there's lots' going on here. We had a saxophonist who came and played. They deliver me a paper every day." The home had two activity coordinators who organised a range of activities around the home. During our inspection we saw a quiz taking place and people were involved in making cakes which were then shared around the unit. Other activities included bingo and singing sessions. One of the activity coordinators brought their dog into the home every week to visit people. We saw that people were happy to see the dog and people told us they looked forward to the visits. We also saw a residents meeting being held to discuss future activities. Visitors were also encouraged to take part in the activities. People we spoke with said "We had a quiz this morning. It's good; it gets your brain working and helps you meet people" and "I do enjoy going down to the coffee lounge and the church services." A regular church service was organised and during our inspection we saw that people were supported to attend and the service was held in the garden as the weather was good. There were indoor gardens areas in the lounges in two units which included a range of indoor plants that people could look after. The garden was accessible from the dining room and some of the ground floor bedrooms. There was garden seating with an area for people who wanted to smoke and we saw staff supported people to access this area when required. However, one person we spoke with told us they would like to go into the garden on their own but did not feel safe using their frame over the lip of the door frame as they felt they could fall forward. Consequently they did not go outside.

The deputy manager told us they had an open door session for people using the service and relatives to come in and see her on a Thursday afternoon but people could also see her at any other time during the week. Meetings were held

Inadequate

Is the service responsive?

for relatives and one relative told us the last meeting was in January 2015 to meet the most recent manager but there had not been a meeting since the manager had left. We saw the provider displayed a copy of the resident's charter of rights for the service, the mission statement and quality policy in the reception area. People using the service were given a welcome pack which also included information about the philosophy of care in place at the home.

Inadequate

Is the service well-led?

Our findings

The provider's quality monitoring systems were not effective in identifying issues. They had various audits in place to monitor the quality of the care provided but these did not provide appropriate information to identify issues with the quality of the service. During our inspection we observed a range of issues and problems in relation to the quality of care provided which the provider's quality monitoring had not identified or put right.

The deputy manager explained an internal quality assurance monitoring audit was carried out throughout the year and we saw a matrix had been developed to schedule the various audits throughout the year. Each quality audit was broken down into key areas and each of these areas would be assessed separately. These key areas included safeguarding, medicine management, privacy and dignity and complaints. We looked at a range of internal quality assurance monitoring audits completed during 2015 and saw that staff did not record which unit was reviewed as part of the audit. The audit forms had a section to record any actions required and an action plan which we saw had not been completed on any of audits. This meant that the actions required, who was responsible for overseeing them, timescale for completion and confirmation when completed was not identified. Therefore improvements to the quality of care provided could not be monitored.

An audit assessing if the service was meeting the nutritional needs of people using the service was completed on 7 February 2015 as part of the quality assurance monitoring audits schedule. As part of this audit care staff completed a meal time experience audit tool on each unit prior to the main nutrition audit which looked at a range of issues including cleanliness, layout of the dining room, infection control and presentation of food. The staff identified issues in relation to how the food was served, interaction between people and staff and the level of support people received. The information from these assessments was not included in the audit. We saw the action plan had been completed with two issues identified but there was no detail relating the specific issue and what actions were required. During the inspection we saw that the issues identified in these audits had not been implemented.

We looked at the catering audit completed in January 2015 and saw a number of expected standards had been assessed as partially or not met. The plan identifying any actions required had not been completed for this audit and therefore we could not be sure the issues had been addressed.

An audit was carried out in relation to the administration of medicines. We saw there was a record sheet to record a check of the medicine administration record (MAR) chart four times a day and this had not been completed for three weeks on one unit. We found problems with medicines records not being completed at the inspection.

An infection control audit and assessment tool was regularly completed and we looked at the audit completed in January 2015. We saw any actions required were identified as part of the audit. However we could not see that actions had been resolved. During the inspection we found concerns about the effectiveness of the infection control procedures and how these were implemented.

The deputy manager told us questionnaires were given to people using the service, relatives and professional visitors annually. We saw the results from the questionnaires sent out in October 2014. Forty five questionnaires were sent to residents with 16 competed forms received. We were told that people who were unable to complete the questionnaire form could be supported by relatives or staff. From the 45 relatives who were sent a form 13 completed forms were received. The results of the questionnaires were analysed with any areas of concern identified for immediate action. People using the service identified they wanted greater involvement in the running of the home and food options on the menus. There were requests for a review of the call bell policy and increased training for staff with the call bell responses being monitored regularly. Any actions identified were added to the main action plan for the home monitored by head office. We asked for but did not receive a copy of the main action plan for the home to check that these issues had been added. The deputy manager explained that questionnaires would usually be sent to staff but this was not done in 2014 due to the increased number of new staff members that had recently joined the home. Therefore staff views had not been identified or acted on.

The above paragraphs demonstrate a breach of Regulation 17 (2) (a) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

At the time of the inspection the home did not have a registered manager in post. The previous manager left on the 13 March 2015 but had not completed the registration process with the Care Quality Commission. The last registered manager left the home on 10 September 2014. The deputy manager was responsible for the day to day running of the home with support from the operations manager. Since the inspection the provider had confirmed that they were recruiting to the post of manager for the home and CQC will continue to monitor this.

We saw that the culture of the home had been affected by the lack of a long term manager over the previous year. We spoke to people using the service, relatives and staff about their views on the home. A person using the service told us "I'd like to know who is in charge. Do you know? Nobody seems to stay long." A relative said "It needs a good manager in charge. It needs better communication and honesty at all levels and between staff and relatives." Another relative told us "A previous manager was very good with residents and took an interest. Now there's no manager, no head of care, no shift coordinators. The deputy manager is covering for three posts. There is not enough support for the deputy manager from head office." Three staff we spoke with told us they felt supported by other staff and they worked closely as a team. However one staff member felt that due to the lack of a registered manager ideas for improving the service were not considered, issues did not get addressed or staff were not supports as well as they could be.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 18 HSCA (RA) Regulations 2014 Staffing **The provider did not deploy sufficient numbers of suitably qualified, competent, skilled and experiences persons. Regulation 18 (1)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person did not ensure the proper and safe management of medicines Regulation 12 (2) (g)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered person did not assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying out of the regulated activity. Regulation 17 (2) (b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person did not assess the risk of, and preventing, detecting and controlling the spread of infections. Regulation 12 (2) (h)**

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person did not do all that is reasonably practicable to mitigate any risks. Regulation 12 (2) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The registered person did not ensure that people employed for the purpose of carrying on a regulated activity had the qualifications, competence, skills and experience which are necessary for the work to be performed by them. Regulation 19 (1) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person did not ensure that persons employed by the service provider in the provision of a regulated activity had received such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The registered person did not act in accordance with the Mental Capacity Act 2005 where a person was 16 or over and was unable to give consent because they lacked capacity to do so. Regulation 11 (3)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **The registered person did not ensure the nutritional and hydration needs of service users were met. Regulation 14 (1)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The registered person did not ensure that service users were treated with dignity and respect. Regulation 10 (1)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The registered person did not ensure the care and treatment of service users was appropriate, met their needs and reflected their preferences. Regulation 9 (1)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered person did not have a system in place to maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. Regulation 17 (2) (c)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person did not have a system in place to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those service) Regulation 17 (20 (a)
	The registered person did not have an effective and accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity. Regulation 16 (2)