Only Care Limited

Rosewood Court

Inspection report

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Date of inspection visit:
15 July 2016
19 July 2016

Date of publication:
13 September 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 15 and 19 July 2016 and was unannounced. The inspection was conducted because of a high number of incidents of concern that the Care Quality Commission (CQC) had been made aware of.

Rosewood Court is a newly built three storey home. It is well appointed with single rooms, all of which have en-suite wet rooms. It was registered with CQC in April 2016 to provide accommodation for up to 66 people who require nursing or personal care. At the time of our inspection, 35 people were living at the home, some of whom had dementia and some who required 'end of life' care.

Although the accommodation was modern, well-appointed, clean and tidy it did not have a homely atmosphere. The décor was not helpful to people who were living with dementia as all doors to rooms looked the same. The provider had failed to acquire and provide the equipment needed before people had been admitted to the home.

People had been admitted to the home before appropriate systems and documentation was in place to provide safe and effective care. Care records had not been developed for some people so that staff understood their care needs. Risks arising from people's care and treatment had not been identified or assessed appropriately to mitigate them as far as was possible. There were no effective complaints or quality monitoring systems in place. People had been admitted at a rate that was unsafe and staff were not able to identify them as neither their care records nor their medicines administration record bore their photograph.

Staffing levels had been determined with no reference to people's dependency levels or needs. Staff were not given appropriate induction or training before they provided care and treatment to people. There was no supervision of staff at which they could discuss their performance, concerns, training needs or suggestions for improvements to the service. There were no checks carried out to determine the effectiveness of the training staff had received or that they were competent to carry out their duties.

Although there were some group activities arranged, there was nothing for people who could not join in with these. People were bored and felt isolated. The home was in the process of developing links with local churches.

During this inspection we identified that there were a significant number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Due to level of our concerns we have taken enforcement action that required the provider to make improvements to the service and has prevented any new people from using the service since 21 July 2016. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore 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. 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.

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.

Staffing levels had not been determined taking into account people's level of needs and staff did not have the skills to provide for all people's care and treatment needs.

Risks associated with people's needs had not always been assessed and systems were not in place to mitigate them.

People's medicines were not administered as they had been prescribed and on a number of occasions, people were not given their medicines due to insufficient stock being held.

Is the service effective?

Inadequate

The service was not effective.

Not all staff had received an induction to the service or training to provide the skills they needed before they provided care and treatment to people.

There were no processes in place to validate that staff had received effective training. There was evidence that moving and handling training had been ineffective with both people and staff being exposed to risk of injury.

Staff had little understanding of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards. There was no evidence that people had consented to the care and treatment provided.

Is the service caring?

Inadequate

The service was not caring.

Staff providing palliative care did not have the skills, knowledge or experience to do so.

People had mixed feelings about the attitude of the staff that cared for and treated them. Whilst most were happy with the experienced staff, they were unhappy with the care given by the

agency staff.

There was little information readily available to people or their relatives, but relatives were able to visit whenever they wanted to.

Is the service responsive?

Inadequate

The service was not responsive.

People had not been involved in the development of their care plans and there was little information about their likes and preferences. When this information was available it had not been used in the development of people's care plans.

People were not supported to maintain their hobbies and interests. Many people complained of feeling bored and being isolated in their rooms.

There was no system to management concerns and complaints.

Is the service well-led?

Inadequate

The service was not well-led.

There were no quality monitoring processes in place to assess the service's level of compliance with the fundamental requirements of a care and nursing service. There was insufficient oversight of the service to ensure that processes were in place to provide sufficient trained, experienced staff to provide for people's care and treatment needs. Those needs, plans to provide for them and the risks associated with the care and treatment had not been fully identified and assessed.

The registered manager had not been well supported by the provider's Regional Manager who had arranged for an unacceptably high number of people being admitted to the service in their absence.

People's monies were not being managed appropriately.

Rosewood Court

Detailed findings

Background to this inspection

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

This inspection took place on 15 and 19 July 2016 and was unannounced. The inspection was carried out by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information available to us, such as notifications and information provided by the local authority, the public or staff. A notification is information about important events which the provider is required to send us by law. We spoke with five members of staff from the commissioning bodies who had arranged for people to be placed at the home.

During our inspection we spoke with twelve people and seven relatives of people who lived at the home. We also spoke with two care workers, two senior care workers, a nurse, a housekeeper, the administrator, the deputy manager, and the registered manager. We met the provider's Regional Operations manager. We also spoke with two health care professionals who visited the home during our inspection.

We observed the interactions between members of staff and the people who lived at the home and looked at care records and risk assessments for five people. We also looked at how people's medicines were managed and the ways in which complaints were handled.

We looked at three staff recruitment records and reviewed information on how the quality of the service was monitored and managed.

After the inspection we received feedback from another healthcare professional who supported a person who lived at the home and a representative of one of the organisations that had commissioned service from the home.

Inadequate

Is the service safe?

Our findings

People told us that they did not always receive their medicines when they were due. A relative told us, "I don't think he is safe here at the moment for a number of reasons including running out of essential medication." We looked at the medicines administration records (MAR) for 11 people who lived at the home. Of these, only two had photographs of the person to whom it referred. This caused us concern as there was a high level of staffing from agencies and most people had not been living at the home for very long. This meant that there was a possibility that medicines could have been given to the wrong person. The deputy manager told us that no member of staff was able to administer medicines to people unless they had been trained and assessed as competent to do so. However, a member of staff told us that although they had only just been signed off as competent they had been administering medicines for some weeks.

We noted that there were several gaps in the MAR which raised concerns that people might not have been given their medicines. The deputy manager told us that they had made similar findings in a recent audit and a letter had been drafted by the registered manager for issue to all staff who administered medicines to people, reminding them of the importance of keeping accurate records. However, in addition to the gaps we noted that there had been numerous entries in MAR that showed that people had not received their medicines for periods of up to a week because the medicines were 'out of stock'. We noted that when the service ran out of stock of two medicines prescribed for an individual on 2 July 2016, an urgent request for a repeat prescription was not made to the GP surgery until 6 July 2016. The MAR showed that one of the medicines was not given to the person for a further three days after it had been received. The individual was given one dose of the medicine on 9 July 2016, but it was again not given from 10 July 2016 until 12 July 2016. As this medicine is used to treat and prevent ulcers in the stomach and intestines, failure to administer it for over a week may have caused the person pain and discomfort. Another person had been prescribed medicine used to treat symptoms of anxiety. The MAR showed that this medicine had run out on 27 June 2016. From 11 July 2016, the GP had prescribed the medicine to be given on an 'as needed' basis (PRN). This meant that the person had not had the medicine for 13 days prior to the change.

We found that there were no protocols in place that advised staff when medicines prescribed as PRN should be offered. This meant that people were at risk of receiving the medicine inappropriately. To receive too much of some of the medicines that had been prescribed as PRN could have long term effects on people's health and well-being.

The service did not hold a copy of the British National Formulary which provides authoritative and practical information on the selection and clinical use of medicines and drug interactions. Staff were therefore unable to identify symptoms that may indicate that people could be experiencing an adverse reaction to medicines that had been prescribed for them.

Care and treatment was not provided in a safe way. Although there were some assessments in place for risks to people associated with their care needs, assessments had not been fully completed for everyone. People and their relatives told us that they had not been involved in determining the level of risk that they were happy to accept. A member of staff told us, "I have concerns about the risk assessments. I feel all the

residents are not safe until they are in place." Another member of staff said, "We still have very few risk assessments for using the hoist and for individual service users, but we didn't have any at all before this week." We saw that there was an incomplete risk assessment for a person who was at risk of falling prior to moving to the home. There was no management plan to reduce the risk for the person. Three members of staff had attended a training course on 'falls prevention' provided by the local authority on 23 June 2016 and had been nominated as 'Falls Champions' for the service. Although the training had provided tools that could be used to reduce the risk of people falling, these were not in use at the time of the inspection. There was no monitoring system in place and no procedures for staff to follow in the event of someone falling.

A person had been visited by their GP because they were concerned that they had been losing weight. There was no assessment of this risk to them and there was no guidance for staff to reduce the risk. The person had been put at further risk because staff had not followed guidance by the GP to monitor the risk. Other risk assessments such as for skin integrity and other general risk assessments had also not been completed, even though the person had moved into the home two weeks prior to our inspection. Staff told us that risks to people were discussed at handover meetings, but that this was ineffective. One member of staff told us, "I feel the handover is too short. It only lasts from 8.00am until 8.05am. How can we get enough information in five minutes? If the risks information is written down people don't always read it."

The registered manager told us that although accidents and incidents, such as people falling were recorded, there was no analysis of these to identify themes to enable preventive actions to be taken. We saw that copies of the incident and accident forms were held within individual care records. However, we saw no evidence that actions had been taken to identify the causes of the incidents in order to reduce the risk of recurrence.

There was insufficient equipment to keep people safe. One member of staff told us that one of the challenges that faced staff was not having enough equipment and having to wait a long time when it was requested. They also said, "We have been saying since we started that we needed it. The dressing's trolley has only arrived today." There was a heatwave during the period we inspected the home. This caused the building to become excessively hot and there was no air cooling system installed. Although the manager had identified the need for fans to circulate air in the home and requested these in early June 2016, they had not been supplied. Consequently, bedrooms and communal areas within the home were hot and stifling. People could not find relief from the heat by going outside as there were no parasols to provide shade at the tables in the garden. Fans and parasols were later provided after we made our concerns known to the provider. Other healthcare professionals made us aware of other missing equipment that had only been provided when they had raised concerns. For example, there was not all the equipment required to ensure that a person could be given their medicines by a syringe driver which is used to deliver medicines at a steady rate over a 24 hr period. We noted that there was six hours delay before the person could be given their medicines and this would have caused unnecessary suffering for the person who was in severe pain.

The above were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People, relatives and staff told us that there were insufficient skilled staff to provide for their needs effectively. One relative told us, "On two occasions I have seen a lady go to the toilet in a waste paper basket. Quite simply there are not enough staff to look after the needs of the residents here. Some days it is worse than others, but even on the good days they are waiting a long time for attention."

The registered manager told us that they had not used a tool to determine the numbers of staff required to safely support the people who lived at the home. A member of staff told us, "I am hoping once care plans are

in place we can assess people's dependency needs and then properly assess how many staff we need." The registered manager had told us that staffing levels on each floor were based on the number of rooms occupied, with the exception of one person who was in receipt of one to one care. Nineteen people lived on the floor which included the nursing unit and it had been determined that five staff including a registered nurse were sufficient to support everyone. On the residential floor, 16 people were being supported by one senior care worker and three care workers. Many of the staff on duty during our inspection had been supplied by an agency. People were unhappy about this. One relative told us, "We only have [relative]'s word for it but [relative] feels there are not enough staff. [Relative] hates the agency staff because of their poor language skills." A member of staff told us, "They use quite a few agency staff and I feel the residents need continuity. There are a few language issues with the agency staff for the elderly residents. One lady keeps complaining to me about how long it takes for them to answer her bell."

We looked at the records of the call bell system to ensure that people were not put at risk by delays in supporting them. These showed that the longest a person who frequently used their call bell had to wait on the second day of our inspection was approximately six minutes. However, people told us that staff did not always attend to their needs when the bell was deactivated. One person told us, "When I use the bell a carer will put her head around the door, turn off the bell and say 'back in a minute.' If only I had a pound for every time they say that. I don't want to hear that again." A member of staff told us, "The residents are having to wait a long time for attention." The delays that people experience before assistance was given to them would indicate that there was insufficient skilled staff to respond to people's needs.

The failure to have sufficient trained staff to meet people's needs at all times is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the recruitment records of three members of staff. We saw that appropriate checks including Disclosure and Barring Service Checks (DBS), a health questionnaire and evidence of identity had been carried out before new members of staff started work. However, other recruitment processes were not effective in enabling the provider to confirm that staff were suitable for the role to which they were being appointed. A new application form for employment had been recently introduced but we saw that the new form did not ask for dates of employment with previous employers. It was therefore impossible to identify any gaps in employment or explore the reasons for these. We saw that the record of interview for one person was incomplete, did not have the candidates name and had not been signed by the interviewer. The two references obtained for the candidate had both come from the same employer, even though the applicant had been working for two employers in healthcare settings at the same time.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives had mixed views as to whether people were safe at the home. One person told us, "I do feel safe really because the door security is good." Another person said, "I do feel safe. There is always another resident or someone around to give me help if I need it." However, another person said, "I think I do feel safe here but if my door was closed, I could be on the floor for ages before they come. That does not make me feel safe."

Some members of staff were able to fully describe the safeguarding procedures and the signs of possible abuse that they would look for. However, other members of staff who had received training on safeguarding during their induction period, were unable to identify organisations to which safeguarding issues should be reported. All staff said that they would report any concerns to the registered manager. We saw that the provider's whistleblowing policy was clearly displayed in the staff room. Whistleblowing is a way in which

staff can report misconduct or concerns within their workplace without fear of the consequences of doing so. Staff told us that they would be confident to use it should the need arise. We noted that on two occasions members of staff had raised their concerns about the service with CQC. We were concerned when we were told that money provided for people by their relatives was deposited into a bank account used by the service for petty cash. People's money was then withdrawn and held in a safe at the home. We found this system did not provide sufficient protection for people's money if the provider was unable to access this account for any reason.

The registered manager told us that the home had been purchased fully fitted to the provider's requirements and maintenance of the building, fittings and furniture were subject to the terms of the agreement. The home had a maintenance person who completed minor tasks, such as hanging pictures for people in their rooms. When maintenance was required the service sent requests to the builders and monitored if the work had been completed. The registered manager told us that an ongoing problem had occurred within the boiler room and the hot water system kept losing pressure. This meant there was a loss of hot water in some parts of the home. Both the maintenance person and the registered manager had been shown how to re-pressurise the system to minimise the inconvenience to people.

There were emergency evacuation plans in place for each person and a fire contingency plan had been developed. However, there was as yet, no contingency plans in place for other emergencies, such as the loss of fuel or water, or if the building became unusable. The registered manager told us that there was a verbal agreement with the hotel opposite the home, but no written agreement that this could be used to house people in the event of an emergency.

Inadequate

Is the service effective?

Our findings

People and their relatives were unsure as to whether staff had been trained to care for them effectively. One person told us, "Well as far as I can tell they are, but some are better than others. There is a lot of pulling me about you see, tugging and pulling. Sometimes I send them away because I am not in the mood for all that manhandling." Another person said, "They seem to be, but I don't really know. I get myself washed and dressed. They have only helped me with one shower." A relative said, "I don't think that they have had enough end of life palliative care training, especially the agency staff."

Some members of staff told us that they had received training before the home had opened. One member of staff said, "I did two weeks of training over at the [hotel] before the home opened. We had a training package including manual handling, first aid, challenging behaviours and end of life care. I can't remember doing any safeguarding training." Another member of staff told us that they also had completed the training at the hotel. However, they told us that their back was hurting them as they had to continually bend at awkward angles when using a hoist to transfer people. This indicated that they may not have learned correct techniques for using a hoist during the manual handling training. Prior to our inspection we had been informed that a person had suffered an injury to their shoulder because of the incorrect lifting technique used. Following our inspection we received information from the local safeguarding team that a person had fallen through a sling when they were being hoisted. Although there had been no injury on that occasion, this showed that people were at risk of harm by staff using incorrect techniques. We asked the registered manager how staff's learning from training was tested and we were told that there were no processes in place to review this.

One member of staff told us, "I have not had any training since I started here [X] weeks ago." Another member of staff who had worked at the home since it opened, told us, "I haven't had a formal induction. I have worked in care homes [before] so I have a fair understanding generally and what risks it involves. I fall back on my previous induction." A healthcare professional expressed their concerns about the level of competency of the nursing staff to care for people with complex palliative needs. A member of staff had admitted to feeling out of their depth. They had told the healthcare professional that a person who received palliative care had so many tablets to take it was difficult for them to know what ones were important.

On the first day of our inspection the registered manager told us that there was no overall training record that would show what training staff had received. However, they subsequently completed one which they showed us on the second day of the inspection. This showed that a number of staff required training. The registered manager told us that the provider used an external company to deliver training in blocks of two weeks. Training had been delivered to staff who had been employed to work at the home prior to its opening in February 2016 and a further two weeks had been undertaken in May 2016 by staff employed after the initial group. The registered manager told us that further training had been booked in August and October 2016 and care workers who were new to care would be expected to complete the Care Certificate via Skills for Care. The registered manager told us that staff new to the service had a week of induction in which they shadowed experienced staff before they were expected to care for people. There was no on-line training facility for staff. This meant that new staff who had joined in the three months period between the

training in May 2016 and that to be held in August 2016 would have been caring for people before they had been trained to do so.

The registered manager told us that no supervision of staff had been undertaken. They had recently devised the documentation needed to complete supervision meetings and they and their deputy planned to devise a schedule for supervision to be completed for current staff. The registered manager told us that they were to source training on supervision for senior staff members to enable them to hold supervisions with their team members.

Poor training and a lack of supervision was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some staff had received training on the requirements of the Mental Capacity Act 2005. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We noted that in one care record, the person who had completed the pre-admission assessment had judged that the person had full capacity to make their own decisions. However, they had marked the section of the form that referred to MCA as 'To Assess'. This indicated that they may not have undertaken a full assessment of whether the person had capacity to make decisions about their care. One member of staff told us, "We don't have a place to log best interest decisions as such. We do from time to time log them on the daily log but the detail on these sheets is very basic and does not lend itself to being logged properly here."

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw that requests for authorisation for DoLS had been made for a number of people who lived at the home. However, the registered manager told us that staff were not confident that they fully understood the requirements of MCA and DoLS. They had arranged for the lead officer from the local authority to deliver training to the senior staff at the home on 28 July 2016, with further training arranged for all staff in September 2016.

We saw that care records contained consent for the service to use people's photographs for identity purposes. However there was no evidence within the care records to suggest that people had given their consent to the care provided. Nor was there evidence that decisions to provide care to people who lacked the capacity to give informed consent had been made in their best interests. A member of staff told us they gained verbal consent to provide care by saying, "Good morning how are you? Are you ready to get up yet?" We observed that staff had sought consent from people before they put clothes protectors on in the dining room before lunch. However, staff did not ask one person if they wished to move before transferring them to a wheelchair and taking them back to their room after lunch.

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

Staff explained to us how they communicated with people who were unable to make their needs known verbally. One member of staff told us, "Where people struggle to communicate, I communicate by looking for facial expressions, look at their body language and sometimes I use a picture book. It has been difficult with so many new residents and very limited information. It really has been guess work, trying everything to communicate."

The registered manager told us that the menus had been devised with the cook before people had moved into the home. A relative told us, "At a review last month my [relative] told them [they] suffered from constipation and wanted pureed prunes and fresh orange juice every day but they are not getting this. They only get offered watery sweet squash so tends to have tea or water. The only fruit they get is canned." People's likes and dislikes had therefore not been taken into account.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had mixed views about the food and drinks that they received. One person told us, "I really enjoy my meals here. I feel every day is good. The choice of food suites me." Another person said, "Sometimes it's pretty good, others it's yuck! We do get carrots. I had two bananas the other day but fruit is limited. We don't get a fruit bowl in the lounge. We do get a choice of sorts but today its fish and fish. We do get roast dinners on Sunday." Another person said, "It's just alright, not impressed really." However one person said, "Generally the food is ok. Choice is a problem. You see I don't really like fish and there was only fish today. If I don't eat what they give me I don't get anything to eat." However, a member of staff told us that if people did not like the choices offered to them, alternatives were available. One member of staff said, "We will always go to the kitchen for an omelette if anyone does not like the main course choice. I did yesterday and they made a cheese omelette for [person]. We do make people toast if they are not eating well, we do go to the kitchen and get them something different and try to find food they do like."

However, a healthcare professional told us that the service provided special desserts for a person living with diabetes. The deputy manager told us that fresh orange, apple and cranberry juice was available for people to drink, but agreed that there was very little in the way of fresh fruit available to people unless they had specifically requested it. The deputy manager told us that one person received a plate of cut up fruit on a daily basis which they kept in the refrigerator in their room.

We observed the lunchtime experience in the dining areas on both the ground and first floors. On the ground floor staff were available to cut up food for people if they needed this. However, staff did not know whether people required such assistance and people had to ask the staff for help. One person had adapted cutlery and was able to eat their meal unaided once their food had been cut up for them. On the first floor we observed that the food was delivered to the dining room in a hot trolley but once on the unit the trays of food were removed from the hot trolley. Some food was still waiting to be served more than 20 minutes after it had been taken out of the hot trolley and would therefore have been cold. This was confirmed when one person told us, "It [the food] is alright but not great. It's often cold and tasteless. Like today the fish was tasteless and cold." People told us that there were also delays in them being taken to the dining room to have their meal. One person told us, "Take the example of tea time. They have to come and get me to walk down to the dining room. Well I can be left until 6.30 before they come for me and tea time starts between 5.00pm and 5.30pm. I am in their hands."

We observed two members of staff as they assisted two people to eat their meal on the first floor. There was no interaction with the people they were helping to eat. One of the members of staff was looking at a programme on the television and the other member of staff was gazing around the room and along the corridor. One person who required assistance to eat, had their meal placed beside them and a member of staff stood over them as they assisted them to eat. The person was given one spoonful of food before the member of staff was called away. This did not enhance the mealtime experience for the people who required assistance to eat their food.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

Staff told us that if there were concerns about people's weight then action was taken to monitor how much they were eating and to provide additional nutrition by way of milkshakes and fruit drinks. Food and fluid intake was monitored where this was thought to be appropriate. One member of staff told us, "We have food and fluid charts and we weigh people monthly. If we have concerns we may weigh them weekly." However, one care record showed that a GP had asked on 5 July 2016 that a person should be weighed weekly because they had expressed concern that they were losing weight. We noted that this had not been done two weeks after the GP had made the request.. The deputy manager arranged for them to be weighed immediately and it was found that they had gained almost a kilogram in weight since their admission to the home.

People told us that they were supported to maintain their health and well-being. Most people still used their own dentists and hairdressers. Full salon facilities were available for visiting hairdressers to use. One person expressed concern because they had contacted their GP, who visited the home regularly. They told us, "I rang the surgery and they said that they would ring back. Well they did ring back here. They didn't let me speak to the surgery but they came and told me off. They said, I am not allowed to phone the surgery. If I need a doctor they will get one. I am not allowed to phone for a GP."

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A relative told us, "They do get the GP out for [relative], they did last week." Another relative said, "They got the paramedics out last weekend. They will get help if they think it is necessary." One healthcare told us that staff at the home were always helpful when they visited. A person told us that they were waiting for an optician to visit the home. They told us, "The optician was supposed to be coming this week but I haven't seen him. I need my eyes tested." Another person said, "I am desperate to have my eyes tested. I would like them tested but I am scared to ask."

Inadequate

Is the service caring?

Our findings

The home had admitted people who were at the end of their life but staff had not been given the necessary training and support to do this effectively. A relative of one person told us, "I just don't think they are geared up for palliative care." Although the service worked closely with specialist palliative care professionals, staff did not appear to understand their roles or responsibilities in supporting the healthcare professionals, the individual or the family. Equipment needed was not available at the time it was required, medicines were not administered as they had been prescribed and people had suffered unnecessary pain and distress because of this.

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

People had mixed opinions about the care they received and the staff that delivered it. One person told us, "Here is just like being in a prison. It's the way the carers care for us, they are so argumentative with all the residents. They do it their way you see, we don't seem to be able to say anything." A relative said, "It is like a five star hotel with the cushions, carpets and chandeliers but the fundamental intimacy and care isn't here." However people were happy with the staff. One person told us, "Carers are helpful, happy and kind. Good and kind to me. No trouble at all." Another person said that staff were "…all kind and patient with me."

People told us that staff did not know them well. One person said, "I would like them to help me get washed. I need their help to have a shower or bath but no-one has asked me about that. No-one has asked me when I like to get up. I haven't used the bell. I just go out and get someone. How do I get them to know what I need?" When we asked another person whether staff sat with them to find out about their lives and their preferences they told us, "They don't have time for that. They are very busy." People said the staff supporting them with personal care did listen to them during their care, but generally they felt they were not listened to. One person told us, "They have to listen to us because with the agency staff they don't know much about us. I get fed up having to explain to someone new all the time what I need with my personal care. It's private you see."

People said that they were treated with respect and dignity by all of the staff including the housekeeping staff. One person told us, "They put the towel over me when they give me a bed bath, or if I have a shower they cover my lap with a towel in the chair. No problems at all." Staff told us of ways in which they promoted people's dignity. A member of staff told us, "During personal care we cover service users with a towel, we always close the door and curtains. In the lounge we also close the curtains when we are using the hoist. We don't have a screen for service users but we do close the curtains." The registered manager told us that they had requested privacy screens to be purchased to promote people's dignity when they were transferred using a hoist in the communal areas. Shortly after our inspection we were advised that these had been purchased.

People had been encouraged to bring items from their homes to personalise their rooms. We saw that in one room the person had armchairs and a bookcase. The doors to people's rooms were identical and could

cause confusion for people with memory loss. Although people's names were on their doors there was no photograph or memory box to assist people who were living with dementia to recognise their own room. This had caused distress to one person when another person had inadvertently entered their room. Shortly after our inspection we were advised that memory boxes had been ordered and would be placed outside people's doors so that objects that had meaning to the individual could be used for them to recognise their room.

People had been given little information about the home beyond that available on the service's website which had been completed prior to the home opening. An information booklet had been produced, in conjunction with the local authority, for people who had moved into the home from one that was being closed. An information booklet had also been designed to be given to other people at the home and their relatives but this had not yet been printed. The reception area had a digital display screen that was supposed to provide information for people, including details of the staff on duty. However, there was a fault on the system and little information other than a photograph of the home was available. Information about complaints was contained in a small framed document holder displayed behind the administrator's desk in the reception area together with framed registration and insurance certificates. It was neither easily accessible nor readily identifiable as important information.

People and their relatives told us that visitors were welcome at the home at any time. One relative told us that they spent 12 hours a day visiting their loved one at the home. Relatives told us that they could make themselves a drink in the kitchen areas in each dining room. The registered manager told us that relatives had been provided with both food and drink in the past when they visited people at the home, but this practice had now ceased.

Inadequate

Is the service responsive?

Our findings

People told us that before they had been admitted to the home someone had visited them to discuss whether the home could meet their needs. A relative told us, "My [partner] was present when they came to talk to my [relative]. They asked about what [relative] likes to eat and drink."

There was little evidence that people and their relatives had been involved in developing their care plans. We found that care plans were not always in place to address people's identified needs. For example a pre-admission assessment for one person had identified a specific need for mouth care to be given but there was no care plan in their records to identify what care was needed, how this was to be delivered or the frequency of it. There was a mouth care chart included in the record, but this was a tick chart and did not specify what care had been given. The deputy manager agreed that it was not possible to be assured that the care given had met the person's needs. This was of particular concern as in June 2016 another person who had required mouth care was found to have food caked to the inside of their mouth which had caused particular distress. A member of staff told us, "I would like care plans to be in place when the resident arrives, to take the guess work out of managing their care."

Information about the life histories, likes and dislikes for people who had transferred from another home had been included in a 'This is Me' booklet that had accompanied them on their move to the home. However, this information had not been gathered for the other people who lived at the home. In the 'This is Me' booklet in one care record, the person had stated that they preferred their personal care to be provided by a female member of staff. However, this was the only place within the care record that this information had been recorded and their care plans for washing and dressing and continence care did not include this information. As a consequence they may have been supported by a male member of staff.

We found that where care plans for specific needs had been developed these had not always been updated when the person's needs had changed. For example in one care record, the care plan for the person's continence requirements showed that they had a catheter in place when they had been admitted to the home. However, this had been removed a short while after their admission. The care plan had been annotated to this effect, but it had not been amended to explain how their continence needs were to be met. We also found that information not relevant to the particular care plan had been included in the evaluation of it by the staff. For example information about a person's catheter being removed had been included in the evaluation of their communication care plan.

People, relatives and staff told us that people had to wait a long time for assistance if they used their call bell and this had put people at risk of harm. One person told us, "It takes them for ever to come. I have waited for over two hours. On average it's over 30 minutes. I have not had any accidents yet. I go [to the bathroom] myself with my frame. I am not supposed to go on my own but I can't wait for them to come." Another person said, "Well response to the [the call] bell varies really. You do have to wait for attention. I think it is because they are seeing to someone else, that's why they can't come but you can wait up to 20 minutes for them to come. In the morning I ring the bell. Usually someone will come in and say that they will be back. Trouble is that when they come back, it can be 10 minutes, can be 30 minutes or more. You see sometimes I

need a bottle [for urine collection] to keep me going until they have more time. They just give me it. Like now it's sitting over there on the bedside table." We saw that a bottle containing urine was sitting on the person's table next to their drink. This was not only unpleasant, but represented a health infection risk to the individual.

One person we spoke with wanted to be assisted to sit in the chair in their room so that they could have a drink. We pressed the call bell for them and noted that it was 13 minutes before an agency member of staff came to see what they needed. They went off and returned with another member of staff who again asked what the person wanted. Only after the person had repeated their request to the second member of staff did the first member of staff get the equipment needed to assist the person.

There was an activities co-ordinator in post and we saw that they had arranged group activities for people. On the morning of our first day of inspection they had arranged a carpet bowls session in one of the lounges. However, there were no one to one activities provided for people who stayed in their rooms. One person told us, "I only have my TV to keep me occupied. There have not been any outings since I have been here. I would love to go out; it would be a nice change." Another person said, "I am very lonely and I am bored really. I need them to take me down to the lounge and if I call them they don't come for ages. It really annoys me waiting for them all the time so I have stopped asking them to take me down. I am very isolated here. I had more company at home with my neighbours." A relative told us, "[Relative] spends most of the time in their room watching television. I had hoped they would be getting more social interaction. I am hoping that they will be encouraged to join in activities." Another relative said, "My [relative] is dying of boredom. There is only one young girl doing activities for the whole of the building and she was serving breakfast and making tea earlier. [Relative] is very religious and there is no church service for them. [Another person] who was the life and soul at [relative's previous care home] is very subdued. People spend most of the day in front of the television in various stages of sleeping."

We spoke with the activities co-ordinator who told us that they had formed links with a local church and once a month were going to take people to a lunch club at the church, which was preceded by a church service. The church had also provided some song books and occasionally they had arranged for a sing-a-long. Although equipment was available for board games, this was tidied away when an activity had been completed and people did not seem to have access to it whenever they wanted.

Failure to identify and address people's health, care, social and emotional needs was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although the service's complaints policy was displayed in the reception area of the home, people and their relatives were not aware of this. None of the people we spoke with had been given a copy of the complaints policy. However, one person told us that they had made a complaint. They said, "I have complained to the manager about how long I have to wait to get up and washed in the morning. There does not seem to be any difference since I complained. I have complained about the food. When we get apple crumble three days running it's not good enough." The registered manager told us that they did not keep a record of the complaints that had been made or the steps taken to resolve them. They said that they usually spoke with the complainant face to face, but did not record their conversations.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We overheard a conversation at one of the tables in the dining room at which people compared the service to a prison. One person commented, "It's just like being in a prison here." Another person disagreed saying,

"If it was a prison at least things would happen on time, like getting our food on time and getting up at a certain time." The first person replied, "Well that's very true." The registered manager told us that there were plans to ask people for their views on the quality of the service and any improvements required in a quarterly survey of people and their relatives. However, this had not yet been done.

Inadequate

Is the service well-led?

Our findings

During our inspection we found that there were no systems in place to assess the quality of the service provided in order to identify any improvements required. On the second day of our inspection the registered manager showed us documentation for quality audits that they had developed. They planned to undertake these, but only one audit of medicines had been completed. This audit had concentrated on medicines administration records being completed, but had failed to identify that people had not received their medicines as stocks had run out. It was therefore ineffective.

When we raised the lack of quality monitoring systems with the provider during our inspection, they advised us that their Regional Manager would be undertaking quarterly assessments of quality from the end of July 2016, and that the registered manager and other senior staff would implement a schedule of quality audits. We also noted that the registered manager could only monitor the call bell system using the administrator's computer terminal, which meant that they had limited access to these records. The registered manager and the administrator told us that they could not produce reports that would enable them to monitor call bell response times over a period of time. Although they could look at specific instances of when a call bell was activated and how long the response time was, this did not give them sufficient information to address people's concerns about the length of time they had to wait to be supported.

Although people's records were kept securely, we found that they were not complete and did not contain any information as to who had made decisions about people's care and treatment. The registered manager had been on leave for a two week period during which they had made arrangements for one person to be admitted to the home. However, on their return, they found that eleven people had been admitted. The additional admissions had been arranged by the provider's Regional Manager with no proper arrangements to ensure that this would be well managed. One person told us, "One of the managers came out and assessed me on the Tuesday and asked me to take up the room the next Monday. I didn't dare say no in case I lost the room. It was all a big rush to leave my home. I really regret this scramble to get here. If I had known what goes on here I would not have come." There had been no determination of whether more staff would be required to meet the additional pressure caused by the admissions placed on the service. There were insufficient trained staff to meet people's needs and the service relied heavily on agency staff.

Staff had been treating and supporting people even though some had not received appropriate induction and training. There was no system in place to identify the training and support needs of staff employed by the service. Staff were insufficiently skilled to provide safe and effective treatment for people who were receiving end of life care.

People were not supported to maintain their hobbies and interests, nor were their religious needs fully met. The environment did not meet the needs of people who were living with dementia. The atmosphere of the home was very impersonal, with no homely touches to make people comfortable, such as bowls of fruit for them to help themselves.

People, relatives and staff told us that as yet there were no meetings at which they could discuss

developments and improvements they wished to see made to the service. They had not been involved in determining food or drink choices. Food was not always of an appropriate quality or temperature to encourage people to eat sufficient to maintain their health and well-being.

We had a discussion with the registered manager about the procurement process for equipment for the home. During this, we found that monies paid to the service by relatives for the personal use of the people who lived at the home were paid into the bank account in the service's name. Even though the registered manager withdrew these funds at the first possible opportunity, we were concerned that people's money would be at risk in the event that the provider was unable to withdraw monies from the account for any reason.

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

The service had a registered manager in post who was supported by a regional manager and a deputy manager who was a registered nurse. People and staff told us that they found the registered manager to be very supportive and approachable, but they were always busy. One person said, "She's run off her feet that lady." Another person told us, "I have only just met her this week because she has been on holiday, but she came and introduced herself on Monday." A relative said, "She wants to do the right thing and is dedicated, but I am not sure she is getting the back-up she needs. There are things she wants to implement, but has not been able to." They told us they had met the Regional Manager and said, "The first thing I found is they are very superficial. I have met them four times now and each time they greet me it is as if they have never met me. They are buzzing about at 100 miles an hour."

We asked the provider to tell us how they would address our serious concerns for the safety of people who lived at the home. They provided us with a plan of actions that they intended to take. This included employing a specialist consultancy company to support the registered manager in ensuring that processes, procedures and necessary documentation were in place to ensure that people received good quality care and treatment that met their needs, in a safe way.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not have a choice of food and drink that met their personal preferences Regulation 9(3)(i) Neither people nor their relatives were involved in developing their care plans and these were not developed taking their personal preferences into account People's social and emotional needs were not met. People were isolated and bored. Regulation 9(3)(b) Care plans were not reviewed and updated when people's circumstances changed. Regulation 9(3)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and their actions were not always respected. Regulation 10(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent There was no evidence that people had given their consent to the care and treatment

	provided. Where people lacked capacity to make informed decisions there was no evidence that decisions made on their behalf were in accordance with the Mental Capacity Act 2005. Regulation 11(1) and (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's medicines were not available There was insufficient equipment and medical devices available Staff who had not been trained administered people's medicines Procedures for the ordering and supply of medicines were ineffective. Risk assessments had not been completed There was no analysis of incidents Staff did not have relative experience

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Food was not always served at appropriate temperature Regulation 14(4)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints There was no effective complaints system in place. People did not know how to make a complaint and there was no record of any complaint having been received, investigated and responded to. Regulation 16(2)

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 There were no systems or processed in place to ensure compliance with the regulations. Regulation 17(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Applicants had not been asked to provide dates of former employment and therefore gaps could neither be identified nor the reasons for them explored. Regulation 19(3)

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 number of staff needed to meet people's needs had not been determined with a systematic approach based on people's needs. There appeared to be insufficient staff to meet people's needs. Regulation 18(1) There was an ineffective induction and training programme. Training, learning and developments needs of individual staff members had not been carried out at the start of their employment and there was no supervision programme in place. Regulation 18(2)(a)