Care Quality Commission

Dryband One Limited

Bradley House Care Home

Inspection report

Bradley Road
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Ratings

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

Overall summary

Bradley House Care Home is registered to provide residential and nursing care for up to 56 older people who may have a physical disability and who may be living with dementia. Twelve nursing places are provided within a self-contained recovery and recuperation unit. Accommodation is provided over two floors with both stairs and lift access to the first floor. The home is situated on the outskirts of the town of Grimsby.

The service had a registered manager in post, although they had resigned and were working their notice at the time of the inspection. 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.

This inspection was unannounced and took place over three days on the 3, 4 and 5 June 2015. The previous

Summary of findings

inspection of the service took place on 7 March 2014 and was found to be compliant with all of the regulations inspected. During the inspection there were 26 people using the service.

During the inspection we had concerns about the overall management of aspects of the service. This had impacted on areas of care and support provided to people who used the service. The quality of the service had not been monitored effectively and shortfalls had not been dealt with or had not been identified.

We found some people on the residential unit did not have risk assessments in place for specific concerns and incidents and accidents had not been analysed to help find ways to reduce them.

The care plans for people residing on the residential unit were not always personalised or kept up to date, so they did not provide staff with the direction about people's care.

Sufficient numbers of staff were not provided on the residential unit to ensure people's needs were safely met. Not all staff had received relevant training and support for their role.

We found many parts of the environment on the residential unit required attention to make sure they were hygienic and maintained. There was no renewal programme in place.

The above areas breached regulations in staffing, person centred care, cleanliness and infection control, premises/ equipment and monitoring the quality of the service. You can see what action we told the registered provider to take at the back of the full version of the report.

Some people who used the service lacked stimulation and they spent long periods of time without any meaningful occupation or activity. We have made recommendations about providing meaningful activities to people who are living with dementia and supporting their independence and orientation in their environment.

New staff were recruited safely and employment checks were carried out before they started work in the service.

A range of health and social care professionals were involved in the care and treatment of people who used the service. We saw evidence to confirm that when people's needs changed relevant professionals were contacted in a timely way to ensure people received the most appropriate care to meet their needs.

Staff supported people to make their own decisions and choices where possible about the care they received. When people were unable to make their own decisions staff followed the correct procedures and involved relatives and other professionals when important decisions about care had to be made.

People received their medicines as prescribed and they were held securely. We found some minor issues around recording which we mentioned to the registered manager to address.

People liked the meals they were provided with. Menus reflected a range of nutritional meals.

There were positive comments from people who used the service and their relatives about the staff team and the approach they used when supporting people.

There were systems in place to manage complaints and people who used the service and their relatives told us they felt able to raise concerns and complaints.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'special measures' by CQC. The purpose of special measures is to:

- Ensure that registered providers found to be providing inadequate care significantly improve.
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which registered providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made, such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the registered provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will

Summary of findings

be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

Areas of the residential unit were dirty, malodorous and unhygienic. Systems to protect people from the risk of infection were not effective.

The home did not have sufficient staff on duty in the residential unit to meet people's needs safely. Staff were recruited safely.

People who used the service were protected from the risk of abuse. Staff spoken with knew what to do if they had any concerns, although not all staff had received training about safeguarding adults from abuse. Risk had not always been managed effectively which could lead to people injuring themselves.

People received their medicines on time and as prescribed.

Is the service effective?

Inadequate

The service was not always effective.

Not all staff had received relevant training and support for their role.

Many areas of the residential unit required redecoration and refurbishment. The grounds needed to be maintained. There were minimal environmental adaptations to promote the independence and orientation of people living with dementia.

Where people lacked capacity to consent to their care and treatment, decisions were made in people's best interest and according to legal requirements.

The service liaised and worked well with community health care staff to ensure people's health and reablement needs were met.

Is the service caring?

Requires improvement

The service was not always caring.

Staff did not always keep people's personal information private and confidential.

Staff treated people with kindness and spoke with them in a caring way. At times, the care and support provided to people living on the residential unit was tasked based and not individualised.

People's dignity was generally respected, although some people in the residential unit required more support with their personal care and appearance. The lack of privacy locks on people's bedroom doors and some bathrooms may impact on their access to privacy.

Summary of findings

Is the service responsive?

Requires improvement 

The service was not always responsive.

The care people needed, and how they wanted this to be provided, was not always clearly described in their care plans, so they may not receive this as they wished or needed. Not every person had a plan of care to meet all their needs and some plans needed updating.

There were some activities provided to people, although these were dependent on care staff having time available.

The service had a complaints policy and procedure and people told us they felt able to complain to the registered manager or registered provider.

Is the service well-led?

Inadequate 

The service was not always well led.

There was a quality monitoring system in place but this had not been used effectively. Audits had not picked up concerns or when shortfalls were highlighted, they had not been addressed.

There was a lack of analysing and learning from incidents and accidents that occurred in the service so that practice could be changed and risks minimised.

There had been some difficulties in the last year which had led to a lack of senior management oversight of the service. This meant the registered manager had not received all the necessary support and direction.

Bradley House Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 3,4 & 5 June 2015 and was unannounced. The inspection was led by an adult social care inspector who was accompanied by an expert by experience who had experience of supporting older people living with dementia. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we looked at notifications sent in to us by the registered provider, which gave us information about how incidents and accidents were managed. We spoke with the local authority safeguarding team, and contracts and commissioning team about their views of the service. The commissioning team provided us with information from their recent assessment.

We spoke with eleven people who used the service and five of their relatives who were visiting during the inspection. We observed how staff interacted with people who used the service and monitored how staff supported people during lunch. We spoke with four community nurses who visited the service during the inspection. We also spoke with the Operations Manager for Care Trust Plus [commissioners for the 12 bedded respite unit], two nurse practitioners and an occupational therapist attached to the rapid response team working at the service.

We spoke with the registered providers, registered manager, the administrator, cook, domestic, laundry assistant, registered nurse, two team leaders, care worker and maintenance person.

We looked around all areas of the service and spent time observing care. We also used the Short Observational Framework for Inspection [SOFI]. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at five care files which belonged to people who used the service. We also looked at other important documentation relating to people who used the service such as incident and accident records and 20 medication administration records [MARs]. We looked at how the service used the Mental Capacity Act 2005 and Deprivation of Liberty code of practice to ensure that when people were deprived of their liberty or assessed as lacking capacity to make their own decisions, actions were taken in line with the legislation.

We looked at a selection of documentation relating to the management and running of the service. These included three staff recruitment files, the training record, the staff rotas, minutes of meetings with staff and people who used the service, quality assurance audits and maintenance of equipment records.

Inadequate

Is the service safe?

Our findings

People told us they felt safe living at Bradley House and staff treated them well. Comments included, "It was safer to come here than go straight home, until I can walk a bit better", "Very safe" and "Staff are always kind and polite; they treat us well." People also said they received their medicines on time. Comments included, "Always get them on time, they are very good with that" and "I need to take regular pain relief tablets and they are always on the ball."

We received some mixed comments from people and their relatives about the cleanliness of the home and the staffing levels. Comments included, "The staff seem to be well organised but they have too much on their plates", "Sometimes they seem a bit short of staff", "Always have plenty of staff", "Not enough staff, sometimes have to wait for assistance and they are always very busy", "Generally clean and tidy" and "I've noticed smells on occasions, but the cleaners do come round."

There was an infection control policy and procedure and contracts in place for domestic and clinical waste disposal. Records showed some staff had received training on infection prevention and control. We completed a check of the environment to ensure it was clean and safe for people who used the service and found all areas in the respite and recuperation unit were safe, clean and hygienic. However, in the residential unit many areas were not clean such as floors and paintwork. Some rooms in particular such as the treatment room and laundry required attention to flooring, cupboards, equipment and air vents. We found there was an unpleasant odour in some parts of the residential unit and carpets were heavily stained in both communal and bedroom areas. Cleaning records showed tasks were completed, however the cleaning record was not comprehensive enough. The registered manager confirmed flooring in the service was steam cleaned where necessary, but there were no records to show how regularly this was completed.

We noted some of the vinyl covered chairs, bed rail protectors and some people's bed bases had rips and tears in the fabric which meant they couldn't be cleaned effectively. We also found some of the wooden commodes in people's rooms were worn and the varnish covering on wooden areas of arm chairs had worn off which also meant these areas could not be cleaned effectively. The waste bins in some bathrooms and people's rooms had been removed which meant after hand washing, people had to dispose of the paper towel elsewhere. When we checked equipment in the residential unit such as wheelchairs and hoists, we found they were not all clean. Our observations indicated to us that the registered provider was not taking adequate steps to protect vulnerable people from the risks associated with an unclean environment. This was a breach of Regulation 12 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

Discussions with staff, visiting professionals and people who used the service confirmed staffing levels in the respite unit were satisfactory. However, we found some concerns with the numbers of staff on duty in the residential unit. The staffing rotas showed there were three members of care staff on duty during the day to support up to 20 people, some of whom were living with dementia and needed additional attention. On the first day of the inspection one member of staff escorted a person who used the service for their hospital outpatient's appointment; this took three hours and meant only two staff were on duty in this unit. During this time we had to request support for people from the staff in relation to support with toileting and personal care. Although additional support was provided by a member of staff from the respite unit, this was only for an hour at tea time. We also observed people sitting in the lounge unobserved by staff for long periods of time and people with dementia wandering into other people's rooms.

The registered manager told us they used a staffing tool to calculate how many staff were required to meet the needs of people who used the service. When we looked at the records of people's dependency levels, which were used to support the staffing calculations, we found they were not up to date and new admissions to the service had not been included. The registered manager confirmed occupancy levels had increased by five people in the last four weeks and the staffing levels had not been adjusted accordingly. During the inspection, the registered provider increased the staffing levels in the residential unit to four care staff during the day. When we followed this up after the inspection visit, the registered manager confirmed they had not maintained the increased numbers. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the action we have asked the registered provider to take can be found at the back of this report.

Inadequate

Is the service safe?

Staff told us people were safe and were able to tell us how they would respond to allegations or incidents of abuse, although not all staff had received safeguarding training. We saw that the safeguarding policy and procedure contained contact details for the local authority and was easily accessible for staff. The registered manager was aware of the local safeguarding policy and procedure for alerting them to concerns about the abuse of vulnerable adults. We saw safeguarding information displayed on a noticeboard so people and their relatives knew who to contact if they had concerns.

Individual plans were in place for people in the event of an emergency. However, individual risk assessments were not always completed for people who used the service. For example, a person was described as being prone to falls but a risk assessment had not been completed. Risk assessments were also not in place for another person who was at risk of sustaining pressure damage and had complex mobility needs. Most people's records contained a range of risk assessments for areas such as skin integrity, nutrition, choking, falls, moving and handling and the use of bedrails. However, we found some of these had not been reviewed and updated when the person's needs had changed.

Staff spoken with demonstrated a good understanding of people's needs and how to keep them safe. During the inspection, we saw staff competently transferring people between chairs and wheelchairs using a hoist. They explained the procedure to people as they guided them into the chair and made sure they remained safe.

Staff recruitment records showed new employees were only employed after full checks had been carried out. These included application forms to checks gaps in employment, references and disclosure and barring checks to see if people were excluded from working with vulnerable adults. Checks were made on the registration status of qualified nurses to make sure there were no conditions to their practice. In discussions, staff confirmed they were asked to provide references and had police checks prior to starting work. The registered manager confirmed they had been unable to recruit new nursing staff and were using agency staff to fill current vacancies. They used regular agency staff where possible who knew the service which provided a consistency of care.

We found medicines were ordered and stored appropriately. All staff who administered medicines had received the training needed to ensure they knew how to do so safely, and had been assessed as competent to do so. We looked at how medicines were managed and saw people received their medicines as prescribed. There were gaps in recording but when checked these were errors with recording rather than administration. There were some other minor recording issues such as not having a counter signature when changes were made to the medication administration record. Also some people were prescribed medicines to be taken 'when required' (PRN), but clear guidance for staff on when to administer these was not in place. These points were mentioned to the registered manager to address.

Equipment used in the home was serviced at intervals to make sure it was safe to use. There was a coded entrance and all external doors were linked to an alarm system. This alerted staff when people used the external doors and they were able to check if they required assistance.

Inadequate

Is the service effective?

Our findings

People told us they were able to see their GP or nurse when they needed to and also saw opticians, dentists and chiropodists. They said they enjoyed the meals provided and had plenty to eat and drink. Comments included, "Yes, I see my doctor when I need to and I've been to the hospital a few times lately", "If I was ill, I'd ask the girls [staff]", "Great food, good cook", "I love Friday fish and chips" and "Alright 90% of the time; sandwiches are small at teatime, but they will give extra if you want it." A relative was staying for lunch and told us, "You are missing out, the food is really good."

Relatives told us they were happy with how the staff supported people's health care needs. They said, "They look after him well", "He has therapists to help with exercise programmes and getting him back on his feet; it's been very good", and "Haven't needed the GP but they have contacted the district nurse and continence advisor when necessary."

People told us they felt staff had the right skills to meet their needs. A person said, "I think the staff are very good." A relative told us, "From what I've seen the staff are trained well with moving and handling, diet, empathy and communication."

Despite the positive comments we received from people and their relatives about staff skills and competence, we found there were some gaps in the staff training and supervision programmes. Records showed some staff had not received training in some areas which the registered provider considered essential such as safeguarding, infection prevention and control, food hygiene, dementia, Mental Capacity Act 2005 (MCA) and first aid. We also found some refresher courses such as fire safety training were out of date. Checks of staff supervision and appraisal records showed there were some gaps in the programmes where staff had not had opportunities to discuss their work role and responsibilities for some time. The registered manager confirmed 60% of staff had received supervision from their line manager in the last two months and 14 staff had attended an appraisal meeting in the last 12 months. Staff on the nursing unit considered they were well supported; however, staff on the residential unit felt they did not have supervision regularly and the registered manager was not always available. The staff also said there had been less opportunities for training in recent months. One member of staff said, "There have been some recent improvements with supervision sessions but training is less organised." The findings above show that not all staff were provided with appropriate support and training which was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the action we have asked the registered provider to take can be found at the back of this report

We found the environment had not been adapted to suit everyone's needs. There was no signage to help people living with dementia or a sensory impairment to find their way round the home. People were observed walking about confused and entering other people's rooms. Corridors were bland and little effort had been made to provide colour coding on doors and door frames to assist with orientation. The majority of carpets throughout the home were highly patterned which may cause people living with dementia to confuse the pattern for objects and try and pick these up, providing an increased risk of falls.

We recommend that the service seek advice and guidance from a reputable source, about environmental adaptations to promote the independence, orientation and safety of people living with dementia.

We found the respite unit was generally well maintained and décor and furniture was of a good standard. However, we found aspects of the décor and furnishings in the residential unit did not support people's comfort, dignity and wellbeing. The majority of carpets in this unit were heavily stained, marked and required replacement. Paintwork was chipped and worn. Many items of furniture in the communal areas and in people's rooms were worn and marked. Curtains were found to be frayed and hanging off the rail in one corridor. Areas were not tidy with the maintenance team storing items in communal areas. We found the quality of some bedding was poor; one person told us they found their pillows and mattress were not comfortable and we passed this to the registered manager to address as a priority. A toilet seat in one of the bathrooms was broken and replaced during our inspection. We also found the grounds were untidy, over grown and areas of fencing and garden furniture required replacement. Redundant and broken electrical equipment, mobility aids and other equipment had not been disposed of and left outside. There was minimal evidence of any redecoration in the last 12 months and there was no annual renewal programme in place which had been

Is the service effective?

agreed and approved by the registered provider. The findings above show the premises were not properly maintained which is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw menus provided people with a range of nutritious meals. We found the menus were not posted around the home or provided in pictorial format and daily choices were not recorded on the white board in the main dining room. We asked the registered manager to address these issues.

We observed the lunchtime and tea time experience for people and found this was calm and unhurried. Most people had low level needs regarding their nutritional intake and were able to manage their meal unassisted or with minimal help from staff. The care files showed most people had nutritional screening to check for any potential risks, a care plan which detailed the support they required and lists of their likes and dislikes. People were weighed regularly. Where there were concerns about the amount people who used the service were eating and drinking, staff completed food and fluid monitoring charts. This meant they monitored people's nutritional intake and supported them to increase this if needed. The cook told us, "The staff tell us if people have weight loss and we give them a fortified diet." The staff told us how they supported and encouraged people to eat well. This included involving a GP, a dietician and speech and language therapist to provide advice on diet and ways of overcoming swallowing difficulties.

We saw people being offered drinks and snacks regularly during the day. We noted the snacks were limited to biscuits and cakes; there were no snacks and fresh fruit readily available in communal areas, which the registered manager confirmed they would review. A member of staff told us, "We take time to make sure people have enough to eat and drink, we try to provide whatever they want."

There was evidence people had access to health care professionals when required. These included GPs, district nurses, dieticians, the falls team, emergency care practitioners, speech and language therapists and podiatrists. In discussions, staff described how they recognised when people's health was deteriorating and when they would call for a GP. Community nurses and therapists were visiting people during the inspection to provide treatment and advice regarding their health care. They told us their patients were satisfied with the care at the service. They also said the staff followed their directions and advice about care and treatment and made appropriate referrals for support.

The Care Quality Commission is required by law to monitor the use of Deprivation of Liberty Safeguards [DoLS]. DoLS are applied for when people who use the service lack capacity and the care they require to keep them safe amounts to continuous supervision and control. There were no people subject to a DoLS at the time of this inspection and records showed the registered manager had submitted four applications which were awaiting assessment by the review body.

Records showed when people were assessed as lacking the capacity to consent to treatment or to make their own decisions about important matters, best interest meetings were held; we saw decisions were made with the involvement of family and other health professionals. Staff were clear about how they gained consent when carrying out care tasks. They said, "We always ask people about their care and support; for people who don't have capacity we know our approach is important."

Requires improvement

Is the service caring?

Our findings

People told us the staff team were caring and treated them with dignity and respect. Comments included, "They take good care of us", "They [the staff] are very considerate", "They [the staff] are pretty good and they do feed us well", "Yes, very caring, they have a lot to put up with" and "The staff always knock on my door and ask if they can come in." People also told us they felt informed about their care and treatment. One person said, "They explain everything they are going to do."

Relatives told us, "They seem really caring to my mother", "Yes, they are kind and caring, they try and take time to talk with her", "Very kind staff, can't do enough for us all", "He has only been here a short time, but speaks highly of the staff" and "They [staff] are always respectful and knock on the door and ask if they can do something. They seem to respect their privacy and dignity."

Visiting health care professionals said, "I have no issues with the staff, they all seem kind and caring" and "The staff are respectful to people."

Observations during the inspection showed the majority of people looked well cared for, but a small number of people did not always receive the support they needed with their personal care and appearance. We noted some of the ladies had not received support with their hair styling and looked unkempt. Similarly some of the men had not shaved and when we checked their care files we found the support they needed and their preferences around shaving were not detailed in their care plans. This issue was passed on to the registered manager to follow up and address.

Some bedroom doors did not have privacy locks and staff told us people were asked years ago if they wanted them but they declined. We also noted that some of the bathroom and toilet doors did not have privacy locks and the registered manager confirmed they would report this to the maintenance team. The registered manager told us they would install privacy locks to bedroom doors if people wanted them. We found four people had metal stair gates fixed to their doorframes and all chose to use these during our inspection. In discussions, they said they had been in place for a long time and originally put up to prevent a specific person from entering their rooms. There were risk assessments in place to support this provision, however we asked the registered manager to discuss with people and their relatives and review the continued use of such equipment, given the person was no longer at the home.

We saw staff did not always keep people's personal information private and confidential. In the residential unit, we found people's medication administration records were left in the dining room on the first day of the inspection. People's care records were kept in the staff office but this was not locked. The registered manager confirmed there was a lock in place and they would address this with staff. On the respite unit, we found staff supervision files were stored on a bookshelf in the staff office; the registered manager removed these to their office during the inspection.

Dignity champions had been appointed to act as role models and promote good practice with regard to respect, compassion and dignity within the service. Staff we spoke with could not provide examples of how these dignity champions had made a difference to the care being provided.

We found some people were unable to speak with us due to their complex needs. Therefore we spent time observing the interactions between staff and people who used the service. People appeared happy and relaxed with staff, who communicated with them at a level they could understand. We observed staff treated people with kindness and compassion. Staff were patient and understanding when supporting people although due to staffing levels we saw some evidence that staff had a task-based approach to care at times.

We observed staff supporting people to maintain their independence during the inspection. The majority of people in the respite unit were admitted for short-stay, reablement support to assist them to return home. The programmes in place included self-medication, promotion of self-care for personal support and exercises to improve mobility. In the residential unit, we observed staff promoted people's independence where possible; we observed people were offered clothes protectors and some people had equipment such as slip mats and plate guards to assist them at meal times. We also observed people were supported to walk and mobilise. In discussions, staff

Requires improvement

Is the service caring?

told us, “We always encourage people to do what they can for themselves and maintain their independence” and “It’s very rewarding to see how people regain their strength and independence to go home.”

People told us they were supported to express their views and be actively involved in making decisions about their care. Some of the people we spoke with told us about their care and said they knew staff had written information about the care they needed. Records showed people had been involved in their initial assessment where possible.

Entries in the care plans showed people’s needs were kept under review and reflected that they, and those that mattered to them, had a say in how their care was provided. The registered manager confirmed they would support people where necessary to access independent advocacy services if they needed assistance in making decisions about their life choices. Records we saw showed an Independent Mental Capacity Advocate [IMCA] had been involved with end of life discussions for one person who used the service.

Requires improvement

Is the service responsive?

Our findings

People told us they would feel able to complain and these would be listened to and sorted out. They said, "I would be speak to one of the nurses or the manager" and "I haven't had to complain but would speak up if I had to." Relatives spoken with said, "They have dealt with a couple of things I've mentioned, but it wasn't anything very serious" and "I've not had to raise any but I'm confident that staff would address any concerns."

People told us they would like activities and social stimulation. They said, "There are no activities really; sometimes we get entertainers in and people that do reminiscence which is good", "I usually read or watch television", "We did have a singer come in a long time ago" and "I don't think there is really enough to do." One person told us they spent large amounts of time in their bedroom looking at the wall and that sleeping helped pass the time. Another person told us they preferred to stay in their room as the lounge was too depressing.

We observed there was a lack of stimulation for people, especially those people living with dementia; they were sat with nothing to do for long periods of time, sleeping or disengaged. Some people wandered the corridors going into the bedrooms. There were items of interest, such as period clothing and other memorabilia, located in the reminiscence room for people to look at and touch if they wished to; we did not see anyone enter this room during the inspection. The activity co-ordinator post was vacant. The registered manager confirmed two of the team leaders had lead roles in activities. But we found that although entertainment was arranged each month and ecumenical church services were held, there was no day to day activity programme in place. Staff told us there had been some activities in the recent past such as games, singing and crafts but when we checked documentation these had not been recorded. This meant there was a risk of people becoming bored and their needs not fully met. Staff told us they tried to complete activities with people but they had little time and could be called away to attend to people's personal care needs. On one inspection day we observed staff supporting a group of people to play skittles, which they were enjoying.

We recommend that the service seek advice and guidance from a reputable source, about the provision of activities and social stimulation for people living with dementia.

Each person had a set of care records to provide staff with guidance on how to meet their needs. We found inconsistencies in the assessment and planning of care for people who were residing on the residential unit. For example, one care file we looked at contained person-centred information including life history records and information about preferences for personal care tasks and food likes and dislikes; there was also information about routines of the day. The person had individual care plans for a range of needs, for example how they mobilised and how many staff were required to assist in transfers. Other care files we checked did not contain information about the person's background or their preferences for how they wanted their care delivered.

Some of the care files we looked at were reviewed and updated, but we saw some people's care plans were not reviewed and updated on a regular basis, so they would not show if the person had undergone any change of need. There were evaluations of care plans taking place, but some of these were not completed accurately. For example, we found care plans had been evaluated that were either no longer relevant or written as if the care was still being followed when it wasn't.

We looked at the file for one person whose needs had changed significantly in recent weeks and found the risk assessments and care plans had not been reviewed and updated to reflect their current care needs. This meant there was a risk that the person would not receive all the care they needed or the care may be inconsistent.

There were people with needs where care had not been sufficiently planned. For example, one person who had been admitted in the last three weeks, only had a care plan in place to support the management of aspects of their catheter. They did not have any care plans or risk assessments in place to support other needs in relation to their diabetes, communication, risk of pressure damage, mobility and personal care. Another person who had been admitted in recent weeks, demonstrated behaviours which challenged the service yet these were not detailed in any risk assessments or plans of care. Neither were the person's needs in relation to pressure damage or confusion

Requires improvement

Is the service responsive?

identified in a care plan. The care plan to support the management of the person's catheter was poor; it did not provide guidance for staff in how to manage the catheter effectively.

The shortfalls in assessing needs and planning care meant there had been a breach in Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the action we have asked the registered provider to take can be found at the back of this report.

Family members we spoke with told us they felt the home was responsive to their relative's changing needs. They gave examples of how staff contacted them in a timely manner when changes occurred and said they seemed to act promptly to address any concerns.

There was a complaints procedure on display in the entrance hall. The complaints policy and procedure informed people of who to speak with if they had any concerns. It also provided the registered manager with guidance on timescales for addressing complaints and responding to people. Staff were aware of the complaints procedure. The complaints file showed there had been no formal complaints received in the last 12 months; people's concerns were investigated and responded to appropriately.

Inadequate

Is the service well-led?

Our findings

Visitors, people who used the service and staff gave mixed views about the management of the service and whether their suggestions would be listened to and acted upon. Visitors felt they could approach staff and said they listened to them. One person said, "Yes, staff take action if we mention something or make a suggestion." Another person said, "I've recently received a survey to fill out." Two sets of relatives we spoke with did not know who the manager was and were not aware of any meetings where they could meet with the management of the service . Staff told us they required more support and guidance at times but this had not always been available when they needed it. Staff meetings were held and minutes were seen of those held in April 2015.

The inspection visit showed very different findings between the residential and respite [nursing] units in the service. The nursing unit has 12 directly commissioned beds to provide care and support for people who needed a period of respite care following discharge from hospital or to prevent a hospital admission. The staffing complement of care and qualified staff were funded by the commissioning authority who also completed their own quality monitoring programme in the unit. Following an audit of infection prevention and control, they had taken action to provide additional hand gel stations and provide additional training for staff. The nursing unit was situated in a newer extension facility and we found the environment was decorated and furnished to a satisfactory standard. During the inspection, we met the operations manager for the commissioning authority who confirmed they visited the service regularly to monitor the quality of care provision, support staff and meet with the registered manager.

We found there were some concerns about the way the residential unit was managed. The registered manager told us they had not been able to keep on top of management issues due to specific reasons. They confirmed they had handed in their notice to resign and would be working the following two weeks. The registered manager confirmed there had been less senior management oversight by the registered provider in recent months. When we asked for records of senior management meetings, the registered manager could not provide these.

The service had a basic quality monitoring system in place, with themed audits completed monthly, bi monthly or quarterly. However, some of the audits had not been maintained or there were no action plans developed to deal with identified shortfalls. For example, medicine audits were done regularly and identified some low level issues, however, there were no action plans put in place to deal with these and the same issues regarding the standard of recording were found during the inspection.

We found no audits of care plans, staff training or the environment were completed and significant shortfalls were found in these areas during the inspection. There was no effective system in place for renewal to ensure the premises were clean, safe and well maintained.

External audits on infection prevention and control and pressure damage had been completed on 25 November 2014 by the care home liaison team for North East Lincolnshire Clinical Commissioning Group. Both audits failed to achieve compliance and significant deficiencies were identified and action plans provided. We found no evidence of action taken to make the necessary improvements and the inspection highlighted that the issues remained.

Records showed satisfaction surveys were issued regularly and recently. The sample we checked indicated there was mixed feedback from the respondents; there were no action plans to address the shortfalls. We discussed with the registered manager how the results of the surveys and any action taken could be displayed on the notice board so people who completed them could see their views had been listened to.

Records showed accidents and incidents were recorded and appropriate, immediate actions taken. However, there was no analysis of the cause, time and place of accidents and incidents which would help identify patterns and trends in order to reduce the risk of any further incidents. We also found the management of risk in the service was inconsistent; some people's risk assessments had not been reviewed and updated following incidents and some had not been put in place to promote people's safety.

The above issues regarding the lack of effective quality monitoring meant there has been a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the action we have asked the registered provider to take can be found at the back of this report.

Inadequate

Is the service well-led?

Records showed the last 'residents meeting' was held on 5 October 2014 and topics discussed included menus and activities. The registered manager confirmed that a meeting had been arranged in January 2015 but no-one had turned up.

Discussions with staff evidenced there were no staff incentives in place at the home. The service had undergone assessment by North East Lincolnshire Clinical Commissioning Group (NELCCG) in 2013 where quality standards were reviewed within the authority's Quality Framework Award. Overall, the service had met the criteria for a 'Bronze' rating, which indicated the service used best practice but could improve in a few areas. Further assessment visits had been completed in 2014 and 2015, and the findings from this assessment have not yet been published.

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	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Care plans were not always designed or in place to meet people's preferences and needs. Regulation 9 (1) (a) (b) (c) (3) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The home did not have sufficient staff on duty in the residential unit to meet people's needs safely. Not all staff had received training, supervision and professional development to enable them to deliver care and treatment to people in the home safely and to an appropriate standard. Regulation 18 (1) (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance People who use services and others were not protected against the risks associated with unsafe care and treatment, by means of an effective operation of systems designed to monitor the quality and safety of the service. Systems for identifying, assessing and managing risks relating to the health and welfare of service users had not always been effective. Regulation 17(1) (2) (a) (b)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Systems to support effective infection prevention and control in the residential unit were not safe. Regulation 12(2)(h)

The enforcement action we took:
We have issued a warning notice for Regulation 12, Safe care and treatment, to the registered provider. They have to be compliant with this regulation by 1 October 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance and renewal. Regulation 15 (1) (a) (c) (e)

The enforcement action we took:
We have issued a warning notice for Regulation 15, Premises and equipment, to the registered provider. They have to be compliant with this regulation by 1 October 2015.