Hill Care 3 Ltd

Deangate Care Home

Inspection report

Towngate
Mapplewell
Barnsley
S75 6AT
Tel: 01226 383441
Website: www.hillcare.net

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Ratings

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

Overall summary

The inspection took place on 11 and 18 November 2014 and was unannounced which meant the provider did not know we were attending. On the 18 November 2014 we attended at 04:00 hours to observe how the service operated during a night shift.

The service was last inspected on 14 October 2013 and was found to be meeting the requirements of the regulations we inspected at that time.

Deangate care home accommodates up to 50 older people that require nursing and personal care. Included within this is a unit called Poppy Lodge which can accommodate up to 12 people who are living with dementia. At the time of our inspection there were 43 people using the service; 12 people in the Poppy Lodge unit and 31 people in the main part of the home, referred to as Deangate.

There was a registered manager in place at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

Summary of findings

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 were not safe and were not protected from risk of harm. Staffing arrangements were insufficient and care was not being delivered in a way to meet people's needs. The second part of our inspection took place during a night shift and we found a number of concerns. On our arrival we saw four staff were on duty but none of the staff were located on Poppy Lodge. We found that some people on Poppy Lodge were locked in their rooms by staff who told us this was done to keep the person safe. Staff told us that none of them were based on the unit and they made regular checks on people during the night. We observed one person on Poppy Lodge getting in and out of other people's beds. Staff comments and records showed this was a regular occurrence with some people on Poppy Lodge. People were mainly unsupervised despite their care plans stating they needed supervision for their own safety as well as the safety of others.

Some people displayed behaviours that challenged the service which resulted in physical incidents occurring. Our review of records showed that some incidents had not been referred to the local authority safeguarding team which meant the service was not meeting requirements to ensure people were protected people against the risk of abuse.

People were not protected from the risks associated with unsafe medicines management.

We observed unsafe practices during medication administration. Where people had medicines prescribed 'as required' there were not always clear guidelines in medication records as to what criteria was to be used to determine when these should be given .

Staff were not appropriately supported to ensure they fulfilled the responsibilities of their roles. The induction process was not of a sufficient level to ensure people were equipped with appropriate knowledge to competently perform their duties.

The Mental Capacity Act (MCA) 2005 is an act which applies to people who are unable to make all or some decisions for themselves. We saw examples of where staff did not act in accordance with this and had consented to decisions for people without following the procedures set out in the act.

People's nutritional needs were not always met as individual preferences were not always taken into account. We saw instances where people needed support to eat their meals and their daily records did not always show what people had consumed. We noted some people in the home had experienced weight loss. Referrals had been made to other health professionals where this had been identified.

There was a lack of stimulation for people using the service. Very few activities were observed with none being seen to take place on Poppy Lodge. People were observed to sit for long periods with little or no interaction. Care duties were performed in a routine like manner that benefitted the staff as opposed to meeting the individual needs of the person.

Although we saw instances of caring interactions between staff and people using the service, we saw occasions where people were not respected and did not have their dignity maintained. We observed that staff at times did not speak to people or offer reassurance when they were providing support. A care worker audibly disclosed personal information about a person at the home in front of them and other people.

Observations around the home showed that infection control processes were not robust enough to minimise and prevent the risk of spread of infection.

Audits and quality monitoring of the service were not effective and issues identified were not acted upon accordingly. Analysis of incidents was not of a level to identify trends and investigate ways to try to reduce these.

We found ten 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.

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. Staffing arrangements were insufficient and did not ensure that people were safe from harm. Staff locked some people in their rooms without consent to prevent them from being harmed by others.

Incidents of abuse were not always referred to appropriate authorities and acted upon accordingly which meant people were exposed to further risk of harm.

Medicines were not handled in a safe way to ensure people were protected from risks associated with unsafe management of medicines. Infection control processes were not robust enough to minimise the risk of spread of infection.

Is the service effective?

Inadequate

The service was not effective. Arrangements for people's nutrition were not of a level to meet people's individual needs.

Where people did not have capacity to consent to specific decisions, the service did not act in accordance with the Mental Capacity Act 2005. As such, it could not be demonstrated that decisions made were always in people's best interests.

The induction programme in place was not effective and did not provide suitable support for staff to fulfil their roles competently. Staff had training in a number of areas. However, it was not clear that the training equipped them with the knowledge and skills to care for people with complex behaviours

Is the service caring?

Requires Improvement

The service was not always caring. Although some people gave positive comments about staff and how they were cared for, this was not consistent.

A lack of positive interaction and communication from staff towards people when providing support was observed. We saw instances where people's privacy and dignity was not maintained.

Is the service responsive?

Inadequate

The service was not responsive. There was a lack of stimulation and interaction available for people. Care was provided to suit a task based approach as opposed to meeting the personalised needs of people.

Resident and relatives meetings did not take place which meant there were limited opportunities to obtain feedback from people using the service.

There was a complaints procedure in place and most people and relatives told us they would approach the registered manager with any issues.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well led. Audits and quality monitoring did not effectively identify areas for improvement. Where any areas had been identified, actions to address these were not always implemented.

Communication between staff was limited with team meetings rarely taking place. None had occurred in 2014 and only one had taken place in 2013.

Incidents and accidents were collated and analysed but the findings had not been fully explored to identify trends and to protect people from risk.

Deangate 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 checked 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.

The inspection took place on 11 and 18 November 2014 and was unannounced.

On the first day, the inspection team consisted of an adult social care inspector, a specialist advisor who was a registered nurse 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. The expert by experience had experience in older people's care services. On the second day of the inspection, the inspection team consisted of two adult social care inspectors.

Before our inspection, we reviewed information we held about the service which included statutory notifications of deaths and incidents. We contacted commissioners of the service, the local authority safeguarding team and the local Healthwatch, for any relevant information they held. We asked the provider to complete a provider information return [PIR] which helped us to prepare for the inspection. This is a document that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We contacted several health and social care professionals who had involvement with Deangate Care Home and received feedback from two community nurses.

During the inspection we spoke with thirteen people who lived at the home. Due to the nature of their conditions, verbal feedback from some of the people was limited. We spoke with six relatives of people who visited the home. We undertook informal observations and spent time with people in communal areas to observe the care and support being provided.

We spoke with the regional manager, the registered manager, two nurses, a senior care worker, four care workers, the cook, the activities co-ordinator and two members of housekeeping staff.

We viewed a range of records about people's care and how the home was managed. These included the care records for ten people and the recruitment records for four staff members.

Is the service safe?

Our findings

On the first day of our inspection, the manager told us the usual staffing levels in the home. For care staff, this consisted of a nurse, senior care worker and five care workers during the day, which reduced to a nurse, senior care worker and two care workers at night time. She informed us that two staff members worked on Poppy Lodge at all times.

For the second day of the inspection, we wanted to see how the service operated during a night shift so we carried out an unannounced visit at 4am. On entering the home, all four staff members present attended the reception area, none arriving from the Poppy Lodge unit. We asked about staffing arrangements and they told us they worked in alternating pairs and undertook two hourly checks on people throughout the home. All staff said they did not spend time constantly on Poppy Lodge but told us they often went into the unit in between the two hourly checks. This arrangement differed from what the registered manager told us was in place.

On our visit during the night shift, we entered Poppy Lodge where we saw one person walking up and down the corridor, holding a set of false teeth that we later discovered did not belong to them. We observed the person go into other people's bedrooms and attempt to pick up various items. We had to ask a staff member to remove a person's razors which were accessible in a bedroom that the person went into. There was a risk the person could harm themselves or others if they had obtained these. We also saw the person climb into another person's empty bed. A staff member told us the person, "very rarely wanders in rooms." However, observations in a period of a less than an hour did not support this statement. The person's daily records contained several entries that referred to the person 'wandering' at night times. The person's care plan for 'maintaining a safe environment' stated '[Name] is to be observed by staff when on the corridor and in the lounge' and staff were to 'ensure [the person] was supervised when mobilising to offer guidance and support'.

The nurse we spoke with on the night shift told us they could recall two occasions within the last two months when they had been a staff member short at night, leaving three staff members for the whole home. Four care plans we looked at for people who resided on Poppy Lodge, stated that the people required supervision from staff with respect to their mobility and safety. The regional manager subsequently informed us that five people on Poppy Lodge required the assistance of two staff members to support them with care needs. The staffing arrangements in place did not allow for suitable supervision of people in order to keep them safe and meet their needs. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The nurse we spoke with told us of prior instances where other people on Poppy Lodge had gone into other people's rooms whilst they were occupied. Records we looked at contained numerous entries about one person going into other people's rooms and beds and sometimes refusing to leave. Additionally, the nurse told us that several hours earlier another person had been found in bed with someone else on the unit when staff had gone to do their checks. Staff told us the person whose bed it was did not know how to use a call bell and would therefore not be able to summons assistance. As staff had not been present in the unit when this incident had occurred, there was no way of ascertaining the length of time the person in the bed was left without assistance.

We found that six people's doors were locked on Poppy Lodge. The nurse said that one person chose to lock their door but that the other five people's doors were locked by staff for their own safety. This was confirmed by the other night staff we spoke with. When we asked how this decision had been made and who by, the nurse told us "It's something I personally do for people's safety." When we asked whether the people had the means to summons assistance by way of a call bell to alert staff, the staff told us that the people would not have the capacity to understand how to use one. This posed serious safety concerns as it meant people were locked in their rooms, on a locked unit with no staff in the vicinity for the majority of the time. The arrangements in place were unreasonably excessive, wholly inadequate and did not ensure that people were safeguarded from the risk of abuse. Reasonable steps had not been taken to identify the possibility of abuse or prevent it before it occurred.

Although most staff we asked told us they were aware of how to spot abuse and said they would report this, the night nurse we spoke with told us they were not clear of the process for reporting incidents as they had never had to complete an incident form. This meant there was also a risk

Is the service safe?

of some incidents of abuse not being recorded and referred on to relevant parties appropriately. In the daily notes of care records we saw there were several physical incidents documented that had not been reported to the local authority safeguarding team.

Our findings demonstrated a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Following our visit to the home on 18 November 2014, we told the registered manager and regional manager that immediate action needed to be taken to ensure Poppy Lodge was suitably staffed. We informed them that no person should be locked in their room, unless this was by personal choice where the person had capacity to make that decision. We also contacted the local authority safeguarding team and made them aware of our findings and concerns with regards to people's safety.

We observed varying practices during two medication rounds at the home. On our first day of the inspection we saw a nurse and senior care worker administering morning medicines. The medicines trolley was locked when unattended and medication administration record (MAR) charts were not signed until the person had taken their medicine. However, on our second day of the inspection, we observed another staff member administering medicines in an unsafe way. We saw several occasions where the medication trolley was unlocked with the trolley doors open when the nurse was not in the vicinity of it. For example, when the nurse was administering medicines on Poppy Lodge, we saw the trolley open and accessible situated outside of the lounge. The nurse was sat further up the corridor with their back to the trolley trying to encourage a person to take their medication. We observed three people walking along the corridor passing the open trolley to go into the lounge. One person attempted to pick up some items but had to be distracted by a member of the inspection team to prevent them from doing so. The person's care plan stated they 'required close supervision during medication rounds as they sometimes pick things up'. No staff had been observing the person when we saw this. We advised the nurse at the time we witnessed this about the need to ensure that medication was appropriately secured.

On the second day of the inspection, we observed morning medicines still being administered at 10.45am by the nurse and by the senior care worker. The nurse told us it was sometimes 9.30am when they started their medication round. This meant they were not always able to accommodate the needs of people who needed to take medicines in line with certain requirements, such as prior to, or with, food. This could potentially result in medicines not being effective as people were not taking some in the manner in which they were prescribed.

In the controlled drugs (CD) cupboard we saw three bottles of a controlled drug that needed to be discarded within three months of being opened. These had been opened but there was no indication on the bottles of what date they were opened which meant they could potentially be out of date and unsuitable for administering.

In care plans we looked at, we saw most had guidance about when a person required prn (as required) medicines. This gave information about indications for taking the medicine and possible side effects. However, when we looked at MAR charts there was inconsistent information recorded to notify relevant staff about when prn medicines should be administered and in what amounts. For example, one person's medication which was given as prn stated '1 or 2 a day' with no information in place as to how this was to be determined. When asked about another person's prn medicines and when they would require these, one staff member told us they would have to "make a judgement." It is important that information and guidance is in place for staff to follow about medicines prescribed to be given 'as required' to ensure people are given their medicines safely and consistently.

The registered manager and several other staff members said no-one was currently receiving any medicines covertly but two other staff members told us that one person did receive some of their medicines this way. We saw a letter from the person's GP which said following a discussion with a staff member it was considered to be in the person's best interests to have this medicine covertly. There was no evidence that the person themselves, their family members and/or advocates had been involved in this decision. Therefore it was not possible to show that the person being administered medication in this way was in their best interests.

Our findings showed that people were not protected against the risks associated with unsafe management of medicines. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Is the service safe?

The registered manager told us two cleaning staff were scheduled to be on duty each day. Only one was working on the first day of our inspection. They told us that when a cleaner was absent, their work was not covered. This meant one person was responsible for double the amount of work which limited what they were able to do. Another cleaner we spoke with on the second day of the inspection confirmed that absences of cleaning staff were not covered and told us, "It's hard with just one of us." The registered manager told us they had problems covering absences of cleaning staff as people did not want to rely on ad hoc hours.

During our inspection we saw areas of concern which posed a risk to effective infection prevention and control. We noted one staff member not wearing gloves, in line with good practice, when administering medication which they placed in someone's mouth. We saw laundry skips stored on corridors which also created a safety hazard and obstruction for people in the home. Two people we saw in their rooms had bedside rails in place. The padding around these was very dirty and heavily stained. One person pointed to theirs to show us and pulled a disgusted face. We were also able to smell noticeable malodours throughout the home several times on both days we were there. We saw various mobility aids such as handling belts and hoist slings stored over rails on corridors and hung up on bathroom doors. People did not have their own slings and a staff member said they used whatever they considered to be suitable in terms of size. This increased the possibility of cross infection occurring.

Some rooms had very sticky floors and one bathroom we saw had a used continence pad and soiled clothing on the floor. We also saw a layer of debris on the bottom of a bath in Poppy Lodge. We noticed stains on a radiator and furniture and saw food crumbs and particles on chairs and floors. We saw that one person's bed had been made up but the bedding was stained. We found a tablet on a folded wheelchair in a corridor which supported our view that it had not been sufficiently cleaned. Our observations showed that effective infection control processes were not being maintained. Feedback prior to our inspection from an infection control nurse stated that despite three visits by them, no action plan had been received from the registered manager of how to address areas identified as requiring attention several months previously. Our findings also evidenced that a number of areas were still outstanding.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw several further potential hazards during our observations as some rooms that stated they were to be kept locked were open and accessible to people. These included a boiler room, a sluice and a store room. No staff were in the vicinity of these rooms at the times we saw them open.

We looked at the recruitment files for four members of staff and saw that these contained application forms, details of previous employment history and references. Any gaps in employment had been accounted for. Staff we spoke with confirmed that they had to supply references and have (DBS) Disclosure and Barring Service checks in place prior to commencing employment. DBS checks help employers to make safer recruitment decisions.We saw DBS checks in place for three of four employees files we checked. In one file we did not see details of such a check for a fourth person who had worked at the home several years. The registered manager assured us the person had one in place but we did not receive details of this despite a request made to the registered and regional manager. The information we saw at the time showed that processes were in place to ensure people were assessed as suitable to work at the service.

Is the service effective?

Our findings

We asked people their views of the food and responses were mixed. Some people were positive, with comments including, "They give you a nice dinner" and "The food is good." However, some people expressed dissatisfaction and remarked they were, "Fed up of sandwiches for tea" and that the food was "old fashioned." One person said, "I could do with more cups of tea and really hot, I'm fed up with cold." A relative of another person said their family member had previously liked to drink several large mugs of tea daily but had only been provided with small amounts of tea and not very often, when they lived at the home.

We spoke with the cook who prepared meals from a four week menu planner. The cook told us this menu had not been changed ever since they had commenced employment at the home, two years previously. The registered manager confirmed there had been no variation to the menus and there was no involvement or any input from people at the service as to the content of these.

The cook received details on a daily sheet of where people had certain nutritional requirements such as a liquidised or soft diet so they were able to accommodate these. We saw 'dietary requirements' sheets in care records which gave information about people's likes, dislikes, allergies and preferences. These were reviewed monthly and the record stated that a copy should be kept in the kitchen so that catering staff could refer to them. This was not occurring and ones we did see in the kitchen were not current. Some sheets were from 2011 and related to people no longer at the home. The cook said they "could do with updating."

We observed lunchtime in the main dining room at the service and noted that the dining room tables were set with place mats, table cloths condiments and cutlery. There were menu cards on each table for a two week period but these were quite wordy with small writing and not easy to read. In the dining room on the Poppy Lodge unit, there was a menu board available to display choices for people to see but this had not been completed. Staff we spoke with told us that people who required support to eat their meals sat together and were assisted by a staff member. During our observations on Deangate, we saw there were three care workers in attendance. We noted one person struggling to eat their dessert and one person who lived at the service assisting another person to eat. This meant that prompting and supervision was not always effective to ensure people were supported to eat their meals.

On Poppy Lodge, we saw some people were encouraged to attend the dining room on the unit to eat their meals. However, some people ate their meals in the lounge but there was not always a staff member to provide assistance where required. It was not a calm experience as we saw one care worker struggling to support people into the dining area as some people would often return to the lounge once they were no longer supported or encouraged. One person dropped some meat from their dinner on the floor several times when no staff were present and was distressed throughout their meal. Staff told us they monitored what people ate and any concerns would be referred on appropriately, for example to the speech and language therapy team (SALT). On our first visit of 11 November 2014, we looked at food charts which were in place for people on Poppy Lodge. The last date where these had been completed was 9 November 2014 with nothing recorded since. This meant it was not possible to establish whether these people had received adequate support with their nutrition since that time. We noted some people in the home had experienced weight loss although referrals had been made to other health professionals where this had been identified.

Our findings evidenced a breach or Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The Mental Capacity Act (MCA) 2005 is an act which applies to people who are unable to make all or some decisions for themselves. It promotes and safeguards decision making within a legal framework and states that every adult must be assumed to have capacity to make decisions unless proved otherwise. It also states that an assessment of capacity should be undertaken prior to any decisions being made about care or treatment and, that any decisions taken or any decision made on behalf of a person who lacks capacity must be in their best interests.

In records we looked at we saw several examples where the MCA code of practice had not been followed. For example, we saw in one care plan that a person's relative had signed various agreements on their behalf. This included consent to photographs and authorisation for a flu vaccination. The registered manager told us the person had capacity and we

Is the service effective?

saw where they had signed other consent forms themselves. There was no rationale as to why their relative had given consent for them in the other instances we saw. There was no accompanying documentation to show the person did not have capacity to make the decision in question for themselves and that it was in the person's best interests. We also saw another example of this in a separate care plan where a staff member had signed on behalf of a person giving consent for a specific decision. Again, there was no accompanying capacity assessment or rationale to show this was in the person's best interests. This demonstrated that the principals set out in the MCA code of practice were not being adhered to. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The Deprivation of Liberty Safeguards (DoLS) are part of the MCA and aim to ensure that people are looked after in a way which does not inappropriately restrict their freedom. The manager had identified people within the home who she believed required a DoLS authorisation in place in line with criteria arising from the supreme court judgement. Four applications had been made at the time of our inspection and more were ongoing on a priority basis. She anticipated most people at the home may require an authorisation. A board in the nurses' office displayed a symbol next to people's name which told staff that the person had a DoLS authorisation request in place. However not all staff we spoke with were clear about who was on a DoLS and how this was to be managed which meant there was a risk of care not being delivered in line with requirements of any DoLS safeguards in place.

Staff told us they received regular supervisions and appraisals. They told us of various training they undertook in order to perform their roles, most of which was delivered in house by the deputy manager. We saw workbooks in training staff training files which covered a number of areas such as first aid, infection control and dementia training. They also told us that external training was available where required. For example, one care worker told us how all staff had recently received specialist training to accommodate the health needs of someone who had recently been admitted to the service. When speaking with staff about certain areas of training, for example the MCA 2005, knowledge was varied with some demonstrating an understanding and some not being able to describe how it applied to their role. This meant the variation in staff understanding could lead to inconsistent practices.

At our second visit we asked the nurse, who had recently commenced employment, about their induction process. They told us they attended the home for a day with the deputy manager and were shown where the medicines were stored and what they were expected do on the medication round. In the nurse's training file, we saw a comprehensive RGN (Registered General Nurse) induction log detailing a number of areas that the new staff member had to work though as part of their induction. This had a target date of 12 weeks for completion. The nurse's induction record had all areas signed off as completed on one day, which was prior to their start date. This was not an accurate reflection of what the induction had consisted of as told to us by the nurse, who was also unable to describe how to report incidents. We saw another recent starter's induction record, again with a 12 week target date for completion, which had all been signed as completed on one day. We were not satisfied that the current induction process was being worked through at a required level for staff to be able to demonstrate a sound understanding of their role. This meant that suitable arrangements were not in place to ensure that staff were properly trained by providing a comprehensive induction.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw where people were referred to other health professionals. Care records we looked at evidenced involvement from other professionals to address people's health needs including doctors, memory team professionals and district nurses. Staff told us that where they recognised any change in a person's health this would be reported to a senior staff member who could make any necessary referrals where appropriate to ensure the person got the support they needed to maintain good health. Relatives we spoke with told us that a staff member attended hospital appointments with their family member.

Is the service caring?

Our findings

People's views of the care they received and their opinions of the staff varied. Some people had experienced or witnessed negative interactions. One person said, "Sometimes they [staff] treat the women a bit harshly, they tell them to shut their mouths and talk a bit rough." Another person said that the current staff on duty at the time were "alright." They went on to say "The other night staff are a bit uppity, sometimes it feels like we are here for their benefit and not the other way round." Other people had positive comments to make and told us, "The girls are all kind", "The girls are lovely and look after me well" and "The staff are marvellous." We spoke with four relatives who visited regularly and said they were made to feel welcome and had no concerns. We saw a number of recent complimentary comments and thank you cards displayed in reception

Although we witnessed some caring interactions between staff and people, we saw some interactions that did not demonstrate a caring approach. For example, during lunchtime we saw two staff members assisting people to eat their meals. Whilst this took place, the staff members had a conversation with each other, which did not include the people they were supporting. On some occasions when staff were assisting people to transfer by use of a hoist, they spoke to each other over the top of the person. No communication or reassurance was offered to the person throughout the procedure.

We also heard comments to people from staff that were not respectful. We heard one person shouting out and a staff member walked away from them and commented about the person, "[Name] can get downstairs on her own. She is just wanting attention." The person was told to "Stop shouting." The person later asked the same staff member for an item they needed but was ignored. We saw another care worker assisting a person to transfer from their wheelchair into a chair. The person was agitated and the care worker did provide reassurance. However the care worker then told us audibly and in front of other people about personal health needs that the person had. We spoke with the care worker privately. They were not aware of how they had treated the person by disclosing personal information in front of others or the impact on the person. We also gave feedback of this incident to the registered manager and regional manager.

When we asked one person if staff respected their privacy, they told us, "They knock on the door but they don't wait to be invited in." During the second day of our inspection, we saw two people asleep in the lounge in Poppy Lodge. One male was wearing only a pair of underpants and there was a pile of clothing in the doorway to the lounge. A female was in a chair next to the person and we noticed that a torn incontinence pad was on the floor at their feet with bits scattered throughout the lounge. We had previously seen them tearing this up. It was several hours later that this was discarded and the room tidied. Our observations showed that these people had not been supported by staff to maintain their dignity.

Our findings demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Care plans we saw contained information for end of life care and people's wishes at this time. These were reviewed monthly and people's preferences were in place.

On display in the reception area were details about how people could make use of advocacy services if they required. Since our last inspection, the service had created a 'tea room' which was a room where people were able to spend time in a quieter environment. The registered manager told us that the room had proved popular and afforded a more personal environment for visitors to spend time with their family member and friends.

Is the service responsive?

Our findings

On the first day of our inspection we saw that following breakfast, people were taken into the main lounge. At 10.30am we saw six people sat on hoist slings in wheelchairs awaiting assistance to be transferred into chairs. The people had been taken into the lounge and were seated in a row. Once people who required transferring by the hoist were in the room, staff began to move them one at a time from their wheelchairs into chairs. The hoist slings remained underneath the people which meant this would be uncomfortable and also render any pressure relieving cushions that people were sat on, ineffective. At 11.05am we saw a total of eight people sat on hoist slings who remained like this until they were assisted to move again. This approach was routine led as opposed to meeting the needs of each person by assisting them into a chair once they had been taken into the lounge and making them comfortable at that point.

We looked in people's rooms and saw that some people did not have access to call bells due to there being no lead in place or the wall switch being located in an area not easy to access. One person told us, "It varies on the staff as to how quickly they come." Another person who received care in bed told us that staff sometimes took a while to respond in the day time when they pressed their buzzer. The registered manager and staff told us some people would not be able to use a call bell but we saw no reference to this in their care records. One person had an alarmed mat at the side of their bed which alerted staff when the person stood on it. This was not plugged in so was ineffective. Another person sought attention from staff by walking up and down the corridor to look for someone. We supported them to use their call bell as they were unclear how to use this. Further attention was required with regards to people's capabilities to use equipment to ensure that staff could respond to people's needs appropriately.

Although the service employed an activities co-ordinator, we saw little stimulation available for people. People told us of occasions, such as Christmas and Bonfire night where events had taken place, one person saying, "They put on a good show at Christmas." Photos on display in reception showed some entertainment that had taken place within the home. Comments from people about more regular activities were mixed. One person told us that sometimes the activities co-ordinator took them out to see a show, telling us, "It's lovely." However, others told us, "I like to do crosswords and read a newspaper but there aren't any here" and "They had a 'turn' once but nothing much happens that I'm interested in." We spoke with one person who was not able to communicate verbally but could understand and respond to questions non verbally. They spent time in their room and informed us they were not aware there was an activities co-ordinator at the service. When asked, they said staff did not spend any social time with them.

The activities co-ordinator told us they facilitated art, crafts and baking for people who wanted to take part and people sometimes played dominoes or watched sport. We saw an activities planner on display but noted that the planned activity due to take place at 2.00pm on the first day of our inspection did not occur. The only activity we saw taking place was some people having their nails painted and a hairdresser was also in attendance. We saw no activities of any description take place on Poppy Lodge. The service did not offer a stimulating environment. For example, on Poppy Lodge, several people were known to like walking along the corridor, some people were tactile and liked interacting with things which was displayed by them attempting to pick items up. Apart from some magazines that we saw no one show any interest in, there was nothing available to provide a stimulus for these people. This meant that opportunities for social interaction and stimulation were lacking.

On the second day of our inspection, we saw people being assisted into the dining room in the morning to await breakfast. We did not hear people being asked their preference of where they wanted to wait until breakfast was ready. At 6:30am we saw five people in the dining room, two in wheelchairs, all sat at individual tables. Each person had a hot drink in front of them. There was no stimulation such as any music or a TV and people were not talking with each other. One person was bent over asleep with their head on the table. At 6.55am a staff member came in to retrieve something and spoke only to one person in response to a question they asked. We observed again at 8.00am and saw ten people were present and no staff. Some people started to ask how long breakfast would be. At 8.15am a staff member entered the room but did not greet any of the people and went into the kitchen. Ten minutes later another staff member started to serve breakfast. A staff member told us people got up when they chose and would be assisted into the dining room for

Is the service responsive?

breakfast. Again, our observations evidenced that this appeared to be a routine led arrangement with little thought given to offering stimulation for people who had been sat there from as early as 6:30am with little interaction.

Some people on Poppy Lodge sometimes displayed behaviours that may challenge others due to conditions attributed to living with dementia. Although training statistics showed that 96% of staff had undertaken training in challenging behaviour we found that no information had been recorded about potential triggers for people when this behaviour occurred. A professional from the memory clinic had advised that there must be subtle signs that staff were not picking up on but staff told us they had not been able to identify any. A contributing factor for this was that staff were not always present supervising people and were not responsive to helping manage this behaviour and minimise risk to people using the service.

Our findings evidenced that people were not receiving the care needed to meet their individual needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Care files we looked at included information about people's care needs, medical history and a social profile was in place to provide personalised information about them. This included information about where they were born, their childhood, likes and dislikes and activities they enjoyed. Information was reviewed regularly and, we were told, in response to any change in needs where these had been identified. There was a family communication record which gave details about contact and involvement with family members. Some relatives we spoke with told us they had been involved in their family member's care plan. One relative we spoke with was happy with the care but could not recall being asked about their family member's likes and dislikes. Another relative of the same family member told us the person normally wore glasses and false teeth. However, these had been lost and they were not aware of any efforts by the home to rectify this. The relative told us, "She brightened up last time she had her glasses on, now we don't know where they are. It's been a while." When we asked if the person had had a recent eye test, the other relative said they doubted whether this was possible so had not pursued it. We advised them to discuss this with the registered manager. They told us of positive action taken by the home such as moving their family member into a larger room when they were struggling to manoeuvre in a previous room.

There was a complaint's procedure on display in reception and a number of compliment cards and letters on display from people. The registered manager told us relatives often came into the office if they had any concerns and matters could normally be resolved informally. She said she would record and investigate complaints formally when required. Relatives said they would contact the manager if they had any complaints. One relative told us, "If we have any problems we see [manager] and she sorts it out." A person at the home told us of a previous complaint they had which had been resolved by the registered manager. A complaint was ongoing at the time of our inspection and was being formally investigated by the regional manager.

Relatives and/or residents meetings did not take place as the registered manager told us historically these had not been well attended. This meant opportunities for feedback were limited which restricted how much influence people could potentially have in how the service ran.

Is the service well-led?

Our findings

People gave varying comments about the manager. One person told us she was "not bad" and said they had spoken to her several times. Another person who had been at the home several weeks told us they had never met the manager and someone else had met her only one time. Most staff we spoke with during our inspection told us they felt supported by the registered manager.

The service was not run to suit the needs of the people living there. For example, we fed back to the registered manager on the second day of the inspection that the medication round had not started until after the nurse had assisted people with breakfast, meaning some people were not receiving morning medicines with food and at times they required. The registered manager told us that this particular staff member chose to work this way whereas another nurse, when they were working, chose to start administering medicines earlier and assist people to get up in the morning. This told us that there was no structure and management guidance for staff to adhere to ensure people's needs were met effectively.

Another nurse had also told us that within the last two months, their shift had been short staffed of care staff on two occasions. Both the registered manager and regional manager said there was a protocol to follow when there was a shortage of staff whereby they would be contacted to source additional staff. Neither were aware of any shortage during the periods we informed them about which suggested the process was not working correctly or not fully understood by staff.

We also received conflicting information from the registered manager and staff about the staffing levels required on Poppy Lodge. The registered manager told us that two people were required to be on the unit permanently at all times, later saying that one person was required to be located there full time at night, assisted during two hourly checks by another staff member. However, night staff told us they were not located permanently on Poppy Lodge during the night. This showed there was a lack of consistency and understanding about the required staffing arrangements.

There were no suitable provisions or checks in place ensure the induction and training process for staff was robust and of a level so they fully understood their roles and responsibilities. This meant there was an increased risk of people receiving unsuitable and inappropriate care.

A care worker we spoke with told us they couldn't remember the last time a team meeting had taken place. Another care worker said communication was "mixed", especially between night and day staff. An action identified on a monitoring report completed by the regional manager on 9 July 2014 stated; 'Staff meeting needed by [registered manager] by 31.7.14'. When we asked for the last team meeting minutes, the registered manager told us, "We've not had many." We saw the latest minutes were from over a year ago on 12 August 2013, Prior to this, the last team meeting had taken place in 2012. This meant that there was a lack of sufficient opportunity for staff to be kept informed as a team about relevant information both to their roles and the service.

Various audits were completed to assess the service provision. However, although information was captured it was not always evident that it had been acted upon. For example a medication audit from October 2014 had identified that temperatures in the treatment room had been in excess of the required room temperature to store medicines. There was no information recorded about any action that needed to be taken to address this and we found that this was still occurring in November 2014 which questioned the usefulness of identifying this issue. Additionally, audits did not always identify areas for attention as we identified issues, for example with medicines storage and handling, that had not been picked up on previously.

The registered manager and the service were overseen by a regional manager. Due to a recent restructure, the person fulfilling this role had changed three months previously. We asked for the most recent monitoring reports that were completed as part of this role and were provided with one from July 2014, and one from October 2014 both of which were stated as being completed by the current regional manager. Both reports contained similar items in places and it was evident that some actions identified as being outstanding in July 2014 had not been completed. For example one action to complete the risk assessment for a specific person was identified as 'immediate' on both documents. The regional manager acknowledged that they

Is the service well-led?

did attend the home but more so for 'familiarisation visits' whilst they were relatively new in post. By not maintaining meaningful monitoring visits and following up on previous actions, there was a risk to people using the service as areas for improvement had not been identified and actions were not sufficiently monitored for completion .

Accident and incidents were logged by the registered manager and reviewed each month for any trends or themes that could be identified. This information was then sent to head office for further review. Although we saw specific instances where trends had been recognised pertaining to individuals, it was not clear that any attempts were being made to identify the reasons for accidents and incidents at a wider level. We looked at the analysis for the last three months and saw that each month there was a significant amount of unwitnessed falls and incidents. For example, there were 21 unwitnessed incidents in October 2014,12 in September 2014 and 14 in August 2014. The findings were assessed as 'single incidents' or 'slips and trips with no serious injury'. No further exploration had been undertaken to ascertain whether there were any themes to be derived from these. Some incidents were unexplained with one person being found in their room with cuts and bruises to their head but no further investigation had taken place into these. Our observations indicated that the staffing arrangements were not conducive to maintaining safety of people.

The service did not have effective systems in place to identify, assess and manage risks relating the health, welfare and safety of people using the service. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The registered manager and regional manager told us they had recently sent out quality assurance surveys to relatives but results had not yet been received, collated and analysed. Staff did not receive opportunity to provide their views in this manner. The quality assurance surveys prior to this had been undertaken in July 2013 which showed there was a lack of formal quality assurance undertaken at the service.

The registered manager told us she submitted notifications in accordance with the statutory notifications required to be made in line with the Health and Social Care Act 2008. However, there was a lack of clarity between the regional manager and registered manager as to who was currently responsible for submitting these notifications to the CQC. This led to confusion as to what notifications had been made, who by and whose responsibility it was. The registered manager subsequently informed us that the process had been agreed that they would have oversight of any notifications and the registered manager would then be required for submitting these.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services How the regulation was not being met: People were not protected against the risk of receiving inappropriate and unsafe care as care was not planned to meet people's individual needs. (1) (b) (i) (ii)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse How the regulation was not being met: Service users were not safeguarded against the risk of abuse by means of staff taking reasonable steps to identify the possibility of abuse and prevent it before it occurs and responding appropriately to abuse. Where a form of control or restraint was used, the registered person did not have suitable arrangements to ensure this was not unlawful or otherwise excessive. (1) (a) (b) (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control How the regulation was not being met: The registered person did not ensure that service users and persons employed were protected against identifiable risks of acquiring an infection by having an

This section is primarily information for the provider

Action we have told the provider to take

effective operation of systems to assist the risk and spread of infection. Suitable arrangements were not in place to ensure maintenance of appropriate standards of cleanliness and hygiene.

(1) (a) (b) (2) (a) (c) (i)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines How the regulation was not being met: Service users were not protected against the risks associated with unsafe use and management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs How the regulation was not being met: The registered person did not ensure service users were protected from the risks of inadequate nutrition and dehydration by means of a choice of suitable and nutritious food and hydration in sufficient quantities to meet service users need. (1) (a)

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 How the regulation was not being met: People who use services did not have they dignity maintained and were not treated with consideration and respect. (1) (a) (2) (a)

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment How the regulation was not being met: The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing How the regulation was not being met: There were not sufficient numbers of suitably qualified, skilled and experienced persons in order to safeguard the health, safety and welfare of service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff How the regulation was not being met: New staff were not supported in relation to their roles and responsibilities to enable them to deliver care and treatment safely by way of receiving appropriate training, professional development, supervision and appraisal. (1) (a)

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 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers Service users were not protected against the risk of inappropriate or unsafe care as the operation of systems was not effective in enabling the registered provider to regularly assess and monitor the quality of services or to identify, assess and manage risks relating to the health welfare and safety of service users and others who may be at risk. Regulation 10 (1) (a) (b).

The enforcement action we took:
A warning notice was served on the provider