Minster Care Management Limited

Attlee Court

Inspection report

Attlee Street
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Date of inspection visit:
30 November 2015
02 December 2015
14 December 2015

Date of publication:
03 February 2016

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**

Summary of findings

Overall summary

We carried out this inspection on 30 November, 02 December and 14 December 2015. The inspection was unannounced.

Attlee Court is a nursing home currently providing care for up to a maximum of 68 people. The service has two floors and provides care and support for people with nursing and residential needs including people who are living with dementia. On the day of our visit there were 26 people living at the home.

The service did not have had a registered manager in post at the time of our inspection, although there was a manager who had been in post since August 2015 and had applied for registration. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The new manager had begun to make some improvements to the service and feedback from people, staff and relatives was positive. However, we found renovations were being carried out at the time of the inspection and there were no care strategies or risk assessments in place to ensure people's safety and well-being in relation to the work being done. The management of the refurbishment work was poor and lacked organisation or consideration for associated hazards, such as fire safety.

The premises were in the process of redecoration in response to the previous inspection findings; however, improvements were not complete at the time of this inspection and the environment was not welcoming or homely, particularly for those people living with dementia.

The management of risk was very poor, in relation to the premises and to individual people's care needs. We discussed this at length with the manager during the first two days of the inspection. However, little action had been taken by the time we arrived on day three and we found continued concerns.

Staff practised appropriate infection control measures, such as cleaning and the use of personal protective equipment. However, there were some aspects of infection control and prevention that were not adequately monitored and standards of cleanliness were not always maintained.

Staffing levels were adequate and people did not have to wait for staff assistance. Staff were confident in how to recognise and report suspected abuse, although policies and procedures did not clearly illustrate how staff should report concerns.

Staff recruitment and vetting was appropriately carried out, but where agency staff were used, suitability checks were not robust. Staff induction was not fully evidenced for new staff.

Medicines were managed appropriately.

The menus had been revised since the new manager came into post and people reported improvements in the quality of the meals.

Information in care plans was easy to locate, however, there was conflicting information in some of the records we looked at. Individual risks assessments for people were not always clearly stated, such as for moving and handling.

Staff were kind and caring, although the quality of staff interaction with people varied. There was little respect for this being people's home whilst the building works were ongoing.

There were too few activities for people to be meaningfully engaged and as a result, some people were frequently bored or passive.

There was little management oversight in relation to the premises and to individual people's care needs. Some systems were in place to check the quality of the provision but these were not thoroughly implemented and did not identify concerns we found at this inspection.

The overall rating for this service is 'Inadequate' due to the multiple and continued breaches we found. We noted the provider had made some improvements to the service and was still working towards their action plan at the time of the inspection, but progress was slow.

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.

Building works were not managed safely and there were no risk assessments in place to ensure people's safety during renovations.

Thorough checks were not always made before agency staff worked.

Individual risk assessments were unclear for staff to be able to provide safe care.

Some areas of the home were not adequately cleaned.

Is the service effective?

Inadequate

The service was not effective.

People's health care needs were not always managed effectively.

Although some improvements had been made, the premises were not conducive to caring for people living with dementia.

Where people lacked capacity to consent to care and treatment, there was little evidence to show that best interests processes had been followed in accordance with the Mental Capacity Act 2005.

Is the service caring?

Inadequate

The service was not caring.

There were inconsistencies in the way staff interacted with people; some staff were kind and patient and at other times less so.

There was no respect for Attlee Court being people's home whilst the building works were being carried out.

People's well-being was not promoted.

Is the service responsive?

Inadequate

The service was not responsive

There was a lack of person centred care.

People were bored and there were limited opportunities for them to engage in meaningful activities.

Complaints and concerns were recorded appropriately.

Is the service well-led?

Inadequate

The service was not well led.

Some processes were in place for auditing the quality of service provision but these were not thorough or effective and there was no management oversight of the service or risks to people.

Priorities for improvement since the last inspection were poorly identified and the implementation of the provider's action plan was not robust.

Staff were confident in the new manager's abilities and felt supported in their work.

Attlee Court

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.

We had previously inspected this service in June 2015 and found there were multiple breaches in regulations. We placed the service in special measures and began enforcement action. The provider sent an action plan detailing the improvements and we agreed we would re-inspect to check what improvements had been made.

This inspection took place on 30 November, 02 December and 14 December 2015 and was unannounced. The inspection team consisted of three adult social care inspectors and a specialist professional advisor in dementia care.

Before the inspection we reviewed the information we held about the service. This included looking at any concerns we had received about the service and any statutory notifications we had received from the service. We had received some concerns from members of the public and from anonymous sources that people's needs were not being met in a number of ways.

We used different methods to help us understand the experiences of people who lived in the home. We spoke with 10 people who were living in the home and four visiting relatives. We also spoke with four members of staff including the manager and the cook.

We looked in detail at 10 people's care records and observed care in the communal areas of the home. We looked at two staff recruitment files and staff training records. We also looked at records relating to the management of the service including policies and procedures. We looked round the building and saw people's bedrooms, bathrooms and communal areas.

Inadequate

Is the service safe?

Our findings

People told us they felt safe living in the home. One person said: "I'm safe alright." Another person said: "That's the thing; I don't feel frightened of anything in this place." Relatives we spoke with said they had no concerns about the safety of their family members.

Building work was taking place to refurbish areas of the home when we arrived to inspect on day one. The provider had sent an action plan following the last inspection, which stated their intention to improve the general environment throughout the whole home, although initially concentrating on the dementia unit. We saw one unit upstairs, previously the dementia nursing unit, was closed and was in the process of major refurbishment. The ceiling in the dining room on the first floor had extensive water damage caused by a recent leak. The manager said this was cosmetic damage and not structural, although was unable to evidence how this had been checked or by whom. There was evidence the environment was being improved visually, with walls repainted and decoration taking place. However, we were not informed as to the extent of the works being done and we had concerns about the safety of how this was being implemented.

The manager was unable to provide us with a schedule of works or timescales and we saw there were contractors coming in and out of the building unsupervised throughout the inspection. When we looked round the building there appeared to be no order to the works being done. For example, bathroom work was being carried out on both floors, some doors had been removed and flooring in some areas was being replaced. Areas were not cordoned off and people who lived in the home had to move through or were able to access areas that were being refurbished. The manager told us they agreed the work lacked structure and made arrangements to liaise with the company's estates team for details of a framework for completion. We returned to inspect on day three and found there were continued concerns with the work being done. For example, we saw one corridor was inaccessible for 15 minutes whilst floor covering was being installed. There were two people who had chosen to remain in their rooms during the process but their safety had not been considered. The process entailed adhesive being applied to the floor and the floor being 'screeded', which caused an abundance of dust in the area. We saw staff accompany a person in a wheelchair through this dusty area. We also saw offcuts of floor covering stacked against a person's bedroom door, a two heavy wheeled industrial trolley, a heated sealing device and a hammer, all left in areas where people could access.

We asked the regional manager and the manager to accompany us around the building so that we could discuss the hazards we had seen. Both managers were unable to assure us that any of the risks to people had been assessed to ensure their safety. There had been no revised fire evacuation plan whilst the work was taking place. The manager was unable to tell us whether the dust was harmful to people and although the contractor confirmed it was safe, there was no risk assessment in place to verify this. Both managers could offer no assurance of any oversight of the work being done. There were no clear indications of how many contractors were in the building and the manager gave us an estimate of how many they thought there were. When we checked the contractors' signing in/out book we saw this had not been completed. For example, we had seen at least six workmen, yet there were only four signatures.

We asked to see risk assessments of the building work and to show how arrangements would be made in the event of an emergency, such as a fire. The manager was unable to produce risk assessments and wrote some for us during the first day of the inspection. However, we found these were not effective as no staff people or visitors had been involved or made aware of the content. A lack of risk assessments for refurbishment work had been highlighted at the last inspection. When we returned for day three of the inspection, the manager and regional manager could not demonstrate that staff or visitors had been appraised of the risks or of any additional risks, such as dust. Staff we spoke with told us they would use their best judgement of any hazards to ensure people's safety but they were not informed by managers of specific risks to themselves or others in the environment.

Since the last inspection there had been improvements to the personal emergency evacuation plans (PEEPs) for people and these were filed in care plans and in the entrance. However, although these stated people's individual mobility preferences, it was not clear how people would be helped to mobilise in the event of an emergency. We saw details within the PEEPs were not always accurate. For example, one person's plan stated they walked independently, but we saw this person needed a wheelchair to move around. The PEEPs had not been updated to reflect that some people had moved rooms due to the refurbishment. The manager was not aware whereabouts people were residing in the building; for example, they told us there was only one person in a room off one of the corridors, yet we found there were four. Other staff we spoke with were unable to accurately say who was located in which room following the changes. This would mean that in the event of an emergency evacuation, people may not be easily located for staff to assist them to safety.

We contacted the fire officer during the first day of the inspection. The fire officer visited and asked the home to make immediate improvements in relation to fire doors.

The last inspection had highlighted the need to make bathroom areas safe for people. We saw where there were bathrooms on the ground floor with uneven floor surfaces these were earmarked for renovation, although work had not yet commenced and the bathrooms were still in use. On the first floor there was no working bathroom available for people to use as both bathrooms had been closed and were in the process of being renovated during days one and two of the inspection. We asked staff what facilities were available to people using the first floor. Staff told us people were escorted to the unit that was under renovation, to use the shower room there. We went to see this area and found we had to walk through building debris, such as wood, sawdust and tools. The shower room we were told was in use was not clean, there was builder's dust and the shower area and sink were visibly dirty. The room temperature at this side of the building was chilly. Staff told us they made checks of the area before people were assisted to use it and only used the shower room if it was safe to do so. We returned to inspect on 14 December 2015 and found the bathrooms on the first floor dementia care unit had been made fit for use. People told us they had enjoyed using the new bath and we saw records that illustrated all people had used or been offered the use of the bathroom facilities.

Staff we spoke with were not aware of any risk assessments in place during the building work on the first two days of our inspection. Staff told us they did not know until the work commenced each day, how many builders would be in the units and what they would be doing. We spoke with the contractors who told us they were 'just here to do what was on the job sheet'. They told us they were not aware of any risk assessments, nor had any explanations been given to them about working in people's home. By the time we returned on 14 December 2015, we found no change to this; staff told us they had not been shown any risk assessments and were not aware of any hazards, such as dust created by the work. They did not know how to ensure people were safe from the hazards.

The above examples illustrate the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 12(2)(d) because the provider did not ensure the safety of the premises.

Staffing levels were adequate to meet people's needs. The manager told us that due to the closure of the dementia nursing unit, the numbers of people living in the home had reduced, but that staffing levels had not been reduced as a result. Staff we spoke with told us they thought there were 'enough staff now' and said this was an area that had improved. We found people did not have to wait for staff to assist them and we saw there were ancillary staff on duty. We looked at staff rotas which confirmed staffing levels were appropriate.

The manager told us and we saw that agency staff were still used to cover shortfalls, particularly with qualified nurses. We saw there was an agency nurse on duty on the second day of the inspection, who told us nobody had checked her identification but they may have presumed who they were because of their uniform. The manager was not aware that any identity or competency checks had been made for this person before allowing them to work in the home. The manager said that profiles are usually obtained for agency staff, although this had not been done for the nurse on duty.

Staff we spoke with said they were aware of how to recognise signs of possible abuse and the procedure to follow to report any concerns about people or about staff practise. Staff told us they were confident to refer concerns to the local authority should they remain concerned after reporting to managers. We saw the safeguarding policy and procedure did not make it clear to staff who they could report their concerns to in order to safeguard people. The safeguarding and whistleblowing procedures had not been updated since February 2014.

We were aware that outcomes of the local authority safeguarding case conferences identified that allegations of abuse prior to the last inspection had been substantiated. The manager told us that lessons had been learned from these incidents and as a result a new induction programme had been planned to ensure staff demonstrated competence before working in the home.

Accidents and incidents were recorded and analysed to identify any patterns or trends. The manager told us they reviewed accident and incident forms and we saw that where incidents required referrals to the local authority safeguarding team, this was done in a timely way. Some accidents and incidents referred to items of equipment being involved, such as where one person cut their leg whilst using a wheelchair. We asked the manager what had been done to investigate the cause and avoid a repetition of such an injury. The manager was unable to confirm whether equipment had been checked for safety if this was referred to in an accident or incident report.

Some care plans we looked at contained detailed information, but others were not always accurate or updated in a timely way to ensure people's safety, and contained conflicting information. For example, one person's risk assessment stated they were 'non weight bearing' yet the equipment they required was a 'stand-aid'. Another person's records stated they were both 'continent' and 'incontinent of urine'. It was not clear in people's moving and handling risk assessments the equipment they required or how staff should support the person. For example, one person's record said 'two staff to assist' and 'would need to use the hoist' but there was no instruction for how this should be done to ensure the person's safety.

The above examples illustrate the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 12(2)(a)(b) because risks were not fully assessed and mitigated.

We looked at the systems in place for the receipt, storage and administration of medicines. We saw medicines were stored securely and at an appropriate temperature. We found medicines were only administered by staff that had been appropriately trained. We observed people being given their medicine during our visit and whilst we did not find any breaches in regulations, we noted that practise was not always robust. For example, we saw the nurse assisted a person with their medication whilst the medicines trolley remained open. One person was administered the correct medicine, but the staff administering this took it from the wrong day on the blister pack. Recording of topical creams was not always done accurately. There were protocols in place for giving medicine as required (PRN) and we observed people were asked whether they needed any pain relief.

We saw the Medication Administration Record (MAR) charts. They included details of the medicine, what it was for, the dosage and how the medicine should be taken. We checked a sample of the medicines available against the amounts recorded as received and administered and found these to be correct. The nurse told us they dispensed medications for two people upstairs and then completed the recording downstairs, which may increase the likelihood of an error being made.

We saw the environment was cleaner than at the previous inspection, largely because areas had been repainted and some furniture that had retained dirt and offensive odours had been disposed of. Tablecloths, cutlery, crockery and food trolleys were visibly clean. Areas under renovation posed an infection control hazard, particularly where there was exposed plaster, such as in bathrooms and toilets. Some of these areas that were in use were visibly clean and we saw evidence that cleaning staff were busy throughout the day. Cleaning staff told us the procedures they followed to minimise the spread of infection, such as the disposal of mop heads after use. We saw staff used personal protective equipment (PPE) such as gloves and aprons. However, some areas within the home were not clean. For example, kitchenette areas contained dirty cupboards and sweeping brushes held food debris in the bristles. This had been an issue at the previous inspection.

This was a breach of regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider did not take adequate steps to address and prevent the risk of infection.

Inadequate

Is the service effective?

Our findings

People we spoke with said staff were able to care for them effectively. One person said: "They've got me sussed; they know what I'm like." Another person said: "Yes, they know what they're doing. I've no complaints at all." One relative we spoke with spoke highly of staff's skills and knowledge and told us staff dealt with issues 'promptly and skilfully'.

Care staff we spoke with said there were opportunities to complete mandatory training and they felt supported in their role. We saw a schedule of planned training for all staff to complete and evidence some staff had attended recent training in: safe handling of medicines; safeguarding; privacy and dignity; infection prevention and control; dementia; epilepsy; mental capacity and DoLS; care plan training and fire warden training. Staff we spoke with said the new manager encouraged them to complete training where possible. The nurse we spoke with said there were fewer opportunities for them to complete their continued professional development, as is required of the registered nurse.

Staff told us they had supervision meetings with their line manager. Staff said these meetings gave them chance to discuss their development and identify areas to improve, such as training. The manager showed us a schedule of supervision meetings and we saw these had been held with staff since the manager came into post.

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 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. The manager showed us evidence of where Deprivation of Liberty Safeguards had been authorised or applied for with regard to people living in the home. There were three authorised DoLS and 17 applications in place for people living in the home.

We asked staff about their understanding of mental capacity and Deprivation of Liberty Safeguards. Staff had some understanding of mental capacity and how decisions might be made in someone's best interest if they lacked capacity. Some staff told us they tried to ensure people made their own daily decisions where possible, such as what to wear and what to have for their meals. Staff told us people did not usually go out of the home without someone with them, such as a family member of member of staff, but they were not all clear about who had a DoLS in place.

We looked at ten people's care plans. We saw some mental capacity assessments had been carried out but in some files these were not consistently in place, even where staff said the person lacked capacity to make decisions. There was no evidence people's care files had been shared with them, some people's consent forms were blank and where it was deemed people lacked capacity to make a particular decision, there was no evidence of any best interest discussions having taken place.

We saw many staff offered people choices within the routine of the day, such as what they might like to drink and where they wanted to sit. Staff took care to enable people to make their choices in their own time.

People we spoke with told us they made their own decisions. One person said: "It's up to me what I do, I please myself.". Another person said: "I know my own mind and I have my say.". However, we saw some staff made choices on people's behalf, such as to wear a blue plastic clothes protector at lunchtime. This had been an issue at the previous inspection.

Although there had been some improvements since the last inspection, there was still a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they chose what to have for lunch and we heard staff took time to ask people's preferences. One person showed us where the menus were displayed and we saw there were choices available on the menu. We saw breakfast and lunch time meals were served without consulting with people, so for example, all people were served with soup. Where one person did not want this, they threw it on the floor. We saw where people were assisted with their meals, staff did not always use appropriate pace. For example, one person was coughing, yet staff continued to offer them food.

We spoke with people about the food. People told us they enjoyed their meals. One person said they thought the meals had improved. "I can't grumble about the food here, we are never hungry and there's always something nice." Another person said: "The food is brilliant."

We spoke with the chef who told us they liaised with staff to meet people's dietary needs and staff compiled a list of people's particular requirements. We saw menus contained varied and nutritional contents. In the kitchenette on the dementia unit we saw a list of special diets. However, we saw the list contained names of people, who were not resident; staff confirmed this was out of date. Staff told us they knew people well on the dementia care unit and because there were so few people resident, they did not need to refer to a list to know what people's dietary needs were.

The manager told us how they had made improvements to the menus and consulted with people about the food and what they might like to see on the menus. People had expressed their opinions in a residents meeting and we saw minutes of the meeting. The chef said people's preferences were important when deciding what food to prepare and they tried to incorporate these as much as possible.

Staff we spoke with told us they had no concerns about people's weight loss and they were monitoring people's weight with the input from the dietician. We saw care records did not accurately record people's weight or body mass index (BMI). For example, one person was recorded as having fluctuating weight and BMI yet there was no evidence of what was being done about this.

We noted from people's care plans that one person had diabetes and the care plan said they were to avoid too much sugary food. The care plan also said the person's blood sugar level was to be measured regularly, although did not say how often this should be tested. We saw the last recorded blood sugar level was May 2015. Staff said there was no monitoring of the person's dietary intake. We discussed this with the manager who agreed to look into this to make sure the person's health needs were being managed appropriately.

The above examples illustrate the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 12(2)(b) because risks were not mitigated.

We saw the local authority food safety inspection had resulted in the service being awarded a five star rating

which was displayed.

We saw from people's records that staff sought medical advice and where a GP was needed, they were involved in people's care. Relatives told us the staff always consulted their family member's GP and if their family member needed to go to hospital this was arranged.

Inadequate

Is the service caring?

Our findings

People and their relatives told us staff were caring. One relative said, "The staff give 100 per cent." One person said, "They're kind to us here, nothing is too much trouble."

People were appropriately presented in personal appearance. Some ladies chose to wear jewellery and carry handbags and gentlemen were clean shaven and smartly dressed. We saw staff interaction with people varied. Some staff were actively supportive of people's needs and took time to interact with people and engage in conversation with them. On the dementia care unit we saw examples of kind and positive interaction and staff used appropriate pace and tone of voice, eye contact and facial expressions to communicate with people.

We saw some people enjoyed conversation with staff when staff took time to talk to people about what mattered, such as who might be coming to see them. One person said staff did not always have the time to talk with them and said, "Well they're always so busy."

We found on our arrival there was a person in a wheelchair, outside the building in the rain. The person was not accompanied by staff and was waiting for the ambulance driver to assist them. We discussed with staff whether people were accompanied on appointments and were told they usually were, but on this occasion the person went unaccompanied. Staff told us they were concerned the person may not be able to retain the information told them by the hospital as the person's memory was not always reliable. Staff said the person was usually accompanied by staff to attend hospital appointments but said on this day the nurse in charge had made the decision for the person to go without staff support. Staff were not clear about the reason for this and acknowledged this experience might be daunting for a person. We could see no evidence the person had been consulted or reassured about the process.

We saw occasions on the residential and nursing unit when staff did not interact well with people. Some staff appeared hurried and spoke with people in an impatient manner. At times staff did not communicate at all with people and walked past them without any acknowledgement. We saw on one occasion a person was anxious and spent time looking for their handbag; staff did not appear aware of the person's concerns and do not attempt to help them.

On several occasions the noise levels caused by the renovations resulted in people becoming anxious and upset. We saw people 'jumped' when loud banging noises occurred and staff did not attempt to reassure them. On one occasion we found the noise level intolerable on the dementia care unit and we asked the contractors to stop as we saw this caused significant distress to two people in particular. One person sat with their hands over their ears and their eyes closed and the other person was shaking and had a fearful expression. We discussed this with staff who said the people had been given the choice to move and they had chosen not to. However, we were concerned that staff did not intervene to reassure people or minimise the noise and asked that the work stopped until the people were feeling more secure.

We found there had been little consideration or respect for the fact that this was people's home; contractors

moved freely throughout to carry out the renovations and there was no explanation or consultation with people when they walked through living rooms or communal areas.

The above examples illustrate the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 10 because people were not treated with dignity and respect.

Inadequate

Is the service responsive?

Our findings

Some people told us staff knew their needs and we found through speaking with staff they knew people's personalities and preferences.

We found a calmer atmosphere on the dementia care unit than there had been on the previous inspection due to the closure of one unit and the reduction in the numbers of people. The manager told us that two people were awaiting moves to other homes but when we looked at their care records there was no information about this. We asked the senior staff on the unit about this but they did not know when the people may be moving or whether there were any plans for their transition to a new home. We saw a diary entry which highlighted when another person left the home and this stated '[person] going to new home today, [person] doesn't know they are going'. Staff were unable to tell us how transitions were managed.

We spoke with one person who told us they had requested a move to another home. The manager was aware of this and told us they were helping the person make arrangements to move. However, there was no evidence in the person's care record about this and the person told us they 'didn't know what was happening about it'.

We found there was a clear lack of person centred care and the home felt more like a workplace for staff and contractors than people's home. The dementia care unit was particularly uninviting and although the dining room provided places for people to sit, there was no homely feel and the environmental temperature was too low at times. We saw the provider had begun to change the décor and the manager told us this had been based on research into dementia friendly environments. We were told there were fixtures and fittings on order, such as improved signage to help people orientate round the units and coloured door coverings to help people identify their own rooms. However, these were not in place at the time of the inspection.

People told us they had not been consulted with regard to the decor in the home. One person said, "They just went and did it" but added "it's better though - better than it was." One relative told us they had liked the wall paper that had been previously on, but had not been kept informed of the decoration plans.

We asked staff about bathing facilities for people as both bathrooms on the dementia care unit were out of use and we had been concerned at our observations of the shower room that staff told us people were assisted to use. Staff confirmed people were accompanied to the shower room and we asked to see records of when people may have been assisted to shower as there was no information in people's care plans. Staff showed us a 'bath list' for November/December 2015 which they said was for the shower room. We saw only five people had used the shower during the week preceding the inspection; one person had not been showered for 16 days and another for 13 days. There was no evidence to show people had been offered a choice in this. Staff said people could be assisted to use the bathroom downstairs, but confirmed this had not been offered to people.

We saw people did not have sufficient opportunities to engage in meaningful activity and as a result they

were bored. One person said, "There's nowt happening really" and another said, "I don't mind really, I'm happy watching what goes on." One person told us they could mobilise to go outside in the garden area to smoke and they enjoyed this.

We saw the activities coordinator spent time in the dementia care unit with a small group of people playing games such as music reminiscence and a balloon game. However, other people, some of whom who were less able to communicate verbally did not join in and spent time passively sitting with little to do and limited interaction from staff for a large proportion of the day.

The manager told us the provider had recently appointed a dementia care coordinator. We spoke with this member of staff who told us they were spending time completing their induction and getting to know people gradually by being with them and reading their care plans. We saw from the care plans we looked at there was limited information about people's social histories for staff to be able to establish social opportunities in a meaningful way.

Lounge areas downstairs were frequently unattended by staff and people sat in chairs, or slept.
We saw the television played downstairs but no one watched this. During the afternoon on the first day of the inspection we saw a sports activity took place with exercises in the lounge, offered by an external organisation. Staff and people were not aware in advance this was going to be happening as they thought it had been cancelled, but people who joined in clearly enjoyed this session.

We heard one person ask if they could 'go to the bookies' and staff told them that as it was raining they would not be able to go but promised 'maybe tomorrow'. The person told us they liked to go out with staff and place a bet and they were disappointed they were unable to go. We found when we returned for a second day, the person had been out and they had enjoyed this and won their bet. The person said they would like 'to be able to go whenever they liked'.

The above examples illustrate the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 9(1) because people's care was not person-centred and in keeping with their needs and preferences.

We observed a staff handover between shifts and saw this was conducted thoroughly and communication was detailed for the staff coming on duty to be able to understand people's needs.

Complaints and concerns were appropriately recorded and responded to. The manager showed us letters of acknowledgment to people who had raised complaints and we saw the complaints procedure was available to people. People we spoke with and their relatives told us they would speak with the manager and raise any concerns directly with them or with staff.

Inadequate

Is the service well-led?

Our findings

People and relatives told us they thought the home was managed well, they knew who the manager was and felt they were approachable. Staff we spoke with said they felt the new manager was beginning to make a difference to the quality of care and helped out with the routine, such as at mealtimes. They said things were 'much better than before'. Some staff told us they felt frustrated that the company had been slow to make improvements in the home and in particular, the dementia care environment.

Staff told us they felt supported by the new manager in their daily work and we saw evidence staff meetings had taken place regularly.

The manager said there was no deputy manager in place and it had not been possible to fill this vacancy. They told us they received support from the area manager and the provider and they had read the previous inspection report prior to being appointed. We discussed the provider's action plan and progress towards this following the previous inspection. Although the action plan had stated the environment would be improved, we were not made aware of the extent of the refurbishment being carried out and the manager had not sent a notification about this.

We spoke with the manager about their priorities for the running of the home. They told us their main priority was minimising the disruption to people due to the building work and supporting staff in this. However, we saw little evidence of this and the manager agreed there was a lack of structure to the work. The manager told us they did not have much influence in the building work that was ongoing and as such, were not aware of the schedule of works, its planned programme or the completion date. The manager made contact with the estates manager when we requested a timescale for completion and a plan of work. The manager was unable to explain that any arrangements had been made to support people's needs throughout the disruption and there was no strategy in place. For example, there had been no plans to invite people to one area of the home whilst work in another area was being carried out.

In spite of discussions about safety with the manager on days one and two of the inspection, when we returned for day three we found there little action had been taken to mitigate risks to people and there continued to be no safe oversight of buildings work.

The manager told us they carried out a daily walk around of the home. However, we saw these checks were not recorded daily and the manager confirmed they had not always taken place due to the building works. We discussed with the manager that it would be more critical for the daily checks to be made to ensure people's safety during the building works. It was not clear from the records we saw what had been checked during the manager's walk round, but we saw that concerns raised at this inspection were not identified through these checks.

We saw some audits in place, such as medication, infection control, monthly weights and pressure care areas. The manager told us care plan audits were carried out by the regional manager. We saw these were rated (red/amber/green) to show where improvements were needed, but we saw these had not been

calculated properly to give an accurate score. Where actions were needed, action plans were drawn up with timescales, but the dates for these had passed with no action taken and no further monitoring. As a result care plans contained incorrect information. We saw in the examples of peoples care records we reviewed, there were poor photocopies of staff observation sheets and some information was out of date or conflicting in detail.

Policies and procedures had not been updated since February 2014 and referred to out of date legislation. Risk assessments for the building had been revised by the regional manager in July 2015 but the index for the risk assessments did not match the content and it was unclear who was at risk form the potential hazards identified. A fire risk assessment carried out in April 2015 recommended an action plan, but we saw this was not completed.

The above examples illustrate the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 17(2)(a) (b) because systems to assess, monitor and improve the quality and the safety of services provided was not robust. Systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of people were not robustly in place.