Greasbrough Residential & Nursing Home Limited

Greasbrough Residential and Nursing Home

Inspection report

Potter Hill
Greasbrough
Rotherham
South Yorkshire
S61 4NU

Tel: 01709554644

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The inspection took place on 17 and 18 May 2018 and 6 June 2018 and was unannounced which meant the people living at Greasbrough Residential and Nursing Home and the staff working there didn't know we were visiting.

The service was previously inspected in March 2017, when we identified two breaches of regulations. The registered provider did not meet the regiments of The Mental Capacity Act and there were ineffective systems to monitor the service provision. The service was rated Requires Improvement. At this inspection we found the service had deteriorated and we have rated it Inadequate and it is placed in special measures.

You can read the report from our last inspections, by selecting the 'all reports' link for 'Greasbrough residential and Nursing Home' on our website at www.cqc.org.uk.

At the time of our inspection there was a registered manager in post. 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.

Greasbrough Residential and Nursing Home is a 'care home.' People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service provides accommodation for up to 60 people in one adapted building. On the third day of our inspection there were 52 people using the service.

Staff we spoke with understood what it meant to safeguard vulnerable people from abuse, and they were confident management would take any concerns they had seriously and take appropriate action. However, issues we identified during the day did not support this and we submitted six safeguarding referrals to the local authority.

The home did not have a dependency tool in place to determine what staffing hours were required to meet people's needs. We identified on the second day of our inspection that there were insufficient staff on duty to meet the needs of people who used the service. The registered manager implemented a dependency tool and increased the staffing, this has been maintained. However, on 6 June we found the deployment of staff was still ineffective which meant people's needs were not always met. Staff training and supervision was also ineffective as staff did not follow care plans to ensure people were safe.

Systems were in place to manage medicines safely. However, we found these were not followed to ensure people received medications as prescribed.

Assessments identified risks to people and management plans to reduce the risks were in place to ensure

people's safety. However, they lacked detail, and were not always followed. We observed staff interacting with people and found that staff did not refer to care plans and did not deliver the care and support in line with people's assessed needs. This put people at risk of harm.

We found the service was not always meeting the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). We found people's best interests were not always clearly documented, did not always involve all relevant people and did not clearly detail the outcome. Decisions being made were sometimes very general and not specific.

Staff did not always ensure people received adequate nutrition. Some people had lost weight but records lacked detail to show if people were encouraged and supported to receive adequate nutrition.

We observed staff interacting with people and found they were kind and caring, but only interacted with people when carrying out a task. We also saw that staff had not recognised that some people required support and we had to inform staff that they required assistance. People were also isolated in their bedrooms with no stimulation or interaction.

We found care plans were in place and had been updated since our last inspection. We found predominantly people's needs had been identified. However, we found they did not always reflect peoples current needs and were not always reviewed when their needs changed. We also observed a lack of social stimulation and activities. People we spoke with told us they were bored. Staff we spoke with also told us there was no activity co-ordinator as they had been off work long term.

We looked at records of complaints received and found these had been logged. However, people we spoke with gave mixed opinions about how the registered provider handled their concerns. Some people did not feel listened to, but others felt their concerns had been dealt with satisfactorily.

We found a lack of leadership and oversight on a day to day basis and communication between all levels of staff was poor. This was mainly because the registered manager did not have any supernumerary hours to manage the service. The registered manager was always included on the rota in the required numbers to meet people care and support needs. The clinical lead did not work any supernumerary hours and was also always included in the numbers. Staff we spoke with told us that although they did feel listened to, they said nothing was actioned and at times communication was poor and there was lack of direction.

Systems in place to monitor the service were not effective they did not identify issues we found. People who used the service, their relatives and staff were not provided with forums where they could voice their opinions or be involved in the running of the service.

We found six breaches; two of these were continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered provider to take at the back of the full version of the report.

The overall rating for this service remains 'Inadequate' and the service will therefore remain in 'special measures.'

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made

significant improvements within this timeframe.

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If not enough improvement is made within this timeframe so that there is still 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 provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to 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 so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

Staff understood the safeguarding policies but we found staff had not always identified safeguarding so these were not reported to ensure peoples safety.

Risks were not always identified or reviewed which put people at risk.

The service was in general maintained and clean, although some areas could be improved.

Recruitment procedures were followed to ensure the right people were employed to work with vulnerable people.

Is the service effective?

Inadequate

The service was not effective.

We found the service was not always meeting the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). We found people's best interests were not always considered and conditions were not met.

We found people were offered a well-balanced diet however; support provided to ensure people received adequate nutrition to meet their needs could be improved.

Staff monitored people's healthcare needs, but did not always make referrals to healthcare professionals where appropriate.

Staff received training and supervision to fulfil their roles and responsibilities but this was not effective.

Is the service caring?

Inadequate

The service was not always caring.

People told us that some staff were kind and caring. However, we received some negative comments about staff attitude. We also observed some poor interactions from staff when supporting

people who used the service.

We saw that staff predominantly respected people's privacy and dignity.

We observed that care and support was task orientated and was not based on individual needs and preferences.

Is the service responsive?

Inadequate

People's care needs had not always been identified or reviewed. Where needs had been identified these were not always followed to ensure people's safety.

There was a lack of social stimulation and people were at risk of becoming socially isolated.

The registered provider had a complaints procedure and complaints had been recorded. However, we did not see any analysis or lessons learned documented.

Is the service well-led?

Inadequate

There was lack of governance and oversight as the service had not been effectively managed.

The registered provider had some systems in place to monitor the service and to identify areas to develop. However, we found that these systems had not always been completed or used effectively.

There were no opportunities for people who used the service, staff, or relatives to voice their opinion or be involved in the service.

Greasbrough Residential and Nursing Home

Detailed findings

Background to this inspection

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

This was a comprehensive inspection. This inspection took place on 17 and 18 May 2018 and 6 June 2018 and was unannounced. The membership of the inspection team comprised of three adult social care inspectors and an assistant inspector. The assistant inspector was not on site but phoned relatives to gain feedback.

Prior to the inspection visit we gathered information from a number of sources. We also looked at the information received about the service from notifications sent to the Care Quality Commission by the manager. We also spoke with the local authority and other professionals supporting people at the home, to gain further information about the service.

We spoke with ten people who used the service and twelve relatives, and spent time observing staff supporting with people. 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 carried out three SOFI observations over the inspection.

We spoke with seven care workers, two nurses, the cook, two ancillary staff, the administrator, the maintenance person, the registered manager and the registered provider. The registered provider was also present at the feedback meeting. We looked at documentation relating to people who used the service, staff and the management of the service. We looked at twelve people's care and support records, including the plans of their care. We saw the systems used to manage people's medication, including the storage and records kept. We also looked at the quality assurance systems to check if they were robust and identified

areas for improvement.

Inadequate

Is the service safe?

Our findings

People we spoke with said they felt safe. However, relatives we spoke with were not completely happy with the care and support their relatives received and were not confident their relatives were safe at all times. One relative said, "At times I see no staff around so not sure if it's always safe." Another relative said, "[My relative] is in bed all the time. I think this is because the staff will need to watch them and therefore think they are safer in bed, but they like to get up."

Staff had received training in safeguarding vulnerable adults form abuse and most staff we spoke with were knowledgeable about safeguarding people from abuse. Staff also knew about the registered provider's whistle blowing policy. One staff member said, "I would raise a concern with management and if I needed to raise it in writing or notify CQC." Other staff said they would have no hesitation using the procedure if needed. However, we found that because care plans were not reviewed or evaluated effectively that some concerns had not been identified. We identified concerns that had not been acted on which could result in possible neglect as people's needs were not met. As a result of this we referred six safeguarding concerns to the local authority following the second day of our inspection and identified another two concerns on the third day of our inspection, which the registered manager referred to the local authority.

Risks associated with people's care were not always identified or managed appropriately. Risks were not always monitored to ensure people were kept safe and their freedom respected. We looked at care records and found people had risk assessments in place, however these did not contain enough information to ensure safe care was provided. For example, one person required the use of a hoist to transfer. However the risk assessment did not contain information about the type of sling to use and where the loops should be positioned. This person also had a Personal Emergency Evacuation Plan (PEEP) in place. This stated that the person had mobility issues, but did not state what these were or how to assist the person safely.

Another person had a risk assessment in place for choking. The risk assessment stated that the person should be assisted by staff for all meals and drinks and sat in an upright position. We saw sweets had been left on the over bed table for the person to access. This put the person at risk of choking. We spoke with staff and the registered manager and they referred the person to the dietician. The dietician visited in May 2018 and advised that the person was able to have access to the sweets but only if they were alert and sat upright. We saw on the second day that the sweets had been removed from the person's table. We also saw the care plan had been updated with this advice. However, the old information still remained in place making it very conflicting to read. One person was prescribed a fluid thickener to be added to their drinks, to reduce the risk of choking. We found a beaker of un-thickened fluid, which had been brought in to the person and left at the side of their bed. This meant the person was at risk of choking if new staff or agency had given the fluid at the incorrect consistency. Staff had no access to information to tell them that the person needed their drinks thickening.

We also identified people who were at risk of falls and had been assessed to use the hoist. We found that risk assessments did not fully detail the type of hoist, size of sling or the loop configuration to ensure people were moved safely.

This is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment. Risks associated with people's care were not always managed effectively.

On the second day of our inspection after talking with staff, relatives and people who used the service we identified that there were lack of staff on duty to meet people's needs and keep people safe. There was no dependency tool used to determine what staffing hours were required to be able to meet people needs staffing levels were set by the number of people living at the home not their care needs.

We also found the registered manager did not have any supernumerary hours to manage the service. They were always on the rota covering care hours. One visiting professional said, "It is just like he [the registered manager] is a senior carer."

One care worker told us, "Staffing levels can be very frustrating. Staff are very task orientated because they don't have the time to do the things they would like to with people." Another care worker said, "There is just not enough staff, everyone feels the same. We don't have time to do the person centred stuff." Another care worker explained that they didn't have time to interact with people that were nursed in bed due to staffing levels. We observed there were no activities in place for people nursed in their beds and they were left for long periods of time without any, or very limited social stimulation.

We discussed this with the registered provider who, following the second day of our inspection agreed to ensure the registered manager worked Monday to Friday during office hours and was supernumerary to ensure the management of the home could be improved and ensure safe working practices. The registered manager also introduced a new dependency tool, which identified they were two staff short on each day shift. This was actioned immediately and was in place on the third day of our inspection. We have had reassurances from the registered provider that this will continue to ensure sufficient staff were on duty to meet people's needs.

However, on the third day of our inspection we still saw staff were struggling to meet people's basic care needs. Staff were not deployed effectively to ensure that people were being provided with care and support in a consistent and planned way. This extended to all aspects of people's care and welfare needs including a lack of social activity and mental stimulation. For example, during our observation on the upstairs unit staff were either in people's bedrooms providing personal care or in the bathroom bathing people. There was no staff to observe or meet the needs of the people who remained in bed upstairs. We found one person, when we went in their room to talk with them was cold, they were unable to use their call bell and were waiting for staff to come and see them. We had to find a staff member to get them an extra blanket so they could get warm.

This was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing. Staff were not effectively deployed.

People were not always protected by the prevention and control of infections. The home generally appeared clean although not very well maintained. On the first day of our inspection we completed a tour of the home and found two sluice rooms had no hand washing facilities. We also saw a shower chair which had rusty wheels and shower areas which was quite stained. We also saw wheelchairs were in need of cleaning. We spoke with the registered manager who told us they would action this straight away.

We looked at the laundry room and saw this was organised and there was a good work flow with specific areas dedicated to dirty to clean laundry tasks.

We found medication procedures were in place to guide staff and ensure medicines were administered safely. However, we found the procedures were not always followed by staff. We found many errors with the recording of medication on receipt, administration and when medication was either disposed of or returned to the pharmacy. It was not clear from the evidence we saw that people received their medication as prescribed.

We found there were no carried forward amounts recorded on the mediation administration record (MAR). This meant it was not clear how many medicines were in stock to be able to effectively audit. We found when entries were hand written the staff member recording the medicine did not always sign and there was also not a second signature to confirm it had been checked and was recorded correctly. We found bottles of medicine including eye drops were not always dated when opened and there were gaps on the MAR's, staff had not signed to confirm the medicine had been administered.

Some people were prescribed topical medicines to be applied to the skin, for example creams and ointments. We checked care records and found care staff had not made records to confirm they had applied these treatments as they had been prescribed. It was therefore not possible to determine if these had been applied as prescribed.

We found some people were prescribed medicines to be given on an 'as and when' required basis, known as PRN medicines. We found some people did not have PRN guidelines in place to instruct staff when to administer the medicines. We also saw if they were in place they lacked detail. Some people were living with dementia and were unable to tell staff when they required the medicines. Therefore without any guidelines or protocols in place to guide staff, people may have required these medicines but not been given them. These medicines included pain relief so people may have been left in pain.

We saw medicines were not stored safely. During the first day of our visit we noticed that the medication room didn't lock automatically as the catch was broken. The medication, syringes and equipment stored in this room were accessible for anyone who entered. At various points throughout the day we could gain access to the room without a code. This was rectified, but we were told the lock was temperamental and when we visited again on 6 June 2018 it was still not always locking. We also found a medicine storage trolley did not lock.

Monitoring of medication storage rooms was not always completed. We also found the rooms did not have a minimum/maximum thermometer so it was not possible to determine that the temperature of the rooms over a 24 hour period was maintained within guidelines.

There were occasional gaps in the temperature being taken of the medication storage rooms and fridges used to store medicines in. We also found that one storage room temperature was never monitored. We saw that on the day of our inspection the temperature of the medicines fridge was not in line with guidelines on storing prescribed medicines. The fridge was located in a place where it was in direct sunlight, and not in a well ventilated position away from sources of heat. We also found when we checked the temperature of the downstairs mediation storage room the room temperature was recording 32.1 degrees centigrade the recommended maximum temperature is 25 degrees.

Although we found many errors in medication administration, we saw that staff had received training. Therefore this was not effective as the procedures were not followed or adhered to. Which meant people did not receive their medication as prescribed.

This is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safe care and treatment. Management of medicines was not safe.

The registered provider had a recruitment policy which assisted them in the safe recruitment of staff. This included obtaining pre-employment checks prior to people commencing employment. These included references from previous employers, and a satisfactory Disclosure and Baring Check (DBS). The DBS checks help employers make safer recruitment decisions in preventing unsuitable people from working with vulnerable people. We looked at staff recruitment files and found they contained all the relevant checks. Staff told us that they completed an induction when they commenced work for the registered provider.

We looked at the maintenance records for the home. There were certificates showing fire systems and equipment, electrical systems, gas installations and lifting equipment were tested to ensure their safety at appropriate intervals. The service handy man had oversight of theses checks, which had been completed on a regular basis to ensure equipment was safe. However, we saw that a contractor had made a recommendation in May 2017 that a bath which was used to lift people, needed to be shortly replaced, as it was in poor condition. Another contractor checking the equipment in September 2017 recommended that the bath be replaced, within six months. When we visited the bath had not been replaced in line with recommendations. We discussed this with the Registered Manager and the maintenance person who explained the provider had not provided funding for it to be replaced. This meant that people were being bathed in a bath that was in poor condition and they could be put at risk from failing or breaking.

Inadequate

Is the service effective?

Our findings

At the last inspection we found a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent. Care and treatment was not always provided with the consent of the relevant person and was not always delivered in line with current legislation.

At this inspection we found a continued breach of this regulation, we identified the service was not always meeting the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). The staff we spoke with did not have an understanding and knowledge of this, and were not clear who had an authorised DoLS. Some people had been assessed by the previous registered manager but the information we were shown was out of date. We found some people did have an authorised DoLS in place and some people had a DoLS in place which had conditions attached to the authorisation. We identified some people's conditions in relation to the authorised DoLS were not being followed so they were being deprived of their liberty. For example, one person's condition was to monitor their mood and visits from friends, we found no record of this and when we asked staff they did not know what we meant and said this was not being recorded. When we discussed this with the registered manager he thought this had been implemented but could not find the paperwork.

We identified where people lacked capacity to make specific decisions their consent to care and treatment was not always sought in line with current legislation and guidelines. For example, where people lacked capacity to consent to care and treatment, best interest decision meetings had not taken place to ensure people received appropriate care in the least restrictive way possible. This meant the registered provider did not always ensure that the principles of the Mental Capacity Act were being applied and followed. For example, one person who lacked capacity, had been assessed to use bed rails. There had been no best interest decision documented or considered to ensure this was the least restrictive way to manage the persons care.

We also found many people were nursed in bed and there was no clear evidence why. It was not clear if this was because they were unable to get up due to their conditions or if it was easier for staff to care for them in bed. For example, one person's care plan we looked at clearly showed they could get up for two hours every other day; staff were not doing this and as such were depriving them of their liberty.

This was a continued breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent.

We found although health care professionals did visit and review we identified people were not always referred to other healthcare professionals as required. For example, on the first two days of our inspection we looked at one person's care records and found they had fallen several times. However, no referral had been made to the falls team to ascertain if any action could be taken to minimise the risk of falls. On the third day of our inspection we saw that a referral had been made and the healthcare professional advised that the home to purchase a sensor mat for use when the person was in their bedroom. However, 14 days later this had still not been purchased. During this time the person had fallen again in their bedroom. This

put the person at further risk of falling and possible injury. We spoke with the registered manager who informed us that this had been discussed with the registered provider. The registered provider told us that they had agreed for this to be purchased.

Another person had been seen by a physiotherapist and they had recommended that the person could sit up out of bed for two hours every other day. However, we found records which suggested that the person had only sat out of bed once in seven days. We spoke with staff who told us that they did not have access to care plans and that information is passed over during a handover period. One care worker said, "If we are not asked to get the person out of bed at handover, we don't. I don't know when [person's name] last got out of bed as I have been on my days off."

Another care plan we looked at clearly showed a visit form a community psychiatric nurse to review a person's mental health. They had requested that a behaviour chart be introduced and staff to record what was happening before the behaviour, what the behaviour consisted of and how long it lasted and how it was de-escalated or managed. This was so they could review to determine how the person's behaviour could be managed to improve their quality of life. We found staff were not recording the persons behaviour, yet we observed the person presenting with frustration and some daily records had recorded he had presented with behaviours that could challenge. Therefore staff were not following health care professional's advice and recommendations putting people at risk.

This was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

We observed staff interacting with people in the dining rooms over the lunchtime period to help us understand people's meal time experience. We noted people had a pleasant experience in the dining room. Some people preferred to eat in their own rooms and this was respected.

We saw that people received a varied and nutritious diet in line with their individual needs. People were offered a choice of what they would like to eat and drink and people were able to have second helpings if they chose to. One person didn't want a hot meal so salad and chips had been provided instead. People were given sufficient time and support to eat their meal and the environment was calm and quiet.

Information about people's needs, likes and dislikes in relation to food was gathered and passed onto the Chef who then catered for people accordingly. Drinks and snacks were available throughout the day and staff encouraged and supported people to take fluids outside of mealtimes. One relative told us, "The food is excellent here; they have even offered me a meal. The cook is really good and made a beautiful birthday cake." One service user told us, "I like the food, it's very nice indeed."

We talked to the cook who told us people who were identified as being underweight were offered food with a high fat content, food was enriched with cream or butter, and full fat milk was used. People were given a choice of meals from a daily menu but the kitchen would cater for people that wanted something else that wasn't on the menu. There was a plentiful supply of fresh and frozen vegetables which were used to make a variety of home cooked meals. The chef told us also had a supply of home-made sugar free desserts ready made for people that were diabetic.

However, we also observed the meal time experience for people who were cared for in bed and found this was not always a good experience and people were not supported with their nutritional needs. We saw people were left for long periods without being offered a drink and food and drinks were left in front of people who were not sat up properly. For example, one person's care plan stated they must be sat up to eat

and drink as they were at risk of choking. We observed on a number of occasions they were given food and drink and left on their side and not fully sat up.

We also found a lack of monitoring of people's weight and food intake when they had been assessed at risk of weight loss. People's nutritional intake was also not reviewed or monitored to ensure appropriate management of weight loss. For example, one person had a Malnutrition Universal Screening Tool (MUST) in place which indicated that the person scored zero. However, due to their recent weight loss (February 2018 72kg, March 2018 67kg, April 2018 66.1kg and May 2018 64.2kg) the MUST score should have been scored as one. This would have put the person at medium risk of malnutrition. The person also had a nutritional risk assessment which was assessed as being very high risk of malnutrition and dietetic advice should be sought in line with the registered provider's procedure. The person had been referred to the speech and language therapist (SALT) and information from their letter dated 5 April 2018 advised a pre-mashed diet, normal fluids from a spouted beaker and must be sat upright and midline as possible for all oral intake. We looked at the care plan in place for nutrition, and saw that it instructed weekly weights if the person lost more than 5-10% in a three month period and to refer to dietician if no improvement after providing snacks and fortified drinks for two weeks. There was no evidence to state that the person was being weighed on a weekly basis, or that snacks and fortified foods were being offered.

This was a breach of Regulation 14 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People's dietary needs were not always met in line with their current needs.

We saw at the Environmental Health inspection of the kitchen they had awarded the home 5 stars for hygiene. This showed us effective systems were in place to ensure food was being prepared and stored safely.

We were shown a training record by the registered manager who told us the training was up to date. However, we found some training was not addressed. For example, there was no training for person centred care or managing behaviour that could challenge. We also saw from the records staff had received training in dementia but this was not effective. We found staff hadn't received sufficient knowledge to safely care for people. We talked to one care worker who said, "I have had training in dementia but it wasn't very good, it was basic and didn't cover everything you're expected to know." We spoke to a visiting professional who told us they thought care workers needed more training in dementia to enable them to carry out their roles better. We could see from our observations and discussions with care workers, that some people displayed challenging behaviour, this resulted in staff receiving injuries such as scratches on their arms. Care workers told us they had not received any training on how to best care for people that were challenging and told us when they had discussed this they were told, "You're in the wrong job if you can't handle it."

We were told staff received regular supervision. However, we identified this was not effective as this did not address lack of staff knowledge or lack of effective care. Staff had also not received a medication supervision, which would have addressed the poor practice we identified.

This was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing. Staff did not receive appropriate support and training to enable them to carry out their duties they were employed to perform.

We looked at the design and adaptation of the service and saw people were restricted from accessing outside space. The service had spacious communal lounges, quiet rooms, dining areas and a large enclosed garden, with disabled access. However, during our inspection we noticed that people were not accessing the outside area, despite it being a beautiful sunny day. Some of the patio doors leading to the outside were

locked and access could not be gained. When we asked care workers why people were not using the garden they said "It's too warm for people and we don't have any parasols for people to use." We talked to a professional who said it would be beneficial to the wellbeing of people living with dementia to have access to the outside space. People with dementia generally will be less likely to become agitated and distressed if they can have regular access to fresh air and exercise and a quiet space away from others as needed but this was not provided during any of our visits. One care worker said, "People are generally bored, they have no stimulation and the sensory room is a joke, it's not suitable for people with dementia, neither is most of the environment and décor. There is just so much more that can be done here."

One person told us how they had made some hanging baskets and these were in the courtyard and at the front of the home. They showed us pictures of their house and garden when they used to plant flowers every summer it was obvious they enjoyed being outside and gardening. However, the person was upset as he was unable to go and water the hanging baskets. Staff said, "we don't have time to take them outside and if we do it is just to water then come straight back in as there is no one to observe them [people who used the service] so they can't stay outside." We found out the person had not been outside to water them for three days. This had a negative impact on their well-being and mental health.

This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care. People did not receive care that was personalised and met their needs.

Inadequate

Is the service caring?

Our findings

People we spoke with told us that when staff were giving support and care they were kind and considerate. We observed when staff did engage to give support they were respectful. We found some relatives made positive comments about staff. One said, "I can say I am happy with the care."

However we also had people and relatives tell us staff could be abrupt and uncaring. One relative said, "I am really unhappy with [my relatives] care." Another said, "I am really concerned about [my relatives] care."

We found the staff were not wholly supported by the registered provider to deliver a caring service. Due to the shortfalls we found at the service, the ability of staff to provide a holistic approach to people's care was restricted by safety issues, not obtaining proper consent from people, and ineffective governance and leadership. This meant that people were not always at the centre of the care they received.

During the three days of our inspection we spent time observing staff interacting with people who used the service. On the first two days we found staff were kind and caring and responded to people in a sensitive manner. However, due to the lack of staff available their interactions with people were limited and kept to a minimum. On the second day of our inspection we saw some staff were abrupt with people who used the service, walking past people as they were speaking with them and disregarding what their response was. For example, we observed one care worker walk past someone's bedroom, spoke with them but carried on walking, not even waiting for the person to respond before they carried on past. Another care worker walked past another person's bedroom saying, "Are you going to drink your tea [person's name shortened]." This care worker shortened the person's name, which was not in line with their preferences, and did not offer to assist the person or wait for them to response. We also observed a care worker shouting to another in the dining room that they should not have a drink until after their meal as they might throw it. This was disrespectful to the person and not meeting their needs, or respecting choice.

However, we saw occasions where staff showed concern for people's welfare and responded to people in a kind and appropriate manner.

During our observations we saw one member of staff that didn't knock on people's bedroom doors before entering; they were observed to go in without explaining to people what they were doing there. They appeared to be very task orientated and not aware of people's privacy and dignity.

People's care records were stored in the treatment rooms, which we saw were kept not always locked, when unattended. Staff didn't always maintain people's confidentiality and weren't always mindful when they spoke to their colleagues about people's needs.

The registered provider did not offer many opportunities where people who used the service could express their views and be actively involved in their care. For example, the home did not hold any meetings for people and their families to allow them to engage with the registered provider and registered manager on a formal basis. We spoke with the registered provider and the registered manager about this and were told

that meetings used to take place but relatives did not attend them. We were also told that the registered manager operated an open door policy where people could approach them whenever they felt they needed to discuss anything.

This is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care. People did not always receive care that met their individual needs.

Inadequate

Is the service responsive?

Our findings

We observed staff interacting with people who used the service and found that people did not always receive personalised care that was responsive to their needs. We looked at care records and found they did not always fully reflect people's needs. We saw conflicting information in people's care plans which meant staff weren't always aware of accurate or up to date information. For example, we saw it recorded in one person's care plan they had not been diagnosed with dementia, but another section stated that they had a diagnosis of dementia.

Care plans were kept downstairs and were accessed by the nursing staff. We asked staff if this was difficult as people who lived upstairs had their care plan held downstairs. One nurse said, "It's easier this way. When professionals visit we can access record quickly." However, care workers told us that they never look at care plans and that this was the nurse's role. Care workers only had access to daily records. This put people at risk of not receiving the care they needed. For example we saw that one person had a glass of juice at the side of their bed, the juice had not been thickened in line with their assessed need. As staff didn't have access to the care plans they could have given the unthicken fluid to the person, which would have put them at risk of choking. We brought this to the attention of the registered manager at the time of the inspection, who agreed this was a risk.

The registered provider did not ensure that people's social needs were met. The registered provider did not employ an activity co-ordinator but the administrator organised some events. We looked at one person's care plan in relation to psychological and emotional support. The plan stated that the person enjoyed music and watching TV, but did not participate in activities as they were cared for from bed. There was no mention of any social activities being provided in the person's bedroom. We looked in another care plan and saw it was recorded the persons enjoyed listening to the radio, CD's and had access to an audio newspaper, however we did not see the person having accessing to these things during our visit, nor did we see these activities being recorded within the persons daily records. This showed that the registered provided did not consider other options for the person, which left them at risk of social isolation.

Relatives we spoke with told us there was lack of activities and stimulation. One relative said, "The lounge is always like a waiting room scenario and staff are just sitting around. There is nothing to do just the television on."

This is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care. People did not always receive care that met their individual needs.

The provider had a complaints procedure in place and a record of concerns raised. However, we spoke with some people's relatives and found they had raised concerns with the registered provider, but were not happy with the outcome.

The service provided care and support for people at end of life. We saw there was information in care plans regarding the decision to not resuscitate (DNAR). These had been drawn up by the person's GP and included

the person where relevant and their families. There were end of life care plans in place. However, these lacked detail and the plans did not show consultation with the person to ascertain their wishes, choices or beliefs to ensure these were documented for staff to be able to follow in the event that their health deteriorated.

Inadequate

Is the service well-led?

Our findings

At the time of our inspection the service had a registered manager in post. 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.

There was lack of governance and oversight as the service had not been effectively managed.
The management team consisted of the registered manager, a clinical lead, nurses and senior staff. The home was also supported by an administrator. On the first day of our inspection we looked at the rota and found the registered manager did not have any supernumerary management shifts to enable them to manage the home effectively. This had an impact on the service delivery, governance and the leadership of the service. For example, the registered manager had not had dedicated time to complete audits or evaluate the service in any way. We spoke with the registered provider and the registered manager who told us they would ensure specific time would be identified for the management of the service.

On the third day of our inspection we found the registered manager was completing all their hours' supernumerary to the rota and specifically for management tasks. The registered manager told us they had found this had given them more time to focus on the leadership of the service and they felt they had a better oversight. Due to this we found some changes had occurred, but this needed developing and better oversight and leadership for staff was required.

The registered provider had some systems in place to monitor the service and to identify areas to develop. However, we found that these systems had not always been completed or used effectively. Therefore issues we identified as part of the inspection had not always been identified or where they had been identified, not enough action had been taken to ensure they were addressed effectively. For example, we saw a weight audit had been completed and identified people who had lost weight. However, we saw from people's care records, which no action had been taken to address this.

We also saw that an accident and incident audit had been completed. This included the number of people who had fallen and any injuries sustained. We looked at the audit and found that several people had fallen on a frequent basis, but no action had been taken to minimise this risk and no referrals made to relevant health care professionals. Trends and patterns were not identified or monitored, therefore lessons were not learned when things went wrong. We spoke with the registered manager who completed a deeper analysis by the time we returned on our third day of inspection. However, this process required embedding in to practice.

There were no opportunities for people who used the service, staff, or relatives to voice their opinion or be involved in the service. We asked to look at meetings minutes and the registered manager told us the only meeting which took place was the management meeting. Information was then cascaded down to staff where relevant. However, this did not offer a forum where staff could voice their views and raise issues about the service.

On the third day of our inspection we found small changes had taken place. The registered manager had prioritised urgent areas which needed addressing and had taken some action. However, we still had a lack of confidence in the registered provider to ensure concerns raised on our inspection would be dealt with appropriately and in a timely manner.

This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

Staff told us they felt that improvements needed to be made around the home and with the management of the service. Their comments included, "The manager is good but he's always too busy," and, "The manager is really good, he's very supportive. The provider needs to step back and let the manager do his job and stop changing the goal post about what was expected of the staff." They said this had led to them feeling, "Frustrated as a team." Another care worker said, "We pass ideas on to management in the hope to make improvements but things are not actioned we are just not listened to."

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	People did not receive care that was person centred and met their needs.

The enforcement action we took:

We have taken enforcement action to cancel the registration and issued a notice of proposal.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	peoples consent to care and treatment was not always sought in line with legislation.

The enforcement action we took:

We have taken enforcement action to cancel the registration and issued a notice of proposal.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Risks to people were not managed putting people at risk of harm. Medication was not managed safety and did not ensure people received their medications as prescribed.

The enforcement action we took:

We have taken enforcement action to cancel the registration and issued a notice of proposal.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs
Treatment of disease, disorder or injury	people's nutritional and hydration needs were not met.

The enforcement action we took:

We have taken enforcement action to cancel the registration and issued a notice of proposal.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to ensure systems and processes were established and operated effectively to be able to evidence compliance with regulations.

The enforcement action we took:

We have taken enforcement action to cancel the registration and issued a notice of proposal.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had failed to ensure staff were effectively skilled, experienced, supported and deployed to meet peoples needs.

The enforcement action we took:

We have taken enforcement action to cancel the registration and issued a notice of proposal.