West Villa Residential Home Limited

West Villa Residential Home

Inspection report

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Ratings

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

Overall summary

The inspection took place on 7, 12 and 20 February 2015 and was unannounced.

The service provides accommodation for up to 32 older people. West Villa Residential Home is situated in a residential area of Wakefield.

At the time of our inspection there was a registered manager in post, who was also the provider. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

People told us they felt at home and were happy and content. People said they felt safe and staffing levels were good enough to meet their needs. Relatives told us they were happy with the care provided for their family members.

There were sufficient numbers of care staff and ancillary staff on duty to be able to support people's care. However care staff did not appear to have the skills required to support people safely and in a way that met their needs.

Communal areas and some bedrooms smelled strongly of urine and staff did not give prompt attention to people's personal hygiene needs.

Summary of findings

Individual risks to people were not safely managed and staff were not proactive in recognising concerns about people's safety and welfare.

People were not always treated with respect and their dignity and their rights were not adequately promoted. Staff did not show positive regard for people's abilities and they did not empower them to maintain their independence and be involved in decisions about their care. People were not effectively supported to have enough to eat and drink.

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

Staff had some opportunities for regular training, although there was no professional development to enhance their skills and knowledge of working with the particular needs of people in the service, such as those living with dementia.

People's care records did not provide detailed or accurate information for staff to be able to support their individual needs safely.

Systems to monitor and review the quality of the provision were not robust and the registered manager did not sufficiently maintain an overview of the service.

Some of the issues identified at this inspection had been raised with the registered manager at the previous inspection, and insufficient action had been taken to address these.

We shared our concerns with the local authority, commissioners, safeguarding and the infection control team.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to people were not sufficiently assessed or safely managed to ensure people were protected. Staff did not always identify areas of concern with regard to safeguarding people.

People were not supported to make choices and take risks.

There were suitable systems in place for administering medication.

Effective measures were not in place for the prevention and control of infection. There were strong odours of urine in the home and furniture in communal areas and people's rooms was not clean for people to use.

Is the service effective?

Inadequate

The service was not effective.

Staff lacked the necessary skills and competencies to support the needs of people in their care, such as those living with a diagnosis of dementia.

Staff lacked knowledge of the requirements of the Mental Capacity Act. People's mental capacity had not been assessed. There were restrictive practices in place which meant people did not have freedom to move around the home.

Nutritional support for people was not meeting their individual health needs. We observed that some people had lost weight and this was not being effectively monitored in the home.

Is the service caring?

Inadequate

The service was not caring.

Staff demonstrated a poor attitude to meeting people's needs in a sensitive way, lacked patience and did not relate to people in a way that supported their well-being.

People's dignity was not well promoted.

People had not been given opportunity to discuss their end of life wishes.

Is the service responsive?

Inadequate

The service was not responsive.

People's individual care records did not contain sufficient or accurate information for staff to provide person centred care.

People and their relatives knew how to raise concerns with staff if they wished to and people's concerns were recorded and responded to appropriately.

There were few meaningful activities in place for people to engage in, particularly for people with high dependency needs.

Summary of findings

Is the service well-led?

Inadequate

The service was not well led.

Quality assurance systems were weak and did not sufficiently assess and monitor the care that people received or identify areas to improve which were highlighted by the inspection process.

Actions raised at the previous inspection had not been satisfactorily addressed. There had been a decline in the quality of the care seen at the previous inspection.

West Villa Residential 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 7, 12 and 20 February 2015 and was unannounced.

There were two Adult Social Care inspectors. Prior to our inspection we had received information of concern from whistleblowing information passed to the Care Quality Commission. We also reviewed information from notifications before the inspection. We had not sent the provider a 'Provider Information Return' (PIR) form prior to the inspection. This form enables the provider to submit in advance information about their service to inform the inspection.

We spoke with seven people who used the service and four relatives during our visit. We spoke with the registered manager, the floor manager and three staff. We observed how people were cared for, inspected the premises and reviewed care records for five people. We also reviewed documentation to show how the service was run.

We spoke with the local authority safeguarding adults team, commissioners, the district nurse team and a visiting GP during our inspection. We maintained liaison with the safeguarding adults team throughout our inspection.

Inadequate

Is the service safe?

Our findings

People we spoke with said they felt safe in the home. One person said: "Oh aye, I'm safe enough alright" and another said: "I am safe here with everyone." Relatives we spoke with told us they felt their family members were safe and they said there were always enough staff on duty. One relative said: "There's generally someone about when I visit, you can always find a member of staff if you want one". Another said: "I'm happier about [my relative]'s safety here than when they were at home."

Risk assessments for individual people were poor and incomplete and not all staff were aware of the risks to individual people. For example, staff gave us differing information as to which people needed equipment to support their moving and handling and mobility. One member of staff described moving and handling procedures that were not in line with safe practise. Staff lacked knowledge of the equipment available to support people's moving and handling needs. We observed two incidents of inappropriate moving and handling techniques which posed a risk to people and staff and the inspector had to intervene.

We found areas of practise that were restrictive to peoples' freedom. For example, we asked staff why people's walking frames were not kept within their reach, but stored at the other side of the room. Staff told us this was because these may be a trip hazard. We heard staff tell people this was 'for health and safety'. This meant there were unnecessary restrictions placed on people's freedom as some people were unable to mobilise without this support. We saw one person attempt to mobilise without the stick they needed as this was not accessible to them.

On the second day of our visit, we only saw 28 people out of the 32 people who lived in the home. We asked staff the whereabouts of the other 4 people; staff were not immediately aware and began to check around to find out where they were. Staff were able to locate three of the people but could not be sure of the whereabouts of one person. Staff told us this person was able to independently leave the home and frequently went out; however the person would have to have been 'let out' by a member of staff. We checked with all the staff, none of whom had any knowledge of whether the person was in or out. One member of staff said the person was in their room and another member of staff recalled having seen the person at lunchtime. The person's key worker was unable to tell us where the person was. This gave us some concern that staff would be unable to account for people living in the home, should there be an emergency, such as a fire. There was no safety protocol in place to identify what staff should do if a person went out of the home and did not return. There was no evidence in the person's care record to show whether their safety had been discussed with them. We returned for a third visit a week later and found there had been little improvement to this matter, other than for staff to tell one another when the person left the home.

Staff told us the signs of possible abuse and said if they had any concerns they were confident to report this to managers in the home. We spoke with a senior member of staff about what they would do if they had concerns about the safety of people living at the home. We gave them the scenarios of one person who lives at the home shouting in an abusive manner at another and a person who lives at the home hitting another. The staff member told us they would report the physical abuse to the local authority's safeguarding team but would just make a note of the verbal abuse on the person's daily records.

We saw one person with severe bruising. The senior member of staff told us this had been referred to the district nurse who had confirmed it was a long standing problem caused by the person's medication. However we saw evidence of a cut to the skin within the bruising. We did not see any mention of this within the person's records and there was no accident form relating to this.

All these examples demonstrate people were not safeguarded against possible harm. This was in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, Regulation 11, which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following the inspection visit referrals were made to the safeguarding team for the people whose wellbeing we were concerned about.

Staff we spoke with told us they had never seen any bad practice at the home and if they witnessed this they would immediately report it to the manager or to other relevant authorities. Staff said they understood the whistleblowing procedure and their responsibilities to ensure people were safeguarded.

Inadequate

Is the service safe?

We looked at how accidents and incidents were recorded. We found that whilst records had been kept, there was no recorded management review of accidents or incidents. This had been raised with the registered manager at the previous inspection in July 2014, yet had not been addressed. We had concerns about one person who had a large bruise, sustained by falling from their chair and asked to see a record of the accident. The acting manager told us they were waiting for a new accident book and details of each accident was recorded in individual files. However, we saw the recording of this incident was not clearly documented to show how this had happened and what might be done to prevent a reoccurrence. We saw an observation chart in place for the person, following this incident. However, it stated only where the person was upon checks made and there was no value in the recording to support staff in ensuring this person was protected from a re-occurrence of the accident.

On the third day of our visit we noticed one person had a large bruise. Staff we spoke with were unclear how this had occurred and they gave differing accounts; one member of staff said the person 'must have fallen in their room' as they had a tendency to get out of bed in the night and another member of staff said 'they must have caught themselves on something'. The person's care record showed the person's bruise had been caused by them rubbing the affected area. A printed, undated and unsigned care plan had been put in place for the bruising but there was no clear knowledge of how this had occurred or how the person's care should be managed properly.

We looked at two staff files and saw the recruitment procedure was robust. Staff files contained evidence of interviews, two references, Disclosure and Barring Service (DBS) checks and identification checks. One of the files we looked at contained only verbal references. The registered manager told us they had received written references but these had not yet been added to the file. We did not see evidence of DBS checks having been obtained for one member of the administration team, who although was largely based in the office, still had contact with people living in the home. This meant not all adults were suitably vetted before being able to work with vulnerable adults.

There were sufficient numbers of staff on duty, however we found they did not have the skills and knowledge sufficient to meet people's needs. This was evident in moving and handling practise and interaction with people who had a diagnosis of dementia. We looked at the staff rotas which indicated sufficient numbers of staff deployed during the day and at night. The staff team was listed in the dining room and there was a named person on call for out of hours contact. Staff told us they felt there were enough staff on duty to be able to meet people's needs.

During our visit we looked at the systems that were in place for the receipt, storage, administration and return to pharmacy of medicines. We saw a monitored dosage system was used for the majority of medicines with others supplied in boxes or bottles. Medicines were stored safely in a locked room. We saw that medicines were signed for on receipt and that medication administration record (MAR) sheets reflected the medicine given at the time it was given. We checked the quantities of four medicines not dispensed against the amounts recorded as received and the amounts recorded as administered. We found all these to be correct. We saw that any medicines not used were recorded as returned to pharmacy and these records had been countersigned by the person from the pharmacy.

We raised some concerns with the registered manager about one person's medication which had been taken from its original packaging and put in a dosette box. This had been signed for by the manager and a senior member of staff. This meant that staff administering medicines did not see the instructions for administration recorded by the pharmacist and this posed a risk that staff may not administer the medication as prescribed. The registered manager told us they had done this as the person was only at the home for a short period of time but had large boxes of medicines. The registered manager understood the risks of taking the medicines from their original packaging and said they would stop this practice.

Staff we spoke with described effective use of personal protective clothing (PPE) and how this helped to minimise the spread of infection. However, we saw aspects within the environment which were not clean and did not demonstrate safe infection control and hygiene practice. For example, we saw some of the chairs in the lounge areas were stained and some had an unpleasant odour. We saw staff support a person to the toilet who had been incontinent in the chair and the pressure cushion on which they had been sitting was wet and unclean as a result. Staff did not take action to remove or clean this cushion and the inspector saw another person sit in the chair. The inspector had to bring this situation to the attention of staff.

Inadequate

Is the service safe?

We saw one of the toilets on the ground floor to have faecal smearing on the seat and bowl. There was an unpleasant smell in the room due to this. When we checked the toilet several hours later, we saw it had not been cleaned. We had seen staff support several people to this toilet during that time. On the third visit to the home we saw a communal toilet which again was dirty and stained.

We saw one person in the lounge given their lunchtime meal on a small table. The table was dirty with dried on food and fluid spillages. After placing the meal on the table, a member of staff brought a cloth, picked the meal up and wiped the table. This did not clean the dried on food off the table. On another occasion we saw staff brought a person's lunch on a dirty tray and during this same meal time another member of staff put a very dirty apron on a person.

When we visited on the second day we observed a person in one lounge who had been incontinent and was sitting with wet clothing with a puddle on the floor. Staff were in the room with this person, yet did not take any action until this was pointed out by the inspectors. Although the person was assisted, the chair and the floor were not cleaned after this incident.

On the third day of our inspection we looked in one person's bedroom and found this to have an overwhelming smell of urine. We found pungent odours from the carpet and the mattress which was heavily soiled and smelling strongly of urine. We alerted the senior member of care staff and the administrator to this and we were told the mattress had been recently cleaned. We asked for this mattress to be put out of use with immediate effect and the senior member of care staff agreed to obtain a new mattress the same day.

We saw some of the chairs in the conservatory lounge to be in a very poor state of repair. The cover on one chair was badly torn and the cover of another chair had been taped together with sticky tape. Some of the seat cushions were damaged which meant they could not be cleaned effectively.

These examples demonstrate people were not protected against the risks of infection. This was a breach of regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have referred our concerns to the Infection Control Team.

Inadequate

Is the service effective?

Our findings

Our concerns were such that we referred immediately to the local authority who provided staffing resources to support in managing the home. Although people and their relatives spoke favourably, we had concerns about how people's needs were met. For example one person told us: "They [the staff] know me and what I'm like". Their visiting relative said they thought staff knew how to manage their [family member]'s particular needs. One person said: "The staff here are good at their job, they know what they're doing." Our observations of practise showed staff lacked the necessary skills to carry out their roles and responsibilities.

Staff told us they had 'plenty of training' and they had 'training all the time'. They said there were always opportunities for training and that much of this was in-house or through watching DVDs. When asked specifically which training staff had undertaken, they were not always clear in their response. For example, one member of staff said: "Oh I can't remember there's been so much training". Staff said they had constant refresher training to make sure their skills were up to date.

We saw evidence of training having been carried out and saw that future training was planned. We saw in two staff files, there was evidence of induction and ongoing training. The training matrix we saw identified the dates staff needed training updates but individual training records had not been kept up to date. The training matrix showed staff had completed training in a number of areas including fire safety, food hygiene, moving and handling and health and safety. The registered manager told us that the majority of training was delivered using DVDs but that practical training such as moving and handling was delivered by a trainer who visited the home or a member of staff who had undergone training to enable them to do this.

The induction programme used by the home was not aligned to the core standards training available through Skills for Care. A senior staff member said the home used to use the Skills for Care Induction package but no longer did so. They were unable to tell us why this was. We spoke with one new member of staff who told us they had been given a thorough induction and they had shadowed more experienced staff until they felt confident to work alone. This member of staff said they felt supported in their role to be able to undertake further training as required. The registered manager told us that all but two of the current staff team had achieved National Vocational Qualifications at level two or above. Those who had not yet achieved this were enrolled on courses to achieve the diploma in care certificates which have replaced NVQs.

Despite this information it was clear from our observations and discussions with staff that in spite of training they lacked knowledge in how to provide suitable care for people and in particular, those people with limited mobility or those living with a diagnosis of dementia.

A senior member of staff had told us that twenty five of the people living at the home were living with a diagnosis of dementia or experiencing some confusion. However, other than one member of staff who had done training in dementia care mapping (an observation tool that looks at the care of people with dementia from the viewpoint of the person with dementia), records did not show that staff had undertaken training in supporting people living with dementia, supporting people in maintaining dignity or effective communication. We also saw that only two staff had received training in Mental Capacity Act and Deprivation of Liberty Safeguards.

These examples illustrate staff did not have relevant training appropriate to meet the needs of the people in the home. This was a breach of regulation 23 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. Staff we spoke with had little or no knowledge or understanding of the MCA and how this impacted upon people's care and rights. This had been raised with the registered manager at the previous inspection in July 2014, yet had not been addressed.

We saw the doors to the home were locked and there were secure codes to gain access to areas within the building. This included one lounge, which had a locked door that required staff to enter a coded number to gain access. This

meant people could not enter the lounge freely as they wished to do. To leave the lounge it was necessary to press a button at the same time as opening the door. We asked staff if all of the people who lived at the home would be able to do that. Staff said some people would not be able to do that. This meant that people could not leave the lounge when they chose. Staff told us people did not have knowledge of the security codes on any of the doors and no one was allowed to leave the building without staff being aware. Staff told us they would actively prevent people from trying to leave the building in order to ensure their safety.

We saw there were no mental capacity assessments for any of the people whose care plans we looked at. We spoke with the registered manager who told us people's mental capacity had not always been assessed. She said there were two staff who had undertaken MCA training but that all staff 'would have the training' in the near future.

Staff had variable knowledge of whether any of the people in the home were subject to DoLS; one member of staff thought there was 'a list', whilst other staff had no knowledge of what these safeguards meant.

We found staff were not consistently aware of the individual risks to people and as such, were not able to manage these risks so as to promote people's freedom and independence and not restrict their liberty. For example, we saw where people required a walking frame to help them move around, these were not always accessible. We spoke with staff about this. One staff member told us they would always bring a person's walking frame to them should they wish to move around, but they stored these out of the way so they would not be a trip hazard. This meant some people were not able to mobilise without having to wait for staff to know they needed their equipment.

We saw one example of this, where a person was assisted with their walking frame into the dining room at 12.10; they were helped to sit on a chair, then staff took away their frame. We saw at 13.30 this person indicated they wanted to leave the dining room and at 13.40 they were the only person left in the room. One member of staff brought the person their frame and gave encouragement for the person to use it. The person was reluctant to use the frame and indicated they did not feel confident to stand. Staff then took the frame away stating 'you're not ready? Ok, we'll try you in a bit', then left the person alone in the room. This happened two more times with different members of staff and in between times the person was left alone in the dining room. We saw the person looked anxiously at the door, called out to try to gain staff attention and attempted to move themselves using their dining chair. At 14.15 a member of staff was successful in enabling the person to use their frame but the person had been indicating for 45 minutes they wished to leave the room.

These examples demonstrate people's rights in relation to the Mental Capacity Act 2005 were not promoted and people's freedom was being restricted. This was a breach of regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were given very little choice in their daily routine. For example, care tasks were carried out with little consultation with the person concerned. We saw evidence of staff moving people without any discussion with them; one person who was walking in the corridor was turned around by staff and directed the other way without any apparent reason or explanation. Staff put protective clothing on people at lunchtime without any discussion and led people by the hand to sit in the lounge without asking if that was what they wanted.

At lunchtime, people were presented with their meals in exactly the same way; shepherd's pie with potatoes, vegetables and gravy. We saw the meal was put in front of people without asking them what quantities or which component parts of the meal they preferred, or whether they wanted gravy. Some people were not offered, and did not have access to condiments. This meant people's choices were restricted.

People were not supported or enabled to express their views or make decisions about their care. This was a breach of regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We saw one person being assisted with their meal in the lounge. The member of staff assisting gave little attention to the person during this but spoke with another person in the room. We saw the person reach out for their beaker of juice from the carer's hand. However the carer pulled their hand containing the beaker of juice away from the person's

reach. We also saw the carer leave the room on one occasion halfway through the person's meal. The carer did not tell the person they were doing that and made no apology either when they left or when they returned. They were gone for a period of five minutes.

We saw staff were not aware of which people had eaten and who had not. For example, we saw one person pushed their meal away and refused to eat it. The person was encouraged to sit in the lounge but no further food or drink was offered. We saw this person was assisted to their room shortly afterwards, yet there was no encouragement from staff or procedures in place to ensure the person had enough to eat or drink. Another person was assisted to the table for a second time, having already had lunch. Staff noticed this and apologised to the person saying: "Sorry, you've already had your dinner" and led the person away from the table, somewhat confused.

On the third day of our visit we saw one person who had been asleep in the lounge and woke intermittently. We saw this person was not offered any lunch and when we asked staff they were not clear who would take responsibility for this. The person had still not been offered anything to eat by mid afternoon.

We saw from two people's care plans that they had good appetites and should be given big portions and offered extra meals as appropriate to their need. We did not see either person offered additional food or given bigger portions.

Staff identified one person to us as at risk of losing weight. We saw this person was reluctant to eat and although we saw staff frequently reminded the person to eat their meal, care records showed their weight was not closely monitored and had not been recorded since 29/11/2014.

Staff we spoke with were not clear about which people had specific dietary or health requirements or who was being monitored for weight loss. For example, one staff member we spoke with told us there was one person in the home with a particular health condition that required monitoring in terms of their nutrition, yet we saw from care records there were two people with this condition.

We looked at one person's care records and this showed they had lost almost 13kg in four months. The nutritional screening tool dated 18 February 2015 showed they were 'minimal risk' of malnutrition and there was no evidence we found that this person had been referred to their GP for weight loss.

We noticed that people with diabetes were given alternative puddings or snacks. We spoke with the chef who told us the pudding at lunch time was made with less sugar for the people with diabetes. We did not see there had been any differential. We asked the cook about the cake people had with afternoon tea. They said it was all the same but that usually they just made cakes with "much less sugar" in them for people with diabetes. There was no sugar substitute available. The chef said people could have yoghurts as an alternative. We saw the yoghurts were low fat. We asked the chef about how they fortified meals. The chef did not understand our question and told us about liquidising meals.

The senior member of staff told us that the GP for one person with diabetes had said they could

have puddings, however we did not see record of this in their care notes.

One person took the inspectors mug of coffee and started to drink it. They said it was nice. A member of care staff came and took it off them saying "You can't have that" The inspector said it was fine but the carer said the person had to have their drinks out of a red cup. The inspector queried this as the person had clearly been enjoying the drink. The member of staff took the drink away and poured it into a red plastic beaker and gave it back to the person. The person put it down and walked away. We saw this person was served a cup of tea later in the day in a white cup. We asked the registered manager why some people have red beakers. They told us it was based on research and was good for helping people living with dementia to recognise the mugs. We asked why they were plastic. The manager said it was because people threw them. We did not see any incident records to evidence that people had thrown mugs of drinks.

During the afternoon a member of staff brought a trolley of drinks into the lounge. The carer poured a cup of tea for everybody in the lounge. We asked if other drinks were available. The carer said there was coffee but they were 'accustomed' to who had what. We asked how someone might have an alternative if they weren't offered. The carer said they knew who liked what. Some people were given a

Is the service effective?

piece of cake. There was no choice but people said the cake was very nice. People were not provided with plates for their cake. One person was not given cake. The carer said it was because they couldn't manage cake and a drink at the same time. The person was not provided with a table. The person did not get any cake.

At tea time we asked one of these people if they had had enough to eat when they had finished their meal. They said no, they were still hungry. We told the care staff and the person was given more sandwiches. They were not offered any choice and the sandwiches had started to curl and dry.

The provider had failed to ensure people were given choices in eating and drinking and that people were effectively supported to eat and drink in line with their dietary requirements.These examples illustrate a breach of regulation 14 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 14 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at care records for one of these people and saw that in their Waterlow assessment (an assessment tool used to determine if a person is at risk of developing a for pressure ulcer) they were assessed as below the recommended weight for their height. However the nutritional assessments for December 2014 and January 2015 assessed the person to be of minimal nutritional risk. We saw that between August 2014 and February 2015 the person had lost 4kg in weight. This was a steady weight loss until the most recent recording where a gain of 0.3 kg had been recorded.

We looked at another person's weight records which indicated they had lost 12.9kg in weight in the last four months. When we looked at this person's nutritional assessment sheet dated February 2015, we saw the person had been assessed as being at minimal risk.

People's care records showed other professionals had been involved in their care where necessary. We spoke with the district nursing team prior to the inspection and we were told the staff at the home were proactive in seeking advice where they had concerns about people's skin integrity. They told us staff followed their advice and they had no concerns about how people's healthcare needs were managed.

On the third day of our inspection we had immediate concerns about one person who appeared to be very ill. Staff told us they had called for the person's GP. We saw the person did not appear to have been given a drink for some time as their mouth and tongue were very dry. When we asked a senior member of staff about this they told us the person was on a fluid balance chart; when we asked to see this we were told there was not one in place. We looked at this person's care file; there was no care plan in place and there were no daily notes from the previous day to show how this person's health had been managed or when the GP had been alerted.

We spoke with a visiting GP who had been called to attend to three people. He told us he had no concerns about the way staff cared for people in the home and that medical advice was always sought promptly if people were ill.

Staff we spoke with told us the procedures they would follow if to ensure people received appropriate help in an emergency. For example, if they thought a person needed emergency medical treatment they would contact the ambulance service without delay. They explained the procedure was to call an ambulance and then contact the manager. This procedure was displayed prominently for staff, along with details of which senior staff to call upon if required out of hours.

Inadequate

Is the service caring?

Our findings

People told us they were happy living in the home. One person said: "I like it here" and another said: "It's where I live, it's alright really." Another person said: "It's very nice here, very good indeed." One person said: "I think I'm ok in this place." Relatives we spoke with told us they thought staff were caring and friendly and they felt welcome to visit at any time.

Some people were clean in appearance and smartly dressed. However others were seen to be wearing stained clothing and some of the gentlemen had not been supported to shave. We saw varied practise among the staff team in their approach to caring. We saw some staff spoke with people patiently and gave people time to respond at their own pace. However, at times we saw staff were not always kind in their interactions with people. For example, we saw one person had picked up a waste bin and a member of staff took this away sharply saying "you're not having that, I'm moving it" without any discussion with the person and this left the person looking bewildered. On another occasion a person indicated they wanted to move from one room into another and whilst staff were on hand to support them, it was evident the person did not feel confident, yet staff gave little reassurance.

On one occasion we saw a person approach staff with their arms out. Staff responded warmly and gave the person a cuddle. On another occasion we saw staff compliment a person on their appearance, which made the person smile.

We observed a contrast in the quality of people's experiences in the home, our observations illustrated the more dependant the needs of the person, on the care from the service, the poorer the experience of care was. For example, we noticed people who were more physically and cognitively able, sat mostly together in one lounge. The environment in this lounge was clean and there was better quality interaction with activity staff. In contrast, people with higher dependency needs were cared for mostly in the far lounge and the adjacent conservatory. We saw care for people with the greatest needs was poor in terms of staff interaction, activities, and cleanliness of the environment and furniture.

We witnessed a number of incidents of staff not interacting with people in a supportive, kind or respectful manner. We observed a care assistant asking one person if they would like to go to the dining room for lunch. The person was confused and responded to the care assistant in a challenging manner saying "what do you mean? Why would I want to go with you?" The carer replied "Oh have it your own way then" and walked away.

One person we saw was dozing at the table after their lunch, when a member of staff walked past, touched their arm and called their name, which made the person wake up suddenly. The staff member had gone past and so the person was left looking startled. They dozed off again and a few minutes later the same member of staff came to them from behind and spoke in their ear, which again made them wake up with a start. This interaction was not caring and had no regard for the person's sleepy state.

We saw one person who was clearly very ill sitting alone in the conservatory lounge. They were seated in an arm chair base without any form of seat cushion, there was a draught coming from the window and we noticed they were inappropriately dressed, with no underwear on their top half. The person's socks were tight, causing a severe indent around the ankle. When we asked staff if the person had been given a drink, staff brought them a drink and offered this from a beaker. The drink spilled out of the person's mouth, down their chin and onto their chest and staff made no attempt to wipe this. We asked staff if the person was comfortable enough as they appeared to be in discomfort; staff then arranged for the person to be assisted to bed. We later saw the person in bed, still wearing their clothes and they had yellow substance all over their mouth and chin, which staff said was medicine. We have referred the concerns we saw about this person's care to the Local Authority.

The provider had not ensured people had effective, safe and appropriate care, treatment and support that met their needs and protected their rights. This was a breach of regulation 9(1)(a)(b) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9(3)(a)(b)-(h) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's privacy and dignity was not promoted as staff were not discreet when dealing with people's personal care. For example, one member of staff looked down the back of a person's trousers when they were seated at the dining table. The member of staff later explained to us they were checking the person's undergarments were securely in place; nevertheless this was not done discreetly. We saw

Is the service caring?

two gentlemen, who whilst being supported to walk, their trousers fell down exposing their underwear. Care staff did not respond to this but both gentlemen tried to hold their trousers up. On a further visit to the home we saw a person who was assisted by staff to walk, yet their trousers were falling down and round their ankles before staff noticed.

Staff showed little regard for people's dignity. For example, we saw the senior member of staff and a carer assist a person to their feet to take them for lunch. The person had visibly been incontinent and there was a strong odour. The senior member of staff spoke across the person to the carer saying loudly "I can smell something" and wrinkling their face in a manner which would indicate the smell was unpleasant.

On one occasion we saw staff assisted a person with their meal, but attempted to do so whilst the person was leaning heavily over the side of their chair. We intervened as this person was clearly not positioned comfortably or correctly and we had concerns they may fall out of their chair. Staff went to get some assistance to reposition the person, although there was no explanation given to the person about this. Staff then proceeded to assist the person with their meal, despite the person having a severely runny nose. Once the person had been assisted the member of staff left them with food on their mouth and face. Another member of staff walked past and said: "Look at you, you've got more round your mouth" yet no attempt was made to help the person clean their face.

We heard staff talking to each other about people who lived at the home without any regard for the person's privacy or dignity. For example one care assistant called out "She's wet, you need to change her trousers".

We saw that not all of the toilets or bathrooms could be locked to provide privacy for the person using them. The senior member of care staff and the registered manager told us this was because "people with dementia might lock themselves in". We pointed out that other toilets had locks in place that staff could operate from outside if they suspected somebody was in need of assistance and that people living with dementia should be afforded the right to privacy.

We saw one person calling out in a distressed manner. The senior member of staff went to them and said "where are your teeth?" but did not offer the person any comfort. We saw this person was clearly agitated and upset at lunchtime and they waited more than 15 minutes at the dinner table, with intermittent attention from staff. When their lunch arrived they pushed it away and staff assisted them to the lounge. The person continued to be upset in the lounge. A member of staff announced "oh I think someone is tired" and suggested the person had a sleep. The person protested and staff led them by the hand out of the lounge. Another member of staff assisted the person to their room by bringing a wheelchair and taking them upstairs. We later heard this person in their room, calling out and we knocked and entered. The person was seated on the edge of their bed, still anxious and upset. When a member of staff came to intervene they could not tell us whether or not the person had been to sleep; it was evident the person was unable to summon help themselves. Staff response to the person being upset was '[they] are always like this' with no indication or understanding as to what might make the person feel better.

We saw a person walking around the lounge whilst the care assistant was serving drinks. The person was trying to get to the drinks trolley. The carer repeatedly told the person to sit down and when they didn't do so, the care assistant started to guide them backwards towards the chair by placing their hand on the person's shoulder. The person became angry and shouted "Don't do that" to the care assistant.

We saw one person coughing badly in the lounge. There were no staff present. After some time of heavy coughing the person vomited. At this point a care assistant came into the room and said "Have you been sick? I'll get someone to help" The care assistant left the room and did not return for another five minutes. The person was not provided with a bowl, assisted to wipe their hands and mouth, or given any comfort.

In one person's care records we saw "[person] has been moved from the bottom lounge to the conservatory lounge, this is because she has targeted two other clients". This would indicate that people are not given choice of where they would like to sit. We observed that people with higher dependency needs or behaviour that challenged the service were seated in the two lounges nearest to the dining room. There was no staff presence in either of these lounges other than when staff were delivering direct care.

People were not supported with maintaining their independence. We saw one person whose care plan said they were independent with their meals. We saw a care

Inadequate

Is the service caring?

assistant take their meal to them and begin feeding them with a spoon. There was no interaction from the care assistant to the person. We saw the person try to reach out to take their drink from the care assistant's hand. The care assistant pulled their hand out of the reach of the person so they were not able reach their drink.

We saw unopened mail in an area outside the registered manager's office. We saw one letter marked as 'To be opened by addressee only' and was from the hospital. The letter was for a person who lived at the home and was post marked December 2014. The manager said the person's relative had said they wanted to open all mail for this person but hadn't visited since the letter arrived. We asked if the person had capacity. The registered manager said they did. We asked why the letter had not been given to the person. The registered manager again said it had to be given to the relative and we discussed with the registered manager that this did not fit with the person's rights under the mental capacity act.

The provider did not ensure people were placed at the centre of their care and treatment or have regard for their dignity and independence. This was a breach of regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 10 and 9(3)(a)-(g) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

People told us there was not enough to do. One person said: "I'm sat here, that's what I do. There's nowt else". Another person said: "The telly is on but I'm not bothered for it". Another person said: "Nobody has time to talk, they [gestured to people in the room] just go to sleep." One person said they looked forward to their visitors coming.

We saw that some people in the largest of the three lounges were being engaged in activities by a member of staff employed for that role. This member of staff chatted sociably with people in this lounge and people appeared content. However, we observed that meaningful activities did not extend to all people in the home.

None of the people in either of the other lounges were engaged in any activity other than the television or radio being on. In one of the lounges, the radio was playing but was tuned incorrectly and therefore was making a loud crackling sound. This went unnoticed by all of the 4 staff who came in and out of the room. The radio was put on station by the registered manager after approximately an hour and a half. The television in this lounge was positioned so that only the people sitting directly opposite would be able to see it. When the television was put on in the afternoon, none of the people in the room were asked what they would like to watch or if they could see or hear it.

In another lounge the television was on but not at a volume loud enough to be heard by people in the room. People were not asked what they would like to watch until we asked a member of staff why this was. We saw a rugby match screened on one television. A group of ladies were in the lounge and none of them were watching it. We heard a member of staff joke with the ladies about them liking the rugby, but there was no attempt made by staff to find out whether people really wanted to watch, or if they wanted the television.

Care plans were not all in place but where they were, we saw they were brief, not developed in a person centred manner and lacked the detail staff needed to support people in the way they needed and preferred. For one person who had been in the home for more than a week, there was only a very sparse record that gave little information, other than to suggest the person was at high risk of falls. We spoke with staff about this and they told us the person was there on a temporary basis and that was why there were no detailed records. However, we were concerned that risks for this person had not been clearly assessed and staff did not have sufficient information to be able to respond the person's needs. We asked the provider to update the person's record to include comprehensive details.

We saw no information in any of the care records we looked at that people's individual needs were regularly assessed, recorded and reviewed. We saw one person had difficulties maintaining a safe posture and had fallen from their chair and injured their head. There was no evidence this person's needs had been assessed or professional advice sought with regard to more appropriate seating. We saw this person was sitting in a large reclining specialist chair, however, staff told us it did not belong to this person. We have discussed this matter with the safeguarding team and the provider.

This had been raised with the registered manager at the previous inspection in July 2014, yet had not been addressed.

The provider had not ensured there was an accurate record in respect of each person which included appropriate information in relation to their care and treatment. This was a breach of regulation 20 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17(2)(d) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We looked at the care file for a person identified to us as living with a diagnosis of dementia. The only information for staff to follow in relation to supporting this person with their dementia was to speak to them regularly, keep them calm and offer reassurance when they became aggressive.

We saw one person who spent much of their time in bed and they had limited mobility. We spoke with this person and saw they were unable to reposition themselves and had a limited view when they were alone in their room. The person's care records stated 'ensure [person] is brought down just before lunch', yet we saw this person was not assisted until 3pm. There were no records in the person's room to show when they had last been attended to by staff, or had a drink. Care plans for this person were not clear in relation to their moving and handling regime. For example, records stated 'sometimes needs a hoist to be transferred (staff to assess)' yet there was no evidence staff had made an assessment of when and why the hoist was required.

Inadequate

Is the service responsive?

When we spoke with staff they were not clear in their knowledge of this person's needs; one staff member said the person was always hoisted and another said they were sometimes hoisted.

This was a breach of regulation 9(1)(a)(b) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9(3)(a)(b)-(h) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they would 'tell the staff' if they wanted to complain and they said they thought staff would take appropriate action. One person told us: "I'm happy, but if I wasn't they'd know about it from me". We saw a record of minor complaints which showed staff had responded when people expressed any dissatisfaction with the service. For example, when a person complained their tea was cold this was documented and actioned. The registered manager told us they took complaints seriously and said there was a good relationship with people and relatives so they could approach staff and managers if they felt unhappy with the standard of care. Relatives we spoke with said they were confident to raise concerns with any member of staff, but added they had no cause to.

Inadequate

Is the service well-led?

Our findings

The registered manager had been responsible for running of the home for many years.

Relatives we spoke with told us they knew who was in charge of the home and they felt they were frequently visible and approachable.

Staff we spoke with said they felt supported in their role and were confident to question practice with colleagues and senior staff. One new member of staff said they had been made to feel welcome in the team and the home was 'like one big happy family'. Some staff reported lower staff morale and they said this was due to recent whistleblowing concerns.

We found there was no monitoring in place of the attitudes and behaviours of staff and aspects of practise we observed to be less than caring had not been identified or addressed by the registered manager. There was no clear vision and values communicated to the staff team.

Quality assurance systems in the home were not robust. We saw that some risk assessments relating to the environment were in place, had been reviewed and were up to date. We saw that although records of weekly checklists on the quality of the environment and equipment were completed, these. For example, wheelchairs and hoist frames were recorded as having been checked and cleaned. We saw the 'handyman working rota' However, these checks had not identified any issues relating to the standards of cleanliness and infection control we observed during our visit.

Accidents and incidents were not being monitored or analysed by the registered manager. When we asked why, the registered manager said they were 'going to start doing it'. However, this had been highlighted at the previous inspection in July 2014 as an area of concern and this had not been addressed, despite an action plan from the provider stating improvements had been made.

We discussed with the registered manager that where significant incidents had occurred these had not always been notified as required to the Care Quality Commission or reported to the local authority safeguarding team. Accidents and incidents were being recorded but not used as a point for staff discussion or learning. The local authority commissioners told us they had issued a notice of breach to the provider about the failure to report such matters accordingly.

We did not see any audits relating to care files and so inconsistencies in people's care plans had not been identified and addressed. We discussed with the registered manager that important matters such as people's end of life wishes had not been discussed with them, and this was also an area highlighted at the last inspection for improvement. The registered manager confirmed these discussions had still not taken place with people to determine their wishes.

The registered manager said she was actively involved in people's care and we saw she was visible in the home on the first day of our inspection. However, when we shared our inspection findings with the registered manager, she confirmed no routine quality checks of practise were made in order to monitor and maintain appropriate standards of care in the home.

The registered manager was not present for the second and third days we visited the home. Arrangements for managing the home were temporarily assigned to the three senior care staff. However, no one person was seen to be in charge and the lines of accountability for standards in the home were not being maintained. We were not immediately notified of these changes.

This was a breach of regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment People were not safeguarded from possible harm or abuse.

The enforcement action we took:
Notice of proposal to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not protected from the risk of infection and the environment was not clean

The enforcement action we took:
Notice of proposal to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People's care and welfare needs were not met

The enforcement action we took:
Notice of proposal to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs People's nutrition and hydration needs were not met

The enforcement action we took:
Notice of proposal to cancel registration

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	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect People's dignity, privacy and independence was not promoted

The enforcement action we took:
Notice of proposal to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People's consent was not sought for their care and treatment

The enforcement action we took:
Notice of proposal to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Records in respect of people's care were not fully in place or accurate in relation to their care and treatment

The enforcement action we took:
Notice of proposal to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance There were no systems to regularly assess and monitor the quality of the service

The enforcement action we took:
Notice of proposal to cancel registration