Care Quality Commission

# Eldercare (Halifax) Limited

# Sun Woodhouse Care Home

## Inspection report

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## Ratings

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

## Overall summary

We inspected Sun Woodhouse over four days on 21, 22 and 26 January and 1 February 2015 and the inspection was unannounced.

Sun Woodhouse provides accommodation and personal care for up to a maximum of 24 older people. At the time of our first visit there were 16 people using the service, this number increased to 17 when a person was admitted for respite care. The accommodation is arranged over two floors and there is a stair lift on the main staircase. There is one lounge and one dining room on the ground floor and bedrooms are all single occupancy.

There is a registered manager who has been in post since March 2014. 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.

People who used the service told us they liked the staff and found them helpful, kind and caring.

We found poor standards of cleanliness and infection control in the home and found that systems were not in place to support safe management of medicines.

# Summary of findings

Systems were in place to make sure staff were recruited safely and staff knew how to recognise signs of abuse what to do to safeguard people.

Staff had received good levels of training and supervision but were not available in sufficient numbers, or through appropriate deployment, to meet the needs of the people living at the home.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. We found that the manager and staff had an understanding of this but it was not reflected in the care plans of people whose needs had been considered in line with the legislation.

People's dignity was not always promoted and there was little to suggest that care was planned and delivered in a person centred manner.

Care plans were not sufficient for staff to be able to support people's individual needs safely.

People did not always have their nutritional needs met.

People told us they enjoyed it when people came to the home to entertain them or when they had parties. However we found little evidence of people being offered meaningful activities on a daily basis.

There were no robust systems to monitor the quality of the service in order to drive improvement.

We found some breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report. Sum

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

Inadequate

The service was not safe. Although people told us they felt safe, we saw poor standards in relation to infection control and level of hygiene within the home.

Systems for managing medicines were not safe.

Management and response to accidents and incidents within the home was not robust.

**Is the service effective?**

Requires Improvement

The service was not always effective.

Staff received training and supervision but did not always put their training into effect through their work. Staffing was not well organised

The registered manager had an understanding of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS).

People's nutritional needs were not always met

**Is the service caring?**

Requires Improvement

The service was caring in that staff were kind in their approach to people.

People told us the staff were good but they did not always take actions to make sure people's dignity needs were met.

**Is the service responsive?**

Inadequate

The service was not responsive

Care was not planned in a person centred manner.

Care plans were not available to make sure people's needs were met safely and in the way they preferred.

There was a lack of meaningful activities on offer for people at the home.

**Is the service well-led?**

Inadequate

The service was not well led.

The manager did not display effective leadership within the home.

There were no effective systems in place to monitor the quality of the service.

Accidents and incidents were not monitored appropriately

# Sun Woodhouse 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 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 over four days on 21, 22 and 26 January and 1 February 2015 and was unannounced. The visit first was interrupted by inclement weather which meant inspectors had to leave and return the next day. Further visits were made to obtain more information about the service and the views of the people who lived there and their relatives.

There were three Adult Social Care inspectors involved in this inspection over the four days. Prior to our inspection we reviewed information from notifications, the local authority commissioners and safeguarding. We had sent the provider a 'Provider Information Return' (PIR) form prior to the inspection. This form enables the provider to submit in advance information about their service to inform the inspection. This form had not been returned by the provider.

We spoke with six people who used the service and three relatives during our visits. We spoke with the registered manager, the Chief Operations Officer and six staff. We observed how people were cared for, inspected the premises and reviewed care records for four people. We also reviewed documentation to show how the service was run.

Inadequate

# Is the service safe?

## Our findings

Three people who lived at the home told us they felt safe at the home and were confident that staff would look after them well. When asked, one person said "Oh yes, these girls wouldn't let any harm come to me."

During our inspection we spoke with three members of staff about what they would do if they had concerns about the safety of people living at the home. Staff were able to tell us what they would do to ensure a person was safeguarded against abuse or neglect and they were knew about whistleblowing procedures should they need to report poor practice.

We looked at how accidents and incidents were recorded. We found that whilst records were kept, some lacked critical detail. For example, we saw an accident record of a person having fallen and we cross checked this with the person's care records. The care records showed the person had sustained a fracture and been taken to hospital, yet the accident record did not reflect this.

The registered manager told us accidents and incidents were monitored and information was reflected in people's care records. For example, if a person had frequent falls, their care plan would be updated and their risk assessment reviewed. However, when we cross referenced accident records with one person's care file, we saw this was not happening in practice. For example, their care file stated on 17 November 2014 'no falls identified', yet accident records showed this person had fallen twice in the previous week.

We saw that staffing levels were arranged at one senior and two care assistants between 8am and 8pm. An additional care assistant worked between 2pm and 5pm to cook and serve the tea-time meal which was the main meal of the day. A chef worked 7am to 1pm and a member of cleaning staff worked 8am to 2pm daily. The registered manager worked mainly 8am to 4pm weekdays and was not included in the care staffing hours.

We observed long periods when care staff were not available in the main lounge area. On two occasions we had to alert staff to people who needed assistance. On one occasion we were unable to find staff and one of the inspectors had to intervene in order to protect the dignity of a person who lived at the home.

This breached Regulation 22 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because there were not enough staff available to meet people's needs.

Only one person in the lounge had ease of access to a call bell which the Registered Manager told us was the person's own emergency call system and not linked to the main call bell system of the home. The system used a pendant and receiver system. The person had the pendant and one member of staff had the only receiver. However, if the member of staff with receiver was busy with another person, they would not be able to react to the pendant alarm. We also noted call bells tied out of reach in toilets and some bedrooms. This meant that people did not always have access to a safe call system.

Prior to our inspection we had seen the findings of an inspection carried out by the infection control nurse from the local council. The initial inspection had taken place in April 2014 and a review completed in June 2014. We saw that many of the instructions given to the service had not been actioned at the time of the review.

On the first day of our inspection we looked around all the communal areas in the home and the majority of bedrooms. In the lounge we saw a number of chairs did not have seat cushions in and we saw a number of dirty side tables.

We saw the visiting hairdresser was using an area in one of the ground floor toilets to wash and cut people's hair. The toilet in this room was behind a partition wall. The toilet was dirty, had not been flushed and there was no toilet paper available. The hairdresser had not been provided with a table for their equipment and was using the clinical waste bin for this.

In another toilet the top of the toilet bowl was so dirty that it posed a risk of cross infection for other people who used the toilet. In the hand wash basin, the tap was constantly dripping and the water from the hot tap was cold. There was no toilet paper available.

Six of the ten bedrooms we looked at were not clean. We saw dirty and stained bed-linen and chairs, cob webs around light fittings in high level areas and noted offensive odours in four of the rooms.

As we were entering one room a member of care staff alerted us that the cleaner had just been in this room and

# Is the service safe?

the floor was still wet. We saw the door to the room was dirty on both sides and the walls of the room were dirty with food and drink spillages. There was a sign in the middle of the room warning people the floor was wet. However the floor was very sticky and there was evidence spillages had not been mopped up. When we looked under the bed, we saw a stain that looked and to the inspector like vomit. There was a collection of dust, dirt and debris under the bed and the bedside drawers. In a cupboard under the sink in the en-suite there was some old orange peel. There were no hand towels and the ceiling light wasn't working. There was no light shade around the light bulb. A shelf had become detached from the wall near the toilet and had been left sitting on top of the radiator. The front and sides of the toilet were dirty. The manager was not able to tell us why the room had not been cleaned.

When we returned the next day we found some cleaning had been done in this room. However we saw, and pointed out to the registered manager, a stain on the floor that had not been cleaned since the previous day. There were no suitable hand washing facilities; the towel dispenser was empty. The floor had dry and fresh urine stains on the floor in the en-suite. The chair in the room had not been cleaned; there was dust and a pen in the chair which the inspector had seen the previous day, as well as staining to the seat. The skirting boards were visibly dirty and there was staining to the walls and the bedroom door. The registered manager insisted the room had been cleaned since the previous day, but the inspector demonstrated their concerns by wiping the floor with a disposable wipe and showing the registered manager dirt removed.

In another room, the inspector pointed out what the manager agreed to be faecal staining on the protector sheet of the mattress. This had been shown to the manager the day before. However, the registered manager stated this mattress had been checked.

On both days we saw that several bedrooms and bathrooms did not have suitable hand washing facilities and many did not have gloves and aprons available for staff to use in order to minimise the risk of cross infection. In the dining room the hand washing facility was empty. This meant staff could not ensure their hands were clean when supporting residents to eat their meals. The manager said the soap for the dispensers had run out and they did not have any further supplies in stock.

We noticed that almost all of the mugs people who lived at the home were using were cracked, damaged and discoloured drinking mugs. We also saw plates used for people to have their meals in the same condition. The chef told us there was no other crockery available to use. On our third visit we saw some new plates had been obtained and we heard the manager asking the handyman to go to the 'Pound Shop' to purchase new mugs.

When we looked in the kitchen we saw a bucket full of very dirty water in the room with a dirty mop standing in the water.

On the second day of the inspection we went to the laundry room which was within the cellar and had steep stone steps leading to it. The laundry was extremely damp with high levels of humidity making it difficult to breathe. This was created by washing and drying laundry with inadequate ventilation. The floor was damaged to the surface of the concrete, very slippery and the whole of the basement area was filthy. We had seen from the most recent inspection, by the infection control nurse, that an instruction had been made to paint the floor. The manager told us it had been done within the last two months. However, when we asked the nominated individual about this, they said it had not been done. There was a broken and dirty commode discarded in a corner, green slimy substance which coated the walls, some used and discarded rubber gloves in a dirty bowl on the floor. The sink had a drainage pipe that ran into an open grate on the concrete floor which was covered in a black slimy film. Appliances for washing and drying people's laundry were filthy; for example the seal and glass door of the washing machine was stained brown. There was a broken fan in operation, precariously propped up against a wall adjacent to the tumble drier. Its base was broken and it was covered in a layer of thick dust. There were three coloured fabric laundry bins used to store items waiting to be washed. These were full of soiled items and there was a pillow on top of the red laundry bin which was heavily stained with a yellow substance. Odours from these laundry bins were overpowering. There were no hand washing facilities or personal protective equipment (PPE) available in the cellar. On a clothes rail we saw there were people's items of laundered clothing, some of which were covered in mould. Also hanging on the rail was a very dirty, mouldy and stained coat. The Registered Manager told us they did not know who the coat belonged to.

Inadequate

# Is the service safe?

When we returned four days later, we saw the cellar area had been cleared of some of the clutter we had seen the previous visit. The wall had been painted over so the green, mouldy surface was less visible. The dusty broken fan was back in operation and there was another piece of equipment, which the registered manager confirmed to us as a dehumidifier. We noted this equipment had little effect on the humidity in the cellar. The clothes rail remained as we had seen it on the previous inspection day with mouldy items of clothing still hung on it. The washing machines were still visibly dirty, one of which appeared not to be in use. This machine had a lumpy substance/debris around the seal. There were two broken baskets of damp laundry on the floor in front of the tumble driers. We saw items were mixed; sheets with underwear, table cloths and towels and some of these items were over spilling the baskets onto the dirty floor.

We saw people's laundered personal items in baskets, some of which were named. When we checked one basket we saw the items named in the basket were different to the label on the basket. We saw one person's underwear items were screwed up, creased and stained, yet in the basket ready to return to their room.

We saw a hoisting sling in the bathroom which was stained and damp. We asked a member of staff about this and we were told this particular sling was only used for one person and the slings were meant to be washed daily. We asked the staff member if the slings were washed daily and they shrugged and shook their head.

We saw staff support a person to change their clothing when they had needed assistance with their personal care. However, when staff returned the person to the lounge, they were about to assist the person to sit back in the chair which was wet with urine. The inspector had to intervene to prevent the person from being seated in the wet chair.

These observations breached Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because systems were not in place to protect people against the risks of cross infection and the premises were not cleaned to an acceptable standard.

During our visit we looked at the systems that were in place for the receipt, storage, administration and return to pharmacy of medicines. We saw a monitored dosage system was used for the majority of medicines with others supplied in boxes or bottles.

On one person's medication administration record (MAR) sheet we saw that thirteen signatures of administration had been recorded for the person's pain relieving tablets. We saw that thirty two tablets had been received from pharmacy. The prescription was for one or two tablets to be given as required. No record had been made of whether one or two tablets had been administered. However we found there were twenty four tablets still in the box. This meant that only eight tablets had been administered.

We looked at three other people's MAR sheets and found we could not reconcile the amounts of tablets still available against the amounts recorded as received and administered. The senior care assistant told us that some tablets had been returned to pharmacy; however no record had been made of this. Another person's tablets could not be reconciled as no record had been made of a further supply of the tablets being delivered to the home.

When we looked in one person's bedroom, we had found a tablet on the floor. The tablet was identified by the Registered Manager. When we looked at the person's MAR sheet, we saw the tablet had been recorded as being administered to the person.

In the manager's office we saw three prescriptions signed by the doctor. One of these was dated two weeks prior to the inspection but two were three months old. The manager told us the medicines had been obtained but the prescriptions had not been handed to the pharmacy.

We looked at the temperature records for the medicine fridge and saw that for the last forty four entries the temperature had been recorded as 4 degrees C with one record of 3 degrees C. However, when we checked the temperature it was minus 2 degrees C. This meant that medicines in the fridge were not being stored at a temperature suitable to maintain their therapeutic effect. It also indicated that temperatures were not being taken accurately.

This breached Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because medicines were not managed safely.

We looked at two staff files and saw the recruitment procedure was robust to ensure staff were vetted before being able to work with vulnerable adults. Staff files

Inadequate

# Is the service safe?

contained evidence of interviews, two references, Disclosure and Barring Service (DBS) checks and identification checks. This meant that staff were recruited safely.

On the first day of our visit we found a drawer in the entrance hall contained a number of tools including a small saw. This drawer was not locked and was in an area used by people who lived at the home. Access to this equipment could have put people at risk. We brought this to the attention of the registered manager who said the equipment belonged to the handyman. When we checked the drawer on our visit the following day we saw the equipment had been removed.

Requires Improvement

# Is the service effective?

## Our findings

People we spoke with told us they enjoyed the food at the home. One person said "It's too good" and another said "I really like it when we have chocolate ice-cream." One person told us they never drank the hot drinks they were given because the staff put too much milk in them. They said they "liked hot drinks" but the milk made them too cool to enjoy. Another person told us their drink was "luke warm" because there was too much milk in it.

During our inspection we looked at two staff personnel files. We saw records of regular supervision and appraisal meetings and a record of staff competency checks for areas of staff knowledge such as administering medication and safeguarding adults.

We saw evidence of training having been carried out and saw that future training was planned. Staff told us they were expected to complete mandatory training for the organisation. We saw in two staff files, there was evidence of induction and ongoing training. The training matrix identified staff had completed recent training in fire safety, food hygiene, moving and handling, health and safety, safeguarding adults, infection control, nutrition, safe handling of medication, Deprivation of Liberty Safeguards (DoLS), care planning, first aid, dementia, palliative care and equality and diversity.

We spoke with one member of staff who confirmed they felt supported to undertake training to enhance their role.

Our findings in relation to poor standards of cleaning, infection control, medicine management, meeting people's dignity needs, care planning, meeting nutritional needs and quality auditing would suggest that staff were not suitably skilled to safeguard the health, safety and welfare of people who live at the home.

This demonstrates further breach of Regulation 22 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because staff did not have the skills necessary to safeguard the health, safety and welfare of people who live at the home.

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

Prior to our inspection we had been informed by the Registered Manager that a person had left the home and had been returned by the Police after getting lost. The manager had told us that in response to this, the front door was to be double latched as well as the key code lock in place.

We looked at this person's care file and saw that a mental capacity assessment had been completed which concluded the person lacked capacity in some areas including making the decision to be able to leave the home independently. We saw the Registered manager had assessed the restriction and discussed it appropriately with the local authority in relation to all the people living at the home. We also saw that the locked door had been discussed with the only person living at the home who went out independently and they had agreed to the restriction in place. We saw this person was still able to leave the home without asking for staff support.

The manager and two staff we spoke with demonstrated an understanding of the Mental Capacity Act but we did not see that this had been incorporated into the care planning process. For example we did not see record of people who lived at the home having been asked for their consent in relation to their care plans. An example of this was a care file for one person which included details of a review of care with the person's next of kin. We also saw the next of kin had signed agreement of the care plans. The manager told us the person did have capacity to understand this process and had been present at the review. However the records did not indicate this had happened.

One care file we looked at had not been updated since November 2014, despite the registered manager stating the person had recently deteriorated in health. Information about the person showed they were high risk of falls, yet there was no information about the equipment they might need or the care and support. We saw on the daily notes in this person's file they had fallen and sustained a fracture. The accident record stated '[person] found on bedroom floor, admitted throwing themselves out of bed' '[person] was demanding and rude, please read care plan' yet there was no corresponding care plan entry. No information was in the file about what had been done in relation to the

person's pain, moving and handling, equipment or risk assessments. We asked the registered manager about this and they told us a follow up appointment was made at the hospital. We looked in the appointments book and saw a hospital card detailing a follow up appointment, but there was no other evidence to show this person had attended the appointment and the care record was not updated.

We saw from weight records that four people had lost weight. This included two people who had been steadily losing weight for a year. This weight loss had not been highlighted as a problem within auditing systems, or referred to healthcare professionals. This was because the people had not lost two kilograms or above in a one month period. This was the trigger within the home's risk assessment tool for referring to the dietician or other healthcare professional. We saw one person had lost over one stone in twelve months and another had lost almost a stone in eight months. Both had experienced a consistent weight loss.

We looked at the care file for one of these people with regard to their nutrition. We saw the person's weight loss had been recorded in a review of their nutritional care plan but the care plan itself did not include details of the person losing weight or what actions staff should take to prevent further weight loss.

We looked at the nutritional intake records for this person for the previous week. The record did not include any detail of the food the person had eaten with just a tick put against the headings 'None, Tspoon, ¼, ½, ¾ or All.' As the food the person had been offered was not included on the record, or how much had been offered, it was impossible to assess whether the diet the person had received was sufficient to meet their needs.

We saw the person had diabetes. We asked the cook what food, in particular desserts, were available for people with diabetes. The cook said they did not have anything, and did not have the means to make anything. For example they did not have any sugar substitutes at all. This meant people with diabetes were not being offered the same choice as other people. The cook was not able to tell us why the service no longer used sugar substitutes and said people with diabetes could have fruit or yoghurt. We saw the yoghurts available were low fat and therefore would not have the calorific content needed to prevent further weight loss.

We asked the cook if any of the people living at the home required fortified food. The cook did not understand what we were asking and told us about soft diets. This meant people who needed to gain weight may not be able to because the cook wasn't aware of how to make the meals more calorific.

This breached Regulation 14 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because people were not receiving the nutrition they needed to meet their needs.

We saw people were offered choice and the cook told us they would always provide an alternative if a person didn't want what was on the menu. We saw the menus were not always well planned to offer variety. For example, on the first day of our inspection the lunchtime meal was pie and peas. The menu showed the tea time meal to be a choice of chicken pie or shepherd's pie with peas and corn. The vegetables for the main meal the following day were also peas and corn.

The manager told us they had recently introduced a change in the way meals had been organised. The main meal was now offered in the evening. The cook only worked mornings and therefore prepared breakfast and the snack style midday meal. The manager told us care staff would be responsible for making the main tea-time meal. This meant that the cook's skills were not being fully utilised and that staff not trained in this area were responsible for the majority of cooking.

We saw from people's records and from speaking to staff that some of the people were living with dementia. However we saw little to support people with orientation. The signage on the toilet doors was worn and not legible. People living with dementia sometimes have problems reading signs and rely on pictures to let them know where facilities, such as the toilet, can be found. There was no information available to support people's orientation to the day, date and time and there was nothing available to let people know of any planned activities. In the corridor to the lounge we saw a large advent calendar shaped like a Christmas tree. This would be very confusing for people with memory problems and could result in disorientation because they may believe it to be Christmas time. There was no information visible letting people know which care staff would be on duty and no photographs of staff had

Requires Improvement

# Is the service effective?

been made available for people who have difficulties with communication. This meant that the needs of people with memory problems or people living with dementia had not been considered.

This breached Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because staff had failed to consider, and take action to meet, the needs of people living with dementia.

We saw from care records that healthcare professionals such as GP and district nurses had been involved in people's care. We spoke briefly with a visiting district nurse who told us they thought staff worked well with them.

Requires Improvement

# Is the service caring?

## Our findings

During our visit we spoke with one visitor who told us they thought their relative received good care in the home. They said staff kept them informed about their relative's health and well-being and welcomed their visits at any time. The visitor said they had spent some time residentially in the home when their family member was ill and they were satisfied staff did what they could to ensure their relative's needs were met. They said when their relative was ill; staff involved the GP and made sure they had their medication on time.

Another relative told us they had had some problems but felt these were starting to be resolved.

One person who lives at the home told us staff were really good and they viewed them as "friends." Another person told us staff were "very good."

We observed staff interacted with people in a kind and friendly manner. However our observations were that staff did not always consider people's dignity needs. For example we saw people wearing clothing with dried on food and drink spillages. We saw one person with a large brown dry stain on their shirt. We spoke with the person's relative, who told us staff had said they were just about to change this as the person had spilled something earlier. They told us their family member was usually well presented.

We checked a sample of three people's clothing in their rooms and saw some items in drawers and wardrobes had stains or vivid black marks on them. The registered manager told us the tumble drier was causing black marks and it was due to be replaced. When asked, she said it had been doing this 'for a few weeks' and the organisation intended to replace people's damaged items. We saw in the maintenance book the tumble drier had been noted as faulty since March 2014. Nothing had been done at the time of our inspection to address the issue of people's clothing being ruined and people were still wearing these clothes.

We saw one person who presented with specific support needs in relation to their appearance. We asked the manager if staff should support this person with the specific need. The manager said they should. When we asked the manager if this was in the person's care plan they said "No but it will be." This meant that the person's need in this area had not been considered until we pointed it out.

On our first visit we saw one person in a state of agitation. Staff took this person to their room and tried to calm them down and find out what was causing their distress. However, this was done with the person's bedroom door open and their calling out and distress could be heard in the lounge.

We saw one person had had an episode of incontinence in the lounge. Staff supported this person to the toilet, but the staff member was not discreet in their conversation with the person and did not attempt to protect the person's dignity in this situation adequately enough. Staff also failed to deal with cleaning the chair until prompted by the inspector.

We saw one person whose clothing was ill-fitting and at times, the person's body was exposed in a way that did not protect their dignity. A person visiting the home told us this was a regular occurrence. We asked the registered manager if they had given any consideration to supporting the person to look for clothing which would better protect their dignity. The manager said they had not.

These examples we observed breached Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because people's dignity needs were not met.

We saw little evidence that people who lived at the home were involved in their care. Care plans and reviews did not reflect that the person had been involved in this process. On several occasions we saw staff writing in people's daily records. However staff did this without any interaction with the person whose records they were completing. This meant that records were made from the point of view of the staff rather that the person involved.

Inadequate

# Is the service responsive?

## Our findings

None of the people we spoke with were able to tell us about how they were involved in making decisions about their care. One person said "Do they have things written down about me?"

When we asked people about activities they told us about events that had taken place such as the Christmas party and when entertainers came to the home. They said they really enjoyed these times. One person told us that they had been enjoying watching a sporting event on the television but staff had changed the channel without consulting anybody. One person told us that staff arranged for people from their religious group to come into the home for Bible studies.

Other than playing dominoes people were unable to tell us about any regular activities taking place in the home. We observed staff playing dominoes with people on three separate occasions during our visit.

We saw the television was on all the time in the L shaped lounge. We asked the people close to the television if they liked the programme that was showing, they said they did not. Staff told us that two of the people sitting in a further part of the lounge did like the programme. However we found these people had limited visibility to the television and could not hear it as the volume was on very low. At one point during the day the inspector noted that the programme on the television included a detailed explanation of intimate feminine issues. There were no ladies watching the television and no staff were available to check if people found this appropriate viewing for them.

During our visit we looked at care records for three people who lived at the home and one person receiving a period of respite care.

None of the care plans had been prepared in a person centred manner. Person centred care means that care is planned in a very individual manner and takes into account the person's needs, preferences, beliefs, histories and social and family network. None of the care plans we saw were developed from the point of view of the person involved.

One of the care files we looked at did not contain up to date details of the person's needs in relation to nutrition, weight loss or diabetes. We saw that none of this person's assessments of need had been reviewed for over six months.

We looked at the care file for a person who the registered manager had identified to us as living with dementia and a physical condition which caused severe pain. There were no care plans in relation to supporting this person with their dementia and related communication difficulties. Neither was there a care plan for managing the person's pain.

We looked at the care records for a person who was at the home for a period of respite care. We saw the care records included assessments in relation to skin integrity, nutrition and falls. However there were no care plans in place. Care staff told us the person had reduced mobility due to physical problems and had particular needs in relation to elimination. There was no information relating to this within the care records. We asked a senior carer what they knew of the person's preferences in relation to their personal care. The staff member said they didn't have that information.

This breached Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because staff did not have the information they needed to meet people's needs safely and in the way they preferred.

This also demonstrated a breach of Regulation 20 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because records were not in place to protect people against the risk of unsafe or inappropriate care.

Inadequate

# Is the service well-led?

## Our findings

One of the visitors we spoke with told us they had met with the registered manager to discuss some issues with their relatives care. They told us things had improved since this meeting.

The home's manager had been registered with the Care Quality Commission since March 2014 but had been managing the home for over a year prior to their registration.

On the second day of our inspection we looked at the systems in place for monitoring standards of service within the home. When we had arrived on our first day the manager told us they were confident that they were keeping good checks on the quality of the environment within the home. They told us they completed a daily walk around and that staff did two other 'walk arounds' every day. We saw manager walk round sheets were filled in, but these did not identify the areas of concern we highlighted through our inspection.

We looked at evidence of quality audits the registered manager showed us. We found these were superficial lists of checks rather than evaluation of quality. These audits lacked rigour and were not robust enough to give assurance of thorough checks having been carried out in the service.

For example, the registered manager told us she had instigated daily mattress audits in response to the inspector's observations the previous day. The registered manager showed us the mattress audit which consisted of a handwritten sheet of paper with the rooms listed where mattresses had been checked. The sheet was not dated or signed but the registered manager confirmed this was a record of what had been checked that day and said the senior care staff member had carried out this audit. Against each room there was a brief comment, such as 'normal intact', 'pressure intact' and 'needs protective cover'. The mattress in one room, which we had seen was still dirty, was on the list as having been checked that day. We spoke with the member of staff who said they had completed the mattress checks that day. However, they confirmed they had not been given any training or demonstration in how to audit the mattresses, but used a guidance document 'to work it out'. We saw a typed mattress audit dated December 2014, but the registered manager could not show us any more audits. She said she transferred the staff's handwritten checks onto a computer matrix and other mattress audits would 'be on the computer'.

The registered manager told us accidents and incidents were monitored and information was reflected in people's care records. We found this was not always the case.

We saw a monthly incident/accident analysis report for August, September and October 2014. The registered manager confirmed no such analysis had been completed for November and December 2014.

The monthly bedrail audit identified bedrails in three rooms. However, we saw there were bedrails in one person's room that were not included on the audit. Staff we spoke with could not tell us when the person had their bedrails installed; one member of staff said 'about a month' and another said 'a few weeks'. There was no information on the person's care records to show when bedrails had been installed and there was no risk assessment in place to support the safe use of this equipment.

There was no evidence of residents' and relatives' meetings having been carried out. The registered manager told us they had tried to introduce these but found people were not interested and so they planned to review this to create other ways to obtain the views of people and their relatives.

No quality satisfaction surveys had been carried out since July 2013. The results of these were displayed in the entrance to the home; however, these were based on only three responses received out of 26 sent.

We saw the maintenance file showed aspects of the premises which had been serviced by external companies. We saw certificates in respect of lifting equipment, legionella checks, electrical and gas safety. We noted on one gas engineer visit report, it was stated the gas pipe work in the kitchen needed replacing. We asked the registered manager about this and she stated the gas engineer had not reported the pipework as unsafe, but made recommendations for improvement. We asked for evidence of plans to do this but the manager was unable to provide this information.

Records showed internal checks had been carried out and the maintenance member of staff completed a weekly maintenance report of these. The maintenance member of

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staff was certified to complete portable electrical appliance testing (PAT). However, our observations of the premises and equipment gave us cause for concern that such maintenance checks on premises and equipment had not been carried out thoroughly as stated on records we looked at. None of the electrical equipment in the laundry had been PAT tested and there were some items of electrical equipment in people's rooms with PAT stickers that were illegible.

We spoke with the Chief Operations Officer who is the Nominated Individual for the service. This is a person nominated by the registered provider to be responsible for making sure that good standards are maintained in the delivery of service to people who live at the home. The Nominated Individual was not able to tell us why they had not been aware of the issues we had identified during our inspection.

We asked to see copies of the most recent quality monitoring visits to the home. Four of these were sent to us by the Chief Operations Officer. They were dated January, May, August and November 2014.

We saw from the audit dated August 2014 that the laundry room had been identified as "infection control risk." None of the quality monitoring visit reports identified any of the issues we had identified during our inspection. This demonstrated that audits were not effective as actions were not taken when issues had been identified.

This also demonstrated a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 due to a lack of effective auditing.

The manager did not display effective leadership within the home. The manager was not aware of many of the issues we highlighted during our inspection and showed poor organisational skills with regard to deployment of staff and awareness of deficits with regard to care planning and practice.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations 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 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services<br><br>The provider failed to deliver care in a way which respected the privacy and dignity of people who used the service. Regulation 17(1)(a) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services<br><br>People who used the service were at risk from not receiving care that met their individual needs. Regulation 9 (1) (b) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines<br><br>The registered person did not ensure there were suitable arrangements for the administration and recording of medication.<br><br>Regulation 13. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs<br><br>People who used the service were at risk of not receiving adequate nutrition to meet their individual needs. |

| Regulated activity | Regulation |
|---|---|

This section is primarily information for the provider

# Action we have told the provider to take

Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing

The registered person did not have suitable arrangements in place to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity.

Regulation 22

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 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control<br><br>The registered provider had failed to protect service users by maintaining appropriate standards of cleanliness and hygiene within the home. |

**The enforcement action we took:**
Warning notice to be issued.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision<br><br>People who use services were not protected from unsafe or inappropriate care as the registered person did not regularly assess and monitor the quality of services provided.<br><br>Regulation 10(1)(a). |

**The enforcement action we took:**
Warning notice to be issued