Care Quality Commission

Roseberry Care Centres GB Limited

Dalewood View

Inspection report

The Dale
Woodseats
Sheffield
South Yorkshire
S8 0PS
Tel: 0114 255 5060

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Ratings

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

Overall summary

We carried out an inspection on 19 May 2015. This was an unannounced inspection which meant the staff and provider did not know we would be inspecting the service. The service was last inspected on 16 and 17 December 2014 and was not meeting the legal requirements of the regulations for care and welfare of people who use services, meeting nutritional needs of people who use services, the management of medicines, and assessing and monitoring the quality of service provision. As a response to the last inspection the provider sent a report of the action they would take to meet the legal requirements in relation to each breach in regulation. The provider informed us they would be fully compliant by the end of April 2015.

Dalewood View is a nursing home that provides care for up to 60 people. It is a purpose built care service. At the time of the inspection there were 43 people living at the service. The service has three floors, a lower ground floor where the service's activities room is based, the ground

Summary of findings

floor which is primarily for people requiring nursing care and the first floor which is primarily for people requiring residential care. At the time of the inspection there were seven people requiring nursing care on the first floor.

There was not a registered manager for this service in post at the time of the inspection. One of the provider's supporting managers and the regional operations manager had been managing the service. A new manager had been appointed; they had only been in post for approximately two weeks. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are "registered persons". Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt "safe" and satisfied with the quality of care they had received. Relatives spoken with felt their family member was safe. Relatives spoken with had mixed views regarding the quality of care their family member had received.

Our discussions with staff told us they were aware of how to raise any safeguarding concerns. However, some staff spoken with told us that they felt unable to raise concerns about individual staff competencies and staff interactions between some nurses and care staff. This meant people were not protected against the risks of improper treatment because the provider had not made sure that they had, and implemented robust procedures and procedures that make sure people we protected.

People told us they were treated with dignity and respect and this was supported by their relatives.

We observed that the interaction and communication between staff and people was mainly focussed around completing tasks. The service had an activities worker who provided a range of activities for people to participate in. They were not working on the day of the inspection.

We checked to see whether improvements had been made to the management of medicines and whether these had been maintained. We found that the provider had not made enough improvements to protect people against the risks associated with the unsafe use and management of medicines.

There was evidence in peoples care plans of involvement from other professionals such as doctors, opticians, tissue viability nurses and speech and language practitioners.

People's preferences and dietary needs were being met, we found the arrangements to ensure people received support with eating and drinking had improved since the last inspection.

Recruitment procedures were in place and appropriate checks were undertaken before staff started work. We saw the process in place to record the checks that had been completed could be more robust. We found the provider did not have appropriate processes for assessing and checking that nurses had the competence, skills and experience required to undertake the role. This meant people who required nursing care were at risk of not being cared for by competent staff.

We found that sufficient improvement had not been made to ensure staff received training suitable for their roles. We found that staff had received supervision sessions since the last inspection. However, some staff spoken with told us they did not feel supported by senior staff within the service.

There was a complaint's process in place in the service, people and/or their representative's concerns had been investigated and action taken to address their concerns.

Meetings had been held with people living at the service and/or their relatives or representative since the last inspection. This meant people and/or their relatives or representatives did have opportunities to be kept informed about information relevant to them.

Our findings demonstrated the provider had not ensured there were effective systems in place to monitor and improve the quality of the service provided. This meant they were not meeting the requirements to protect people from the risk and unsafe care by effectively assessing and monitoring the service being provided.

We saw evidence that checks were undertaken of the premises and equipment and action was taken to ensure peoples safety.

We found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Summary of findings

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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 told us they felt "safe". Staff were aware of how to raise any safeguarding issues if they were concerned people were at risk of abuse.

The service did not have appropriate arrangements in place to manage medicines to ensure people were protected from the risks associated with medicines. We found that the provider had still not made enough improvements to protect people against the risks associated with the unsafe use and management of medicines.

Recruitment procedures were in place and appropriate checks were undertaken before staff started work. The provider did not have appropriate processes for assessing and checking that nurses had the competence, skills and experience required to undertake the role. This meant people who required nursing care were at risk of not being cared for by competent, caring and compassionate staff.

Is the service effective?

Inadequate

The service was not always effective.

At the last inspection we found there was not a robust system in place to ensure staff completed all the training relevant to their role. At this inspection we found sufficient improvements had not been made. Therefore staff had not been supported to deliver care and treatment safely to an appropriate standard.

The service had policies and procedures in place in relation to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). The regional operations manager told us the new manager and supporting manager had recently attended DoLS training. Some staff had minimal understanding of DoLS. The service's training matrix showed that only eight staff had completed training in this area.

People's dietary needs were accommodated and we found that the arrangements to support people with eating and drinking had improved since the last inspection.

Is the service caring?

Requires Improvement

The service was not always caring.

During the inspection we observed the interaction between care staff and people was mainly centred around tasks.

People made positive comments about the staff and people told us they were treated with dignity and respect. People spoken with gave mixed views about their interactions with staff.

Summary of findings

We saw people could choose whether to spend time in their rooms or go to the communal areas. .

Is the service responsive?

Inadequate

The service was not responsive.

At our last inspection we found the provider had not ensured that all the people living at the service had safe and appropriate care and support to meet their needs.

At this inspection we found the provider had not made sufficient improvements to ensure people received care that was appropriate to meet their needs.

We found the service had responded to people's and/or their representative's concerns and taken action to address any issues raised.

Is the service well-led?

Inadequate

The service was not well-led.

At the last inspection we found the checks completed by the operations manager to assess and improve the quality of the service were not effective to ensure people were protected against the risk of inappropriate or unsafe care. At this inspection we found the provider had not made sufficient improvements to ensure these checks were effective.

Since the last inspection in December 2014 the management structure within the provider and service had changed. The regional operations manager and the supporting manager had been managing the service whilst a new manager was appointed.

People's and/or their representatives views had been actively sought to enable people to share their experience of their care since the last inspection.

Dalewood 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.

An inspection took place on the 19 May 2015. This was an unannounced inspection which meant the staff and the provider did not know we would be visiting. The inspection team consisted of two adult social care inspectors, a pharmacist inspector, a specialist advisor who was a registered nurse and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience of older people's care services.

Before our inspection we reviewed the information we held about the service and the provider. For example, notifications of deaths and incidents. We also gathered information from the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We used a number of different methods to help us understand the experiences of people who lived at the service. We spent time observing the daily life in the service including the care and support being delivered. We spoke with eleven people living at the service, two relatives, the supporting manager, the regional operations manager, two nurses, three care assistants, a receptionist, an administrator and the cook. We looked round different areas of the service; the communal areas, the kitchen, bathroom, toilets and with permission where able, some people's rooms. We reviewed a range of records including the following: five people's care records, ten people's medication administration records, three people's personal financial transaction records, four staff files and records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

People spoken with told us they felt 'safe'. One person said they were never worried and that if they ever had any concerns they would speak to a senior care worker. One person expressed worries regarding their clothes going missing. We spoke with the supporting manager; they assured us that they would speak with the person and their representative. Relatives spoken with felt their family member was in a safe place. Relatives comments included: "never had any concerns or problems, [family member] safe and well cared for".

People and relatives did not express any concerns regarding the staffing levels within the service. People spoken with told us that staff responded to their calls for assistance. Their comments included: "only have to press the buzzer and they come" and "they [staff] do come, sometimes they're busy". During the inspection, we noticed that one person was still waiting for their lunch to be delivered to their room at 2pm; the time specified for lunch at the service was 12am to 2pm. We shared our observations with the supporting manager and the regional operations manager.

Some staff spoken with raised concerns about the staffing levels within the service. For example, there were two nurses on duty between 8am and 5pm and only one nurse on duty between 5pm and 8am. Staff were concerned about what would happen if there was an emergency and two people required assistance at the same time whilst only one nurse was on duty. Some care staff also expressed concerns that the service did not have enough permanent staff particularly for the night shifts. The service was relying on agency staff who were not familiar with people's needs to cover the shortfall as the service did not have enough bank staff available to cover. We spoke with the regional operations manager and supporting manager. They provided us with details of the number of staff vacancies; one nurse (33 hours) to work on days and three care assistants (33 hours each) to work on nights. The regional operations manager told us the provider was actively recruiting staff for these vacancies. They also told us they were using agency staff to cover the vacancies and staff were on annual leave. For example, on the day of the inspection an agency nurse was working at the service to cover a nurse's annual leave.

At the last inspection we found that medicines were not handled safely and we told the provider they must take action to improve the safe handling of medicines. They sent us a report of the actions they would take which included updated medication training for staff and that monitoring checks would be carried out on a regular basis to improve safety. During this inspection we found that whilst limited improvements had been made, medicines were still not handled safely. We looked at medicines and records about medicines for 10 people who were receiving nursing care and for four other people receiving residential care. We found that people requiring residential care were given their medicines more safely than those people requiring nursing care.

We checked the stocks of medicines with the records about medicines for seven people receiving nursing care. We found that nurses had not administered as much medication as they had signed for which meant that people were not given some of their doses of their prescribed medicines. This included a wide range of prescribed medicines such as anticoagulants, analgesics and inhalers. Our checks also showed that some people were given more medication than had been prescribed. We checked the stocks of medicines with the records about medicines for three people receiving residential care and found that people had been given their medicines safely as prescribed.

We saw that some of the records about medicines for people receiving nursing care did not show that people were given their medicines properly. We saw there were a number of gaps on the records which meant it was not possible to tell if prescribed doses had been given. It is important for accurate records to be made about the administration of medicines to ensure that people are not given too much or too little medication.

We found there were still limited records about the application of creams; a concerns identified at our last inspection. Staff told us that they had applied creams but they had not filled in charts about creams. We found that staff did not have written guidance available to explain where to apply creams or how often to apply them. We asked the two nurses on duty during our inspection where one person's cream should be applied. One nurse told us it must be applied to the legs and the other nurse said they applied it to the groin area. Without robust information being recorded people could not have their creams applied

Is the service safe?

safely. We looked at one person's records who was receiving residential care and saw that cream charts were in use and they contained clear information about how to apply creams properly. We also saw that appropriate records had been made about the correct application of their creams.

We saw that two people receiving nursing care were prescribed thickener to be used in their fluids to make them thick enough to ensure they did not choke and aspirate when drinking, which may result in a chest infection or pneumonia. We found there was information in their care plans about the amount of thickener to use. However, staff making drinks said they did not check the care plan and they just had to remember how thick to make each person's fluids. They told us there used to be a document in the dining room for them to check when making drinks but it was no longer available. We found no records were made to show that fluids had been thickened. We saw one person who should have had their drink thickened had an unthickened drink within their reach. One nurse told us they had stopped thickening this person's drinks even though that person's care plan showed they still needed their fluids thickened. This placed them at risk of harm.

We found that some action had been taken to improve the times medicines were given with regard to food. However we found that some medicines were still not being given properly. We saw that one antibiotic which should be given at least 30 minutes before food was given with medication which needed to be given with food. If medicines are not given with regards to food they may not be effective.

As at our last visit we saw that there were 'protocols' to follow when people were prescribed medicines to be taken 'when required'. These protocols are designed to help staff give each person their medicines in a safe and consistent manner. However we found that the information still had not been individually tailored for each person. We also found that there was no information to guide staff as to which dose to give when the medicine was prescribed as a variable dose.

We found that medicines were not always stored safely. We found creams not stored securely in people's bedrooms and were instead kept in areas such as window ledges and bathrooms. There were no risk assessments to show it was safe to store medicines in this way.

We saw that two people receiving nursing care had run out of one of their prescribed medicines. One person had run out of a prescribed nutritional supplement. A nurse told us that the supplement was on order. The person's medication administration records (MAR) charts indicated that they were receiving the supplement and staff were using another person's nutritional supplement supplements to compensate for the shortfall. We saw that it had been ordered 18 days before our inspection visits and was still not available. No action had been taken to obtain a supply more speedily. Another nurse told us that one person's prescribed cream had run out the previous day and there was none to apply on the day of our visit. If medicines are not obtained in a timely manner people's health could be placed at risk of harm.

We found people were still not protected from the risks associated with medicines because the service did not have appropriate arrangements in place to manage medicines. We spoke with the regional operations manager and the supporting manager. They assured us that action would be taken regarding the concerns we found during our inspection.

We looked at people's care records. People had individual risk assessments in place so that staff could identify and manage any risks appropriately. The purpose of a risk assessment is to identify any potential risks and then put measures in place to reduce and manage the risks to the person. However, we found the measures in place to ensure these risks were managed were not always followed. For example, staff were not completing daily wound assessments for some people living at the service and these assessments were not completed to an appropriate standard. For example, a measurement was not always being entered each time a dressing was changed,

We found the service was still not meeting the requirements of the regulations in relation to the management of medicines which was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as identified at our last inspection. This continued failure evidenced a breach of the corresponding regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed the staff recruitment records for three staff members. The records contained a range of information including the following: application form, interview records,

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Is the service safe?

Disclosure and Barring Service (DBS) check, references and employment contract. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. We saw evidence where applicable that the nurse's Nursing and Midwifery Council (NMC) registration had been checked. However, we noted that the recording of reference checks could be improved. For example, one staff member's references were not dated and we were unable to ascertain if this was a character reference or a former employer's reference.

Our findings regarding the administration of medicines and the assessment of wounds by nurses showed the provider did not have appropriate processes for assessing and checking that nurses had the competence, skills and experience required to undertake the role. The competence may include the demonstration of a caring and compassionate approach. Staff told us that some nurses did not consider it their role to respond to call bells and to carry out personal care. The calls for assistance and providing personal care were completed by care workers. This meant people who required nursing care were at risk of not being cared for by competent, caring and compassionate staff.

This was in breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the administrator at the service; they showed us the provider's care service software management system to manage people's personal allowances. We looked at three people's financial transaction records and saw where monies had been paid in by a relative or a representative a receipt had been issued. We looked at three people's personal allowance records. We checked a sample of receipts for the cost of the hairdresser and/or the chiropodist. We saw the correct amount had been invoiced for each individual transaction. This showed that there were systems in place to reduce the risk of people being exposed to financial abuse.

The service had a process in place to respond to and record safeguarding vulnerable adults concerns. We saw the service had a copy of the local authority safeguarding adult's protocols to follow to report any events and safeguard people from harm. Information gathered from the local authority and notifications sent the CQC from the provider in relation to safeguarding demonstrated that they followed these protocols. It was clear from discussions with staff that they were aware of how to raise any safeguarding issues regarding people living at the service. However, some staff spoken with told us that they felt unable to raise concerns about individual staff competencies and staff interactions between some nurses and care staff. This meant people were not protected against the risks of improper treatment because the provider had not made sure that they had, and implemented robust procedures and procedures that make sure people are protected.

We shared this information with the regional operations manager, supporting manager and the new manager working at the service.

This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a system in place for staff to record any areas in the service that needed attention and a maintenance worker was employed by the service. We saw evidence that checks were undertaken of the premises. We also saw evidence that checks had been made on equipment used by people living at the service. For example, profile beds and wheelchair visual checks. We saw evidence that a fire drill had been completed recently at the service; on the 9 and 24 April 2015. This showed the provider had processes in place to ensure premises and equipment are safe to use for their intended purpose.

Inadequate

Is the service effective?

Our findings

People spoken with told us they were satisfied with the quality of care they had received. Their comments included: "I think it's very fair", "I think they [staff] know what they are doing, they have a nice way of dealing with difficult people" and "quite satisfied, staff very friendly and helpful".

Relatives spoken with expressed mixed views about the quality of care their family member had been provided with. One relative commented: "they [staff] keep me up to date if I ask about care, if there is anything serious they [staff] would give me a ring". One relative commented: "I think it could be better, they're [people] left quite a lot, they could benefit from a bit more interaction, I am not sure they [staff] really know the residents". We noticed at the last inspection that one person's "this is me" document had not been completed. This is a document that can be used to record people's interests, preferences, life history, likes and dislikes. We found at this inspection that one person's "this is me document" had not been completed. Again we found this could lead to an increased focus on the person's condition rather than the person behind the diagnosis and potentially develop into caring for "what", rather than 'who'.

At the last inspection we found the provider had not ensured that staff were appropriately trained and supported to enable them to deliver care to people safely and to an appropriate standard. At this inspection we found that sufficient improvements had not been made.

The regional operations manager and supporting manager used a staff training spreadsheet to monitor the training completed by staff. We reviewed the service's training spreadsheet and looked at staff records. We saw that staff were provided with a range of training relevant to their role. However, the training spreadsheet showed that some staff had not received training in a range of areas. For example, health and safety, safeguarding and whistleblowing. One staff member had started working at the service in February 2015. They told us they had received training at their previous employment but they had not received any training whilst working at the service. They told us they had completed some questionnaires and worked alongside another member of staff for two days when they started working at the service. The training matrix indicated that they had only received fire drill training. There were no organisational training records for the staff member on file. The explanation given by the regional operations manager for staff not completing training was due to the provider's trainer's unexpected absence.

We saw evidence that staff had received supervision session since the last inspection. Supervision is the name for the regular, planned and recorded sessions between a staff member and their manager. It is an opportunity for staff to discuss their performance, training, wellbeing and raise any concerns they may have. However, we received mixed messages from staff about the support they received from senior staff. Some staff told us they felt supported and could approach senior staff if they had any concerns. Some staff did not feel supported. One staff member described how their supervision sessions were conducted. They commented: "told us what we needed to complete and what to do. Was all about what more we can do. Nothing about how I was doing or if I needed any support". Another staff member commented: "we [staff] just get told what we're doing wrong. No encouragement at all, no recognition, no appreciation, lost staff due to this".

We found the service was still not meeting the requirements of the regulations in relation to supporting staff which was a breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as identified at our last inspection. This continued failure evidenced a breach of the corresponding regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection we observed a care worker approaching people and asking for their meal preferences for the next day. We observed the care worker explain the different options available and they demonstrated knowledge of people's likes and dislikes. Most people spoken with were satisfied with the quality of the food provided at the service. Their comments included: "good food, plenty to eat", "nice food, plenty of it" and "foods lovely, I enjoy it, it's nicely cooked". One person suggested the food needed to be spicier. They commented: "food needs tweaking, I like spicy food".

We spoke with the cook; they gave us details of the four week menu rota. They commented: "if someone doesn't want what's on the menu, they can choose something else". They were aware of the people who had allergies, required a specialised diet and/or soft diet. For example, people

Is the service effective?

who required a vegetarian diet or gluten free diet. During the inspection we saw staff offering snacks like biscuits whilst completing the drinks rounds. However, we noticed that people were not offered fresh fruit to eat.

At the last inspection we found that people had not been appropriately supported to eat and drink at breakfast time in one of the dining rooms. At this inspection we observed that people were being appropriately supported and there was a calm atmosphere in the dining room which was conducive to eating. For example, we observed care workers greeting people as they came into the dining room for breakfast. People were asked by staff if the wanted to wear a 'pinny' to protect their clothes and their choice was respected if they didn't. At lunch time we observed people being supported appropriately to eat in one of the dining rooms. We also observed the cook offering to make a sandwich for a person who did not like what they were eating. The cook returned shortly with a sandwich using white bread as requested.

During the inspection we visited people in their rooms and saw they had access to fluids. We saw there were jugs of fluids located in lounge areas. However, we did not observe staff encouraging people to actively drink fluids during the inspection to maintain their hydration levels.

The Mental Capacity Act (MCA) 2005 is an act which applies to people who are unable to make all or some decisions for themselves. It promotes and safeguards decision-making within a legal framework. The MCA states that every adult must be assumed to have capacity to make decisions unless proved otherwise. It also states that an assessment of capacity should be undertaken prior to any decisions being made about care or treatment. Any decisions taken or any decision made on behalf of a person who lacks capacity must be in their best interests.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and report on what we find. The safeguards are part of the MCA and aim to ensure that people are looked after in a way which does not inappropriately restrict their freedom.

The service had policies and procedures in place in relation to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). The regional operations manager told us the service was in the process of submitting DoLS authorisation for some people living at the service who were unable to make a decision for themselves. During the inspection we did not observe any evidence of unlawful restriction. For example, people being restricted from leaving the premises. During the inspection we also observed staff obtaining consent from people. For example, did the person wish to go to the dining room to have lunch or have it in their room.

During our discussions with staff we found that some staff understanding of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) was minimal. We reviewed the service's training matrix; it indicated that only eight staff out of forty eight staff listed had attended MCA and DoLS training in 2014. The regional operations manager told us the new manager and the supporting manager had recently attended DoLS training.

We observed people moving around the home using their walking frames. Equipment was available in different areas of the service for staff to access easily to support people who could not mobilise independently.

Since the last inspection we saw the recording and communication of the visits from the GP had been improved. The regional operations manager showed us a copy of the new protocol in place to record these visits. We found evidence of involvement from other professionals such opticians, district nurses, tissue viability nurses and speech and language practitioners in people's records.

Requires Improvement

Is the service caring?

Our findings

People spoken with made positive comments about the staff. Their comments included: “everybody’s [staff] pleasant”, “I’m quite content, everybody’s kind to me” and “I can’t grumble at all, staff listen”. People spoken with gave mixed views about their interactions with staff. One person told us that staff would often pop into their room and have a chat. Another person told us that they did not speak with staff very often. We saw people could choose whether to spend time in their rooms or go to the communal areas. For example, one person liked to sit in a particular spot in one of the lounge areas so they could watch the wildlife outside.

The two relatives spoken with gave mixed views regarding the staff being caring: Negative comments included: “I have never seen a carer sat with them [people], I think they [staff] could be more attentive”, “don’t know if they are approachable, they mill about but not with the residents”. Positive comments included: “staff seem caring, they know me, and I can approach any of them [staff]”.

Care staff spoken with told us they enjoyed supporting people at the service. One staff member commented: “I love the residents”. We saw staff greeting people by name. Staff demonstrated knowledge of people’s personal preferences. For example, their likes and dislikes in regards to food and drink and where they liked to spend their time. During the inspection we observed staff explaining their actions to people and gaining consent. We did not observe any activities being undertaken by staff. The activities worker was not working on the day of the inspection due to an unexpected absence.

During the inspection we spent time in different areas of the service observing the daily life. Our observations told us that staff interaction with people was mainly centred round tasks. We saw staff involving people in these decisions. For example, what would they like to eat or drink or where would they like to sit. We saw very little interaction which centred around people’s interests or life history.

People told us they were treated with respect. We saw staff knocking on doors prior to entering. Two people told us that when they were in the rooms staff knocked on their door before coming in. One person commented: “I do get on with people, I’m comfortable with them all, they knock when they want to come in”. However, one person told us that staff did not always respect their privacy and knock on their door prior to entering. They commented: “they [staff] walk in – that’s what I don’t like”.

In the reception area of the service there was a range of information available for people and/or their representatives including details of advocacy services. Advocacy is a process of supporting and enabling people to express their views and concerns, access information and services, defend and promote their rights and responsibilities and explore choices and options.

The staff training matrix indicated that two of the care assistants and the activities worker had completed training in end of life care. The matrix showed that none of the nurses had completed end of life care training. End of life care centres on identifying people approaching the end of life, assessing and agreeing how to meet people’s needs and preferences, using advanced care planning, planning and coordinating care and delivering a high quality services.

Inadequate

Is the service responsive?

Our findings

At our last inspection we found the provider had not ensured that all the people living at the service had safe and appropriate care and support to meet their needs. The provider submitted an action plan following our inspection which detailed the actions they intended to take in order to meet the legal requirements in relation to this breach. We saw that some improvements had been made at the service. For example, people in their rooms had a call bell in reach to call for assistance and had access to fluids. However we found the provider had not taken effective action to ensure that people were protected against the risks of receiving care or treatment that was inappropriate or unsafe.

At our last inspection we found concerns regarding the care being provided to people with wounds. People may have different types of wounds; an ulcer and/or a pressure sore. We looked at four people's care records who required support with wound care. We found a range of concerns in people's records which included; body maps not being completed and/or body maps not being completed correctly. Nurses had not ensured people had a separate care plan for each wound they may have. People's wound assessments were not being completed on a daily basis as stated in their care plan. We also found it difficult to ascertain whether some people's wounds were healing or degrading as different nurses had not completed the wound assessments properly. For example, putting a tick where a measurement was required. This showed that there was a risk that people who required wound care and/or assessment were not receiving appropriate care and support to meet their needs.

Staff told us that the provider had recently introduced a new process to record daily notes called a "rounding chart". For example, repositioning, fluid and food intake, observation and elimination. In one person's records we noticed that an external healthcare professional had sent a letter confirming they had spoken with staff, to request them to monitor the person's bowel elimination due to their medical condition. The person daily notes indicated they had not had a bowel movement recently. We spoke with staff, they told us staff were still familiarise themselves with the new recording system. We found there was not a robust process in place to ensure the person's daily charts were being monitored and the person was at risk of not receiving appropriate care and support to meet their needs. We spoke with the regional operations manager and supporting manager, they assured us that the person would be seen by the GP on the following day to check their wellbeing.

We found the service was still not meeting the legal requirements of the regulations in relation to care and welfare of people using the service which was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as identified at our last inspection. This continued failure evidenced a breach of the corresponding regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People spoken with told us they did not have any concerns or complaints and if they did they would speak with staff or a family member. The complaints process was on display at the service. We noted the complaint's process on display needed updating with details of the new regional operations manager. We reviewed the service's complaints log. We found the regional operations manager had responded to people's and/or their representative's concerns, investigated them and taken action to address their concerns.

We saw that the environment within the home could be improved to make it more dementia friendly. For example, the signage and signs could be clearer. There was an activities room on the lower ground floor area within the service which had access to the garden area. One person told us they liked to go in the garden area. They commented: "they [staff] take me out round the garden if the weather's right, can't expect to go out in this weather".

The activities worker was not working on the day of the inspection. There was an activities board on each floor of the service which provided details of the daily activities but this had not been updated due to the activities workers absence. There were details of the monthly services held by the local churches at the service on display.

During the inspection we did not observe any activities taking place at the service. We saw one person listening to classical music in one of the dining areas. Two people were reading and/or completing word puzzles books in one of the lounge areas. We saw a few people actively watching television. One staff member suggested the service needed

Inadequate

Is the service responsive?

two activities workers as one was not enough to provide people with mental and physical stimulus they needed. They commented: “people are sitting up there bored; we [staff] try to do things”.

Inadequate

Is the service well-led?

Our findings

At our last inspection we found the provider had not ensured there was an effective system in place to regularly assess and monitor of the quality of the service provided. The provider submitted an action plan following our inspection which detailed the actions they intended to take in order to achieve compliance. We saw some improvements had been made at the service since the last inspection. For example, the support provided to people whilst eating in the dining rooms. The provider completed a range of quality assurance checks at the service which included: care plan audits and infection control audits. At this inspection we found the provider had failed to take sufficient action to meet the legal requirements in relation to four breaches identified at our last inspection.

The registered manager for the service had not been in post for over 9 months. They were not managing the regulated activities at this location at the time of the inspection. Since the last inspection in December 2014 the management structure within the provider and service had changed. The provider had appointed a new operations director and regional operations manager. The service's former manager was now the clinical lead for the service. One of the nurses had been appointed as the deputy manager. The regional operations manager and the supporting manager were managing the service whilst a new manager was appointed. A new manager had been in post for approximately two weeks when the service was inspected on the 19 May 2015.

The workplace culture within the service required improvement. The culture within a service directly affects the quality of life of people living at the service. A positive culture has the ethos of care built around the person. Effective leadership and management are essential in creating and maintaining a positive culture.

Some staff did not feel valued, supported or confident to raise concerns about staff individual competencies and the interactions between some nurses and care staff. They told us they did not feel assured that any concerns they raised would be acted upon. This demonstrated that the culture of the service was not conducive to an environment where staff felt able to openly address any issues. Although staff told us they would report any safeguarding concerns with regards to people who used the service, there was still a reluctance to report other alleged behaviours. This meant people were not protected against the risks of improper treatment because the provider had not made sure that robust procedures were implemented and acted upon with regards to identifying and addressing such issues.

At the last inspection we found that some staff had not received training in areas relevant to their roles. At this inspection we found that sufficient action had not been completed by the provider to ensure staff were appropriately trained. This showed that the system for auditing and monitoring staff training was ineffective in practice.

We found the provider did not have appropriate processes for assessing and checking that nurses had the competence, skills and experience required to undertake their role. This meant people who required nursing care were at risk of not being cared for by competent, caring and compassionate staff.

We saw evidence that medication audits had been completed since the last inspection. Our findings during the inspection showed the system in place for monitoring the management of medicines was still not robust. It is essential to have robust monitoring in place in order to identify concerns, to make improvements and changes needed to ensure medicines are managed safely.

This meant the system to regularly assess and monitor of the quality of the service provided was ineffective in practice.

We found the service was still not meeting the requirements of the regulations in relation to assessing and monitoring the quality of service provision which was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as identified at our last inspection. This continued failure evidenced a breach of the corresponding regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since the last inspection the regional operations manager had held two meetings on the 20 April 2015; a residents meeting and a relatives meeting. We reviewed a copy of the minutes and saw that a range of topics were discussed including the outcome of the last inspection and what action the provider was going to take and staffing changes. This meant people and/or their relatives or representatives did have opportunities to be kept informed about information relevant to them.

Inadequate

Is the service well-led?

There was a process in place to ensure incidents were monitored to identify any trends and prevent recurrences where possible. The regional operations manager was aware of their responsibility to inform the CQC about notifiable incidents and circumstances in line with the Health and Social Care Act 2008.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: The provider had not ensured that staff were appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard. The provider had not ensured staff such as health care professionals continue to meet the professional standards which are a condition of their ability to practise or a requirement of their role.

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 How the regulation was not being met: Service users were not protected against the risks of inappropriate or unsafe care or treatment because the provider did not have effective systems to monitor the quality of the service provision.

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 How the regulation was not being met: Service users were not protected against the risks of receiving care or treatment that is inappropriate or unsafe, because the planning and delivery of care did not meet people's needs and ensure the welfare and safety of service users.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Service users were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines.

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 (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: Service users were not protected against the risks of improper treatment because the provider had not made sure that they have, and implement robust procedures and procedures that make sure that service users are protected.

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 How the regulation was not being met. Service user were not protected because the provider did not have appropriate processes for assessing and checking that staff have the competence, skills and experience required to undertake the role.

The enforcement action we took:
The service was placed in special measures.