Mrs G H Copley

Lands House

Inspection report

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Date of inspection visit: 23 February 2015
Date of publication: 01/05/2015

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?	Requires Improvement
Is the service well-led?	Inadequate

Overall summary

The inspection took place on 23 February 2015 and was an unannounced inspection. On the date of the inspection there were 23 people living in the home.Lands House Nursing Home provides accommodation and nursing care for up to 30 people at any one time. The home is located in Rastrick, Brighouse with accommodation spread over two floors. The client group was mainly older people, some of whom were living with dementia.

A registered manager was not required to be in place as the provider was a single individual who also undertook the role of home manager.

People and their relatives spoke positively about standards in the home, they said they felt safe, were well looked after and the food was good.

However we found systems designed to keep people safely were not always in place. Medicines were not safely managed which meant people did not always get their medicines as prescribed putting them at risk of harm or discomfort.

Staffing levels were not sufficient to ensure safe and effective care. We found there were not enough care workers to ensure people were attended to in a timely fashion. A lack of staff resources allocated to the

Summary of findings

medication round meant that the people did not always get their medicines at a time they needed them. There were insufficient resources to allow nursing oversight into the management of the home.

Risks to people's health, safety and welfare were not always identified and assessed. We found the risk associated with bed rails and portable heaters had not been adequately assessed placing people at risk of harm.

People told us the food was good and we saw some staff showed a good level of support in assisting people. Plenty of food and drink was available throughout the day. However, the level of support was inconsistent with some people experiencing interruptions during mealtime assistance.

In some cases, we saw evidence action had been taken following weight loss but in other cases there was a lack of evidence that weight loss had been promptly identified and appropriate action taken. Advice from health professionals had not always been incorporated into plans of care which meant there was a risk their advice was not followed.

People reported staff had the correct skills and knowledge to care for them. We found staff were provided with a range of training, however some staff were overdue training updates.

The Care Quality Commission (CQC) monitors the operation of the DoLS (Deprivation of Liberty Safeguards) which applies to care homes. The provider did not demonstrate a good understanding of DOLS, had not assessed the restrictions placed on people to keep them safe in order to make necessary DoLS applications. We found people's capacity had not always been assessed where key decisions/plans of care were put in place which meant there was a risk their rights were not protected.

People and their relatives told us staff were kind and considerate and treated them well. We saw some good examples of care and support particularly in the downstairs lounge; however this was not consistently applied. For example, we saw one person's privacy was not respected when they were assisted to the toilet as the door was left open.

People's needs were not always fully assessed and some key care plans were missing with regards to specific medical conditions. Some other care plans did not contain sufficient details to allow staff to deliver appropriate care. We saw appropriate care was not always delivered for example the nurse asked care staff to assist one person but three hours later staff had not carried out a procedure necessary to ensure their care and welfare.

Staff told us they were unsure about the lines of accountability in the home and in particular the role of the clinical lead. We found no supernumerary time was allocated to the clinical lead role and there was a lack of nursing management in the home. This meant there was a risk that decisions, checks and audits were not carried out by staff with the appropriate level of expertise.

Some audits were carried out , however these were basic and did not provide assurance that a wide range of areas were looked at, and where issues were found there was no confirmation of what the issues were and the action taken to resolve the problem. We found a number of failings in care quality which should have been identified and rectified sooner had an effective system of quality assurance been in place.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which correspond to regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we asked the provider to take at the back 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. Although people told us they felt safe in the home we found systems designed to keep people safe were not always in place.

Medicines were not safely managed. People did not always receive their medicines at times which suited their individual needs which meant they may not have been effective. Some people's medication was not available due to running out of stock.

Staffing levels were insufficient to ensure safe care. People had to wait for care and support and there was a lack of nurse management to oversee clinical issues.

Risks to people's health, safety and welfare had not been appropriate identified, assessed and managed. This included bed rails, unguarded radiators and a lack of documented action following incidents.

Is the service effective?

Inadequate

The service was not effective. People and their relatives told us that the home delivered effective care and staff had the correct skills to care for them. However we found inconsistencies with the level of support people were provided with at mealtimes. A good level of support was provided in the downstairs lounge, but upstairs we found people were not always supported appropriately.

We found that where people's weight was being monitored effective action was not always taken to investigate weight loss placing people at risk of harm.

The home was not meeting the requirements of the Deprivation of Liberty Safeguards (DOLS). We found a number of restrictions on people's liberty which may constitute a deprivation of liberty, such as the pressure sensors, and restricting access out of the building. The restrictions on people's freedom had not been assessed by the manager. This meant there was a risk their rights were not protected as DOLS guidance was not being followed.

Is the service caring?

Requires Improvement

The service was not always caring. People and their relatives told us staff were kind and caring and treated them well. We saw some positive interactions between staff and people who used the service which demonstrated staff understood the people they were caring for and knew how to meet their individual needs.

However, we also observed some occasions where staff did not treat people in a caring manner. Staff did not always respect people's privacy and broke off from supporting one person during breakfast to attend to other matters.

Summary of findings

Is the service responsive?

Requires Improvement

The service was not always responsive. People's needs were not always fully assessed and some key care plans were missing or care plans did not contain sufficient detail for staff to deliver effective care.

We saw some examples of people not receiving care in line with their

assessed needs. This included one person being left in discomfort because care staff did not attend to the nurse's instructions in a prompt manner. Charts to record people's food and fluid and pressure relief were inconsistently completed or not completed in a timely manner making it difficult to ascertain of people had received care in line with their plans of care.

People said the management was effective in dealing with any concerns and complaints and feedback from people indicated a high level of satisfaction with the service.

Is the service well-led?

Inadequate

The service was not well led. Staff reported some confusion over the management structure in the home and the role of the clinical lead. We found there was a lack of nursing oversight into the care and treatment delivered by the provider which meant there was a lack of necessary expertise and a risk of inconstancies in clinical decisions.

We identified eight breaches of regulation which should have been identified and rectified through a programme of effective quality assurance to help continuously improve the standard of care. Although some audits were completed, these were not detailed enough to demonstrate a range of areas had been critically examined and there were no action plans in place to plan how risks were addressed.

Lands House

Detailed findings

Background to this inspection

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

The inspection took place on 23 February 2015 and was unannounced. The inspection team consisted of four inspectors. We used a number of different methods to help us understand the experiences of people who used the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spoke with 10 people who used the service, a registered nurse, three members of care staff and the cook. We also spoke with the provider and deputy manager. We spent time observing care and support being delivered. We looked at eight people's care records and other records which related to the management of the service such as training records and policies and procedures.

Prior to our inspections we normally ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We did not ask the provider to complete a PIR on this occasion. We reviewed all information we held about the provider. We contacted the local authority safeguarding team, clinical commissioning group to ask them for their views on the service and if they had any concerns. As part of the inspection we also spoke with two health care professionals who regularly visited the service.

Inadequate

Is the service safe?

Our findings

People told us they felt safe in the home and did not raise any safety concerns with us.

We reviewed the medication management system and found medicines were not always managed safely. Medicines were administered to people by trained nursing staff. We spoke with the nurse with regard to the timely administration of medicines. The nurse said with the complexity of people's needs it was not possible to administer medicines in a timely fashion. They said the lateness of finishing the morning medicine round compromised the administration of lunchtime medicines with as little as two hours between people's morning and lunchtimes medicines. Our observation of the entire medicine round confirmed this was an issue and we concluded that one trained nurse could not alone safely administer medicines in line with the requirements of the prescriber. We saw on a number of occasions medicines given after food when the prescriber had clearly indicated the need to administer the medicine before food. This showed people were not always receiving their medication as prescribed.

When PRN (as required) medication had been prescribed we saw staff had not always recorded when medicines had been offered but refused. In addition, we witnessed on one occasion the nurse recorded Paracetamol had been refused yet we did not hear the person being asked if they needed pain-relief. We questioned the nurse who confirmed they had presumed no pain-relief was needed. This showed people were not always asked if they required pain relief which meant they could be left in unnecessary pain. We witnessed another instance where a person was recorded as refusing an inhaler which was prescribed to be given four times a day. We saw from the MAR sheet refusal had been recorded on all occasions for the past three weeks. When challenged, the nurse asked the person if they wanted to have the inhaler. The person accepted the medicine. This indicated this person was not being offered their prescribed medicines.

We saw one person was not given a cream as prescribed. The nurse told us the cream was no longer necessary but no referral to the prescribing GP had been made to ensure this met with their original prescribing intentions. This showed this person was not receiving their medicine as prescribed.

On two occasions we observed a nutritional supplement drink being administered during the morning and being removed by care staff mid-afternoon without any of the drink being consumed. This had been recorded as administered on the Mediation Administration Record (MAR), when in fact it hadn't been taken by the people.

We observed gaps in signatures on MAR sheets which we established were on occasions when people had received their medication but it had not been recorded. This meant it was not possible to confirm people had received their medicines as prescribed.

During the morning administration of medicines to 23 people we observed on five occasions the medicine was not available due to running out of stock. We also observed that one person who required a prescribed thickener to minimise the risk of choking was given another person's prescribed thickener as their thickener was unavailable. Medicines should only be given to the person they are prescribed for. This showed the systems for ordering medication were not sufficiently robust to keep people safe.

On one occasion we saw a person had been prescribed Paracetamol. The persons MAR sheet indicated 124 tablets had been received when the person was admitted to the home just over two weeks prior to our inspection. The person had previously resided at another care home in the area. We could not find a stock of Paracetamol for the person concerned but we did find a stock of 124 Paracetamol tablets for another person not residing at the home. The nurse concluded the person had been admitted to the home with the medicines of another person at their previous care home. This demonstrated the home was not providing due diligence when admitting someone into the home.

We found that eye drops for two people were incorrectly stored in the fridge when they should have been stored at room temperature. This meant they may not have worked effectively.

We found that the registered person had not protected people against the risk of unsafe management of medicines. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service safe?

We looked at the medicine administration record (MAR) for one person who had been prescribed warfarin. We saw this was administered correctly and in line with their needs. We saw that the drug refrigerator and controlled drugs cupboard provided appropriate storage for the amount and type of items in use. The treatment room was locked when not in use. Drug refrigerator and room temperatures were checked and recorded to ensure that medicines were being stored at the required temperatures. Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs. We saw that controlled drug records were managed safely.

We spoke with the manager about staffing levels in the home. The manager told us during the day four care workers and one registered nurse were on duty and at night one registered nurse and two care workers. We concluded staffing levels were not sufficient to ensure safe care. We observed there were times when communal areas were not adequately supervised due to staff assisting people with personal care. During the morning one person asked staff to go to the toilet but it was 21 minutes before staff returned to assist them. We saw another person was still in bed at 10.55am, the person told us they not had a drink or any breakfast. The room also smelt strongly of urine indicating that staff had not yet had time to assist to this person with their care.

Another person who was in bed told us they were waiting for staff to get them out of bed and told us they often had to wait up to an hour to get up in the mornings. At lunchtime, we observed people were sat at the dining table for up to 40 minutes before food arrived and two people fell asleep waiting. We spoke with staff to gauge their views on the level of staffing. They said that whilst all people received the care they needed it was not commonly achievable within the right timescales and that there were not enough staff in the home in the mornings which was in line with our observations. We looked at staff rotas and saw some days for example 16-18 February 2015 where only three care workers had been present during one of the daytime shifts, the manager confirmed this had been the case. This showed the home could not always maintain its target staffing levels and meant on these days staffing would be more stretched with people waiting longer for care than observed on the day of the inspection. The manager told us they were recruiting more staff to deal with these shortfalls and said they were also planning on introducing a fifth care worker during the mornings to improve staffing levels.

The nurse on duty finished the morning medication round at 11.30am and then went onto the lunchtime round shortly after. We concluded this was not conducive to safe care as it was not possible to administer medicines in a timely fashion due to the reliance on one staff member. This showed there were not sufficient staff resources allocated to the administration of medicines.

The manager told us there was no supernumerary nursing management at the home. The manager told us this was not possible at present due to the lack of qualified nursing staff but they were addressing this through recruitment. We found this meant that care plan reviews, and clinical audits did not take place or did not include the necessary level of nursing expertise.

This showed that there were insufficient quantities of suitably trained and skilled staff. This was in breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Two care staff we spoke with told us they were aware of how to detect signs of abuse and were aware of the external agencies they could contact. Questions we asked staff demonstrated they had a credible knowledge and could translate this into practical action. However, we found incidents had not always been reported and action had not been taken to keep people safe. For example, in one person's care file we saw two incidents had occurred in December 2014, one where the person had hit another person in the face and on another occasion thrown a cup of tea over another person. These had not been reported as incidents through the provider's incident form and there was no evidence of any actions taken to prevent a re-occurrence apart from "separating the people". In November 2014 another incident involving the same people had been recorded on an incident form, where the two people had been found fighting on the floor. Again there was no evidence of any clear actions taken to prevent a re-occurrence and keep these people safe. Care plans did not contain any information about this conflict or how staff could prevent it.

Inadequate

Is the service safe?

We looked at another person's care plan. An entry in February 2015 stated "3cm healing break in left hip." We asked the nurse about skin tears to the hip and how these were caused. They said they didn't know, the nurse admitted it was unusual to have a skin tear there and didn't know if people had been handled properly or not. However, there was no evidence this or any of the other skin tears we identified (five in total) had been reported and investigated. This showed insufficient action had been taken to identify and investigate possible allegations of abuse.

This failure to safeguard service users from abuse was in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people's safety had not always been identified, assessed and managed. We saw two people's beds were fitted with bedrails. Scrutiny of their care plans revealed there was no documented evidence to suggest why bed rails were in place for these individuals and that the benefits and risks of rails had been considered. There was no risk assessment detailing whether the combination of bed rail, mattress and bed was suitable. The manager told us they ordered the bed rails separately from the bed but was unable to provide us with any assurance that the safety aspects had been considered and that the bed rails were suitable for the bed and mattress. The manager told us in total eight rooms had bed rails but there were no risk assessments in place considering the combination of equipment used. This meant there was a risk that bed rails were not suitable increasing the risk of injury.

We found three radiators in the dining room were not covered and posed a risk to vulnerable people and a portable radiator in the upstairs lounge was very hot to the touch. The provider told us there were no risk assessments in place to consider how to safely control these risks to people. This demonstrated the manager was not taking action to protect people for incurring injury from hot surfaces.

This failure to identify , assess and managed risks to people's health, safety and welfare 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.

We completed a tour of the premises as part of our inspection. Four people told us they were cold during the inspection, the provider told us they had problems with the heating that morning. We looked in nine people's bedrooms, the linen room, the laundry, a shower room, lounge areas, a dining room. We saw door frames and architraves, skirting boards and doors were damaged with areas worn away. We saw a large area of partially repaired ceiling damage following a leaking roof. We were told by the provider that the roof still had places which let in water. Whilst some radiators had protective covers fitted some were in a poor state of repair and others not adequately fixed to the wall. In one room we found the cold tap was very stiff which would make it difficult to operate. Carpets were in some areas showed signs of poor fitting which may lead to the development of trip hazards. The vinyl floor covering in the laundry was in need of replacement due to large areas being cracked or with pieces missing.

We inspected service and maintenance records for the premises. We saw gas and electrical installation certificates were up-to-date. We observed an electrical contractor had noted during their inspection the premises had a high reliance on domestic extension cables and sockets. Our observations indicated the provider had done nothing to remedy this situation. In one lounge we observed a 13amp extension lead being used with an unfused block adaptor allowing seven appliances to draw electricity from one electrical socket. We brought our observations to the attention of the provider. A number of rooms also contained no locking mechanisms which restricted people's access to privacy.

This failure to maintain safe premises was in breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw fire-fighting equipment was available and emergency lighting was in place. During our inspection we found all fire escapes were kept clear of obstructions. We saw that upstairs windows all had opening restrictors in place to comply with the Health and Safety Executive guidance in relation to falls from windows. Legionella testing had been carried out and a certificate of water safety had been issued. Records of lift and hoist maintenance were examined and found to be correctly inspected by a competent person.

Inadequate

Is the service safe?

Recruitment procedures were in place which reflected good practice in the recruitment of staff. We found this policy to be followed with proof of identity, references and Disclosure and Barring Service (DBS) checks taking place before people were offered a job. This helped to keep people safe.

Inadequate

Is the service effective?

Our findings

People and their relatives spoke positively about the care provided and said staff knew how to provide a good level of care and support. For example, one person said, "I am very comfortable here, it's a nice place." One relative told us they were particularly impressed by the communication from the home in informing them about any changes in their family member's health.

People spoke positively about the food provided by the home and said it was plentiful. For example, one person said, "Food is nice and hot" and another person told us, "Staff know what I don't like and so they don't give me that." We saw the menu ran on a four week cycle and demonstrated a variety of food was offered. Although there was only one main meal choice most days, staff told us and people confirmed to us that the home would provide something else if people didn't like the food on offer. We saw some examples of good support offered to some people, for example a member of staff assisting one person was very patient and asked when they were ready for the next mouthful of food each time. We found people were offered a choice of drinks throughout the day to help keep them hydrated.

However, we found some aspects of the mealtime support could have been improved. The menu board was not used by staff and instead menus were written on an A4 piece of paper which was not clear and was put up just before the meal. We saw staff assisted two people with their meals which were pureed. People were not told what the meal was and although the different parts of the meal were presented separately we saw staff stirred up one person's meal mixing it all together before giving them a spoonful. This meant they would not have been able to distinguish the different taste of the parts of the meal. Two people were seen to have full cups of nutritional supplements but their care records recorded they had taken them. This meant that there was inaccurate information recorded about people's nutritional input which meant the effectiveness of their care and treatment could not be accurately assessed.

Although we saw a good level of care and support given at mealtimes downstairs, in the upstairs lounge we found people were not always offered appropriate support. We saw one person's care plan said they had a pureed meal, and needed to be reminded to chew and to stroke their cheek gently to encourage them to swallow as they had a tendency to hold food in their mouth. We saw this person was given food which was not pureed and they were not offered the level of support described in their care plan.When the person subsequently refused their food staff were quick to walk away and did not ask the person if they would like anything else instead of the meal. This person's care records showed they had a low weight and had lost almost two kilograms in weight over the previous two weeks. here was no information to show what action had been taken in response to this recent weight loss. This demonstrated a lack of appropriate care to this person.

In some cases we found action had been taken regarding weight loss, for example referral to the dietician. However there was inconsistency and a lack of clear procedure for when to take action. In one person's care plan, where they were being weighed weekly to closely monitor their weight there was no evidence of immediate action taken once weight loss was recorded. The person's weight had dropped almost 2kg in a week but actions had not been recorded. In another person's care file we saw they had lost 6kg in a month from 20 January to 15 February 2015. Their nutritional risk assessment had not been updated in February 2015. Their care plan had been updated on 17 February 2015 and said "no changes". There was no evidence this weight loss had been considered for referral. This showed that appropriate care was not being planned and delivered as prompt action was not always taken following weight loss.

We saw evidence people had access to health professionals which included QUEST matrons, dieticians, district nurses and tissue viability nurses. However, advice from health professionals had not always been incorporated into plans of care which presented a risk that effective care would not be provided. For example, one person's care plan, last updated in February 2015, made no reference to the advice stated in a dietician's letter received in January 2015. In another person's file, dietician's advice had also not been incorporated into the person's care plan.

This failure to plan and deliver appropriate care was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with said they had received training in the Mental Capacity Act 2005 (MCA) and specifically on the

Inadequate

Is the service effective?

Deprivation of Liberty Safeguards. Staff demonstrated a variable understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). One member of staff demonstrated a good understanding of the legal framework in which care must be delivered. Another member of staff we asked about DoLS said, "I've never heard of it." They did however say they would ensure they understood the issue at the earliest opportunity. Discussion with the manager also demonstrated an incomplete understanding of the Mental Capacity Act 2005 as it applied to DoLS.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. At the time of our inspection no authorised DoLS were in place nor had any applications been made by the managing authority. We looked in detail at the care arrangements for one person. The person was diagnosed with a dementia. The person had been subject to a mental capacity assessment and found they lacked the capacity to give informed consent to their care and treatment. A pressure mat was located at the side of the person's bed and a room movement sensor was also in use. In additional there was a lock on the front door restricting access out. The evidence we saw suggested staff may be exercising complete and effect control over the care and movement of the person for a significant period i.e. overnight. The person was also at the risk of losing autonomy because they were under continuous supervision during the day. It may be the case that the cumulative effects of continuous staff supervision and the use of mechanical devices constituted a deprivation of liberty. There was no evidence that restrictions on other people had been considered as part of an assessment as to whether DoLS applied. We saw another case where someone had tried to get out of the fire escape and was "always trying to find an exit to the building." Whether this constituted a deprivation of liberty had not been considered by the home. This meant there was a risk these people's rights were not protected as the correct legal framework had not been followed. The manager assured they would seek advice and guidance from the supervising authority with regard to potential deprivation of people's liberties.

We found capacity assessments were not always in place where we suspected people lacked capacity to make decisions in relation to their care and support. This meant there was a risk their rights were not protected in line with the requirements of the MCA. For example, in one person's advanced care plan, their families' wishes were recorded, but there was a lack of capacity assessment to determine whether this person could make these decisions for themselves. In this person's file, although a Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) form had not been agreed with a clinician the board in the office said this person was not to be resuscitated. The manager agreed to immediately amend this because this inaccurate information meant there was a risk that inappropriate care would be provided.

This failure to ensure valid consent was sought was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People reported that staff had the correct skills to care for them. We saw regular training was provided which included manual handling, safeguarding, first aid, health and safety, dementia and mental capacity act. There was evidence of competency assessments to check staff understanding of training topics. We saw induction training was in place and new staff had completed it. However, some staff training was out of date; for example, only 17 out of 31 staff were up-to-date with safeguarding training and only 9 out of 31 staff had done MCA training. Additional specialist training had been provided to some staff such as palliative care and syringe pump training with further specialist training booked in the near future. However, the manager was unable to demonstrate the training they had undertaken and we saw they were heavily involved in the delivery of care and review of care plans. This meant we were unable to confirm whether the manager had the necessary skills and knowledge to care for people effectively. Regular supervisions and appraisals took place which were a forum to offer support and identify training needs. Staff we spoke with said they felt supported and had sufficient opportunity to speak with managers and seniors.

Requires Improvement

Is the service caring?

Our findings

People and their relatives told us staff were kind and compassionate and treated them with dignity and respect. They said staff were always willing to help them and delivered care in a friendly way. Some of their comments included, "Staff are very nice and helpful," and, "They treat my mother with respect and dignity." Nobody raised any concerns with us about the attitude or behaviours of staff.

This was confirmed in some of the interactions we observed where staff were attentive to people's needs, spoke clearly and patiently and made people feel comfortable for example when transferring them using a hoist. We saw examples of staff being attentive to people's individual needs such as encouraging people to elevate their feet, assisting them to use pressure relieving aids and providing plenty of fluids such as tea and juice. We saw staff calling people by their preferred names.

However, we also noted some poor interactions between staff and people which showed staff were not always considerate of people's dignity and privacy. We noted glasses were repeatedly falling off one person's nose and it was clear they needed tightening. The person mentioned this to staff but no assistance was given. In another case, the nurse asked care workers to clean one person's eyes because residue had built up in them meaning they could not open them but three hours later no action had been taken. We found this person had to keep their eyes closed all morning and staff offered them little in the way of reassurance or company.

In the upstairs lounge one person kept saying throughout the morning, "I'm poorly" and "I've got a poorly eye," and, "I'm cold, it's freezing." We raised this with staff who said, "She always says that, she's okay really. She stops saying it in the afternoon." Staff got a thin blanket to put over their legs and asked them if they were all right but other than adjusting their blanket occasionally did nothing else to make them warmer or find out if they were unwell.

We also observed staff assisted one person to the toilet. The bathroom door was left open and people in the lounge could clearly hear what was being said which showed a lack of respect for this person's privacy. We also found a soiled incontinence pad had been left by staff in one person's sink whilst they were in the room, which showed a lack of respect towards that person.

Some interactions we observed at breakfast and lunchtime showed a lack of respect towards people. In one case, we saw staff broke off from assisting a person with food to attend to other matters and then another staff member returned to finish the assistance some five minutes later. We saw two people's meals were mixed up without their consent which meant they didn't get to taste the individual flavours.

This failure to ensure people were treated with dignity and respect was in 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.

Three care plans we looked at lacked evidence they had been agreed with the person or their family and it was difficult to determine whether people had been involved in a care plan review. In two files we looked at there was evidence that people's relatives had been involved in a recent care plan review, but it was not recorded whether the person had capacity to air their views. In these relative reviews, there was also a lack of comments and /or views recorded, the review document simply said what topics had been discussed with the family. This showed that mechanisms to record people's views in relation to the care and treatment were not sufficiently robust.

People told us staff understood them for example what they liked doing and their hobbies. We saw evidence of this in some of the interactions we observed for example where someone liked to sit and how they wanted their possessions arranged. We saw staff were aware of care plans and how to follow them indicating they had a knowledge of people such as taking extra care with a person who had experienced recent falls. In most cases care plans contained details of people's life histories and preferences although one persons plan was missing life history information.

Requires Improvement

Is the service responsive?

Our findings

Care files contained a range of assessments which helped staff deliver appropriate care. These were kept update by nurses and management staff. These included eating and drinking, continence, communication, personal care and behavioural. We saw evidence some people received care in line with their plans such as staff taking care to ensure people were using the correct pressure reliving equipment, and their choices regarding personal care and clothing were adhered to.

However, we found people's needs were not always fully assessed. We looked at a care records for a new person admitted to the home on 20 February 2015. There was no care plan documentation in place by 23 February for staff to follow and the pre-admission document did not contain sufficient information for staff to deliver appropriate care. For example, it did not mention the person was incontinent. It also indicated it had been completed by the home's administrator rather than care management. We established this person had complex needs and there were no assessments or care plans for staff to follow to ensure they received the care they needed safely and appropriately.

Some people had key assessments missing which demonstrated their needs had not been fully assessed. For example, one person had a specific medical condition that affected their vision. At lunchtime we found this person reported that they could not see their meal. Yet there was no care plan in place detailing how staff were to appropriately support them with this condition.

Some care plans were very basic and did not contain a thorough assessment of needs to allow the delivery of appropriate care. For example, one person's care plan said "check regularly" as the person did not know how to use call bell, however it did not specify how often. Another person had a history of pressure sores but conflicting information was recorded in their care file about the agreed treatment option for that person.

We observed one person throughout the inspection; they were sat in a chair withdrawn and/or asleep. The manager told us they spent most of the time during the day and night there and never slept in their room. We looked at the person's care records, the sleeping care plan written in November 2014 stated that adjustments may be needed to their room to meet their emotional needs, but no action had been taken to provide them with a more suitable/ re-arranged room. We also found there had been incidents of violence and aggression but their behavioural care plan did not demonstrate that a full assessment of their needs had been carried out. Their care plan stated, "Person is not in touch with reality" and "Person can be deluded". There was no evidence through thorough care planning that investigated causes and solutions to this person's behaviour had been investigated and action taken, for example gaining advice from specialists. The provider told us, "Can't get anywhere with person." We concluded more could have been done to meet this person's individual needs.

Appropriate care was not always delivered. During the morning we observed the nurse on duty asked care staff to bath one person's eyes as residue had built up in them meaning they could not open them. Three hours later the person's eyes were still shut and had not been cleaned by staff. Throughout the morning we observed there was little interaction from staff with this person to comfort them. This showed that their individual needs had not been met.

We found charts recording people's food and fluid intake and pressure relief were inconsistently completed. Although we observed staff giving people food and drink, this was not always recorded on the charts which meant that an accurate assessment of the person's food and fluid could not be obtained. In one person's records we were looking for evidence that they were offered pressure relief on a 4 hourly basis as specified in their care plan, but charts were missing for five days in February 2015.

Where incidents had occurred care plans and risk assessments were not always responsive to changes in people's needs. For example, one person had two falls since admission however their falls risk assessment showed they were at low risk of falls. The person had bed rails in situ to prevent them falling out of bed. However, since these had been installed, falls had continued to occur, but no re-assessment of their needs had been completed.

This failure to ensure the delivery of appropriate care was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

The deputy manager told us the home did not have a structured plan of activities or dedicated staff to provide them. During this inspection we did not observe any activities taking place and staff were very busy attending to people's care needs. Individual activity records were in place which showed the activities people were involved in. They provided evidence that some activities were periodically provided such as Bingo and Karaoke. However, some of these were blank and others recorded very few activities. We concluded that a better range of activities could have been provided to people.

People and their relatives we spoke with said they had no cause to complain and the feedback we received indicated a high level of satisfaction with the service. People said where minor issues had arisen they had been sorted out by staff. One person said only had minor problems with the home but the staff had sorted them out effectively. We looked at the complaints register which showed no complaints had been received since our last inspection on 3 September 2014. During the same period 14 compliments had been received which had been logged so that the service knew where it was exceeding people's expectations. However, we did find that complaints and concerns received via third parties such as one notified to the service via the local authority safeguarding unit had not been logged as a complaint. This meant there was no plan in place to address these concerns and prevent similar issues being raised in the future. The meant there was a risk that full learning and improvement did not always take place from complaints.

Inadequate

Is the service well-led?

Our findings

People told us the provider and deputy manager were effective, listened to them and people indicated there was a nice atmosphere within the home. For example one person told us, "I can speak with the owner if I need to, there is a nice atmosphere."

We found safeguarding incidents were not always identified and appropriate action was not always taken by the home. This meant that allegations of abuse had not always been notified to the Commission. We also found one pressure sore which was graded as grade 3 in October 2014 but was not reported to us at the time; the deputy manager told us this was due to, "Human error." We warned the provider about the need to ensure all required notifications are reported to the Commission promptly.

Two inspectors spoke together with a registered nurse. The nurse described the chain of command and management at the home as being haphazard. They said that when issues such as the lack of slide sheets and personal protective equipment were brought to the attention of the manager, improvements had not been made. Staff told us the management structure was unclear within the home in particular the role of clinical lead. Staff were unable to describe the function of the role or its responsibility. As staff were unclear about the roles of senior staff this meant there was a risk that care and welfare issues were not escalated to the appropriate person.

The provider told us there was no supernumerary time given to the clinical lead to conduct clinical monitoring but it was something they planned to implement subject to the recruitment of further nursing staff. We found this meant there was a lack of nursing oversight into the home, with neither of the supernumerary management staff being qualified nurses. The provider told us they regularly completed pre-admission assessments for nursing residents and we saw they also completed some care plan reviews, despite no longer being a registered nurse. One pre-admission assessment indicated it had been completed by the home administrator. Audits such as medication and care plans had also been carried out by provider with a lack of nursing input. This presented a risk that the appropriate level of expertise was not being utilised in making decisions in relation to people's care and treatment.

This lack of nursing oversight meant there was a risk clinical decision making was not consistent. The manager told us that there had been inconsistencies in the way nursing staff had categorised pressure ulcers and we saw evidence of this, namely inconsistent descriptions and lack of grading of one person's pressure ulcer and associated treatment. It was also unclear at what point referrals to specialists such as tissue viability nurses, would be made. We found that procedures such as referral for weight loss lacked clarity. The deputy manager told us that if weight loss of 10% or more was found they referred to the dietician. The deputy manager also told us smaller amounts of weight loss would be referred to the QUEST matron and/or fortification of food would commence but there was no clearly defined criteria for this. This meant there was a risk of inconsistent care and treatment.

We saw evidence that some audits and checks were undertaken however we concluded that the quality assurance system was not adequate given we identified eight breaches of regulations. The problems we found with care quality, medication, consent and capacity, dignity and respect, safeguarding should have been identified and rectified through a robust programme of quality assurance. Some "provider/ manager" checks were undertaken but they did not contain sufficient details to provide assurance that thorough quality checks had taken place. For example, one audit said "checked weights" and another said "Checked care plans, some issues, addressed with nurse". The audit did not provide detailed findings, outline the "issues" found or produce an action plan with assigned responsibilities and timeframes so that improvements could be monitored.

We found there were insufficient staffing levels in the home. The manager told us that although individual dependencies were calculated, this information was not collated to inform an overall dependency tool. They confirmed there was no audit to look at staffing levels in the home.

This meant there was a risk staffing levels would not be responsive to people's changing needs.

Although cleaning schedules were in place, the manager told us no infection control audits were undertaken and we found some issues such as odours in chairs which could have been identified and rectified by a robust system of infection control monitoring in line with Department of Health guidance.

Inadequate

Is the service well-led?

Appropriate action was not always taken following incidents. For example, we looked at three incidents involving aggression between the same two people. There was no clear action recorded other than "separated" to evidence action taken to prevent a re-occurrence. We saw another person had "tripped over object as finished climbing stairs" but there was no action recorded as to how this would be prevented from happening again in the future. We were advised by the nurse on duty that five people in the home had skin tears and the records we looked at confirmed this was the case. The nurse on duty thought one of the tears may have been caused by incorrect handling, however there was no evidence these tears had been reported as incidents and investigated.

The manager told us there was no service improvement plan to drive improvements within the home. We found the home had not always been responsive to recommendations made by both the Commission and the local Clinical Commissioning Group. For example, the Clinical Commissioning Group had conducted an audit in 2014 but there was no evidence that action had been taken to address the action plan. We found some recommendations were still outstanding on our inspection, such as deficiencies in topical medication records, a lack of dependency tool for staffing, changing people's medication within authorisation from the prescriber and lack of record of the provider's training. In our September 2014 inspection report, we also reported a number of concerns about the premise and timeliness of the medication round, however we found these issues still persisted during the February 2015 inspection. This showed a lack of commitment to continuous improvement as part of a robust programme of quality assurance.

The provider told us satisfaction surveys were sent out annually. We saw a form which indicated surveys had been sent out in September 2014, but there were only two responses recorded. One response indicated that the person thought there were not enough staff, but there was no evidence of any action taken as a result of this feedback. As only two responses were received, we concluded more could have been done to engage with people and seek their feedback in relation to their perceptions of the service.

This failure to assess and monitor the quality of the service 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.

We saw periodic staff meetings took place and staff were offered support during supervision and appraisal. These were an opportunity for care quality issues to be discussed with staff to help aid improvement.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person had not protected people against the risks associated with the unsafe use and management of medicines because the provider did not have appropriate arrangements for obtaining, recording, handling and safe administration of medicines. The registered person did not ensure that service users and others have access to premises that are protected against the risks associated with unsafe or unsuitable premises.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The registered person did not make suitable arrangements to ensure that the dignity and privacy of service users was maintained as they were not always treated with consideration or respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Care and treatment of service users was not always provided with the consent of the registered person. This is because the registered person did not act in accordance with the 2005 Mental Capacity Act (MCA)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	The registered person had not taken appropriate steps to ensure that at all times there were sufficient quantities of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity
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 The registered person did not make suitable arrangements to ensure that service users were safeguarded against the risk of abuse as it was not taking reasonable steps to identify and respond to allegations of abuse.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person had not taken proper steps to ensure that each service user was protected against the risk of receiving care and treatment that is inappropriate or unsafe because a thorough assessment of people's needs was not carried out and planning and delivery of care did not meet service users individual needs or ensure their safety.

The enforcement action we took:
Warning Notice issued requesting compliance by 7 April 2015.

Regulated activity	Regulation
	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person had not protected service users against the risks of inappropriate or unsafe care and treatment as effective systems to regularly assess and monitor the quality of the service provision were not in place. Risks to service users health safety and welfare were not identified, assess and managed. Mechanisms were not established for ensuring that decisions in relation to the provision of care and treatment were made at the appropriate level.

The enforcement action we took:
Warning Notice issued requesting compliance by 20 April 2015.