Helen McArdle Care

Acomb Court

Inspection report

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Ratings

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

Overall summary

This inspection was unannounced and took place on the 11, 12 and 17 November 2014.

Acomb Court is registered to provide accommodation to up to 76 people with either residential, nursing or dementia care needs. Accommodation is split over three floors and at the time of our inspection there were 68 people living at the home.

The home had a registered manager who had been registered with the Care Quality Commission to manage the service since April 2011. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe living at Acomb Court but some said that staff did not always treat or speak to them appropriately. There were systems in place to protect people from abuse and channels through which staff could raise concerns. However, we received information which we subsequently passed on to the local authority safeguarding team for investigation.

A process was in place to assess people's needs and risks they were exposed to. In addition, care records were regularly reviewed but we found that in practice care

Summary of findings

delivery did not always reflect instructions in care plans. For example, some people at risk of pressure ulcers were not repositioned as they should have been to prevent skin breakdown or promote healing of existing wounds. Medicines were not always administered in a timely manner and systems were not always in place to identify where medicines had expired and should no longer be used. Regular health and safety checks were carried out on the premises and equipment used within the home, but all of the documentation related to these was not available to demonstrate that the premises were suitably maintained. Recruitment processes were thorough and included checks to ensure that staff employed by the home, were of good character. Staffing levels appeared to be sufficient, but in practice the supervision of staff whilst working led to shortfalls in care delivery that need to be addressed.

Staff records showed that staff received regular training that was up to date. However, dementia awareness training was not effective in meeting the needs of people living with dementia. Staff received regular formal supervision and appraisal. The environment did not reflect best practice guidance in relation to attaining the best possible health and quality of life outcomes for people living with dementia. For instance there was no change in the colour of the walls to orient people and a lack of objects to occupy their attention.

CQC monitors the operation of Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act (2005). These safeguards exist to make sure people are looked after in a way that does not inappropriately restrict their freedom. We saw the registered manager had applied for DoLS for a number of people living in the home and that people's ability to make their own informed decisions had been assessed at times, but this was not always fully documented.

People told us and records confirmed that their general healthcare needs were met. We saw that people's general practitioners were called where there were concerns about their welfare and other healthcare professionals such as dentists and chiropodists as and when required. People gave us mixed feedback about the food they were served, some saying it was not nice and others that it was fine. We saw that people's nutritional needs were considered and dieticians and speech and language therapists were involved in people's care.

Some people told us that they were treated with dignity and respect by staff and others told us that they were not. Our observations confirmed that people experienced care and treatment that did not protect and promote their privacy and dignity and we saw several staff did not treat people with respect. The staff team spoke about people amongst themselves when people were present. We saw people were left sitting in an undignified manner at times. Staff did not always display caring and compassionate attitudes towards people.

People had individualised care plans and risk assessments that were regularly reviewed although these reviews did not identify shortfalls in care records or care delivery. Some people received care that was personalised and others did not. For example, one person at risk of social isolation was observed to have very little interaction with staff during the three days of our inspection. People told us and our own observations confirmed that there was little stimulation for people in the home. Some people commented that they were bored and it was a "glum environment".

Some systems were in place to monitor the service provided and care delivered, but we found that these were not always effective and in certain areas, care delivery was not monitored when it should have been. We received mixed feedback from staff, people, their relatives and external healthcare professionals about the leadership and management of the home. Records were not always complete and at times people's care records were difficult to follow.

The registered manager had not notified the Care Quality Commission of two safeguarding issues within the last twelve months that they should have. This was a breach of the Care Quality Commission (Registration) Regulations 2009.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and their corresponding regulations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were; Regulation 11 Safeguarding service users from abuse, which corresponds to Regulation 13, Safeguarding service users from abuse and improper treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Regulation 13, Management of medicines, which corresponds to Regulation 12 (f) & (g), Safe care and treatment, of Health

Summary of findings

and Social Care Act 2008 (Regulated Activities) Regulations 2014; Regulation 17, Respecting and involving people who use services, which corresponds to Regulation 10, Dignity and respect, of the Health and Social Care Act 2008 (Regulated Activities) 2014; and Regulation 20, Records, which corresponds to Regulation 17(2)(d), Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

We found a further two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 where we have taken enforcement action against the provider. These were in respect of Regulation 9, Care and welfare of people who use services, and Regulation 10, Assessing and monitoring the quality of service provision. Information about the enforcement action we have taken is detailed at the back of the full version of this 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.

People were not protected from the risks of receiving care or treatment that was inappropriate or unsafe as care planning, delivery, assessment and monitoring was not always effective. This meant people did not always get the care they needed.

People told us that they felt safe but some described staff practices that were not appropriate. Staff had undertaken training in safeguarding. They were able to tell us about the different types of abuse but our findings told us that people were not always kept safe. People did not always receive their medicines on time and there were shortfalls in the recording of medicines administration.

Staffing levels were appropriate but how staff were deployed and supervised whilst working required improvement to enhance people's care experience. A thorough recruitment process was in place.

Is the service effective?

Requires Improvement

Not all aspects of the service were effective.

People told us that they felt staff met their needs although in practice this was not always the case.

Records showed that staff received training regularly, but we saw that people did not always receive the care they needed because this training was either ineffective, not extensive enough, or staff did not apply what they had learned.

There was evidence that assessments were undertaken in relation to the Mental Capacity Act (2005) to determine the level of people's ability to make informed choices. Applications had been made to the local safeguarding team to ensure that no person had their freedom inappropriately restricted.

Some people reported that the food they received was fine and others said it was not. We saw that generally staff were aware of people's nutritional needs but at times they were confused by contradictions in care records. People had input into their care from external healthcare professionals such as doctors, dentists, dieticians and speech and language therapists.

Is the service caring?

Inadequate

The service was not caring.

People were not always respected by staff and their dignity and privacy was not always maintained. We saw people were spoken to inappropriately by staff and at times they were left sitting in an undignified manner.

Summary of findings

Staff did not always display caring and compassionate attitudes towards people and we saw and heard several interactions between staff and people that concerned us. Some people told us that they were reluctant to ask staff for help as they did not want to bother them.

Is the service responsive?

Requires Improvement

Not all aspects of the service were responsive.

Some people received care that was personalised to their needs and some people did not. Care plans and risk assessments related to a range of activities of daily living but these were not always followed in practice. This meant people did not always receive the care that they required.

There was a lack of stimulation and activity within the home and we found that some people felt socially isolated as they experienced little one to one contact, especially those people who stayed primarily in their own rooms.

Complaints were handled appropriately and the provider had a policy and procedure in place which we saw was followed.

Is the service well-led?

Requires Improvement

Not all aspects of the service were well-led.

There were a range of audits in place designed to monitor care delivery, but these were not always effective. Some elements of care delivery that should have been monitored were not, such as the management of pressure area care and food and fluid intake.

Staff and people reported low morale among the staff team and some people said they were not happy living at the home.

We received varying views and several concerns regarding the leadership within the home from people, their relatives and external healthcare professionals linked to the home.

Acomb 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.

We visited the home on three separate dates, 11, 12 and 17 November 2014. This inspection was unannounced.

The inspection team consisted of two inspectors; a specialist nursing advisor and an expert by experience with experience of older people's care services. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Prior to the inspection, the provider completed a Provider Information Return (PIR). This is a form which asks the provider to give some key information about the service, highlighting what the service does well, and identifying where and how improvements are to be made. We reviewed the information returned to us by the provider in the PIR, alongside information that we held internally within the Commission (CQC) about the home. This included reviewing statutory notifications and safeguarding information that the provider had sent us historically across the last 12 months. In addition, we contacted the commissioners of the service, the local authority safeguarding team, Healthwatch (Northumberland) and the community matron for nursing homes. We also contacted seven healthcare professionals including a clinical psychologist, GP, dentist and speech and language therapist, in order to obtain their views about the care provided in the home. We used the information that they provided us with to inform the planning of our inspection.

During the visit we spoke with 15 people living at Acomb Court, three people's relatives, two nurses, six care staff, the registered manager and the nominated individual. We walked around each floor of the home, looked in the kitchen, people's bedrooms and all communal areas such as lounges and dining rooms. We observed the care and support people received within these communal areas. We reviewed a range of records related to people's individual care and also records related to the management of the service and matters of a health and safety nature. For example, we studied eight people's care records, seven staff recruitment records, training and induction records, 28 people's medication administration records and records related to quality assurance audits and utility supplies certifications .

We also used the Short Observational Framework for Inspection (SOFI). SOFI is a tool used to observe care which helps us understand the experience of people who were unable to communicate their views and feelings to us verbally.

Inadequate

Is the service safe?

Our findings

During our inspection we asked people if they felt safe living at the home. Most people told us they felt safe and comfortable. Comments included; "I feel secure"; "I have no qualms about safety"; and "If I fall down someone comes to help me; I am safe here". Although most people told us they felt safe living at the home, some of the information they told us raised concerns about how staff physically supported them during care delivery. We were also concerned that people may have been subject to psychological harm. One person said, "I'm safe yes, but not happy. Oh they are so rough and rushed and not very sympathetic when you are not feeling very well. I mean most of them are quite nice, but we have those who are not very pleasant." Another person told us, "When staff come they are abrupt. Sometimes they say 'You are useless'. Sometimes they say, 'There is not just you, you know, there are lots of other people here'. They say I am bad tempered."

We observed the care that people received within communal areas of the home and saw some concerning interactions between staff and people. We saw two members of the care staff team sharply lifting people's legs onto wheelchair footrests, without prior warning, which caused them discomfort. Some people cried out verbally during these interactions. We reported our concerns about the practices employed by these staff members to the registered manager and the nominated individual during our inspection. They said they were shocked by our findings and advised us that they would look into these matters. On the last day of our inspection, a staff member raised concerns with us regarding the practice of a specific care worker. We acted on this information and made a referral to Northumberland local authority safeguarding team.

The staff member who reported this abuse to us confirmed that they had completed training in safeguarding and they were fully aware of the provider's safeguarding and whistleblowing policies and procedures. They were able to tell us about the different types of abuse. All other staff that we spoke with were knowledgeable about safeguarding and the provider's policies and procedures.

When we reviewed documents in place to record incidences where people may have displayed behaviours that could be perceived as challenging, we identified an incident where two people had physically hit each other fourteen days earlier. Records showed that this incident had not been logged within the accident and incidents folder and the registered manager and deputy manager told us they were not aware that this incident had taken place. The registered manager confirmed that consequently, this incident had not been reported to the relevant people's care managers or their family members.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2010, which corresponds to a breach in Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed people's care records and found that risks which people may be exposed to in their daily lives had been assessed for most people and instructions written for staff to follow to manage these risks. We observed restrictive practices and found that there was a risk-averse culture which meant the focus was on preventing risks rather than supporting people to manage risks safely. For example, we saw one person, who was at high risk of falls, was seated in view of the staff office on the third floor, so that they could be constantly observed by staff. We saw if this person tried to stand they were encouraged to sit down. We saw people were encouraged to go to their rooms or to sit in the lounge where they could be easily observed by staff. This meant that people's freedom of movement was restricted.

We found risk assessments were not always followed in practice. One person, at high risk of falls, had sensor equipment allocated to them which was designed to alert staff should they try to rise from a seated position. However, this equipment was not always in place and the call bell used for attracting the attention of staff was out of this person's reach. This was contrary to instructions within their risk assessment related to falling. This person's safety was therefore compromised and they were at risk of injuring themselves. Another person, who was at high risk of pressure ulcers, was not transferred from a seated position during the eight hours of the first day of our inspection, despite their care plan saying their position should be changed every two to three hours to protect their skin integrity. We found this person's needs had not been met as records showed that existing pressure damage on their body was not managed appropriately in order to promote wound healing. We made a referral to the local authority safeguarding team in respect of this and

identified there was a resulting breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2010. We have taken enforcement action against the provider in relation to this.

We observed the nursing staff whilst they administered medicines on each of the days that we were present in the home and we looked at how medicines were managed. We found administration practices were safe but we identified concerns around the timing of the morning medicines round on the nursing floor. The nurse told us that the medicine round usually started at 9am and could take up to two and three quarter hours to complete. We saw on our first day of inspection the morning round was not completed until 11.50am and on the second day it was 11.25am. The nurse told us that this was a fairly regular time frame and that they were "regularly pulled away" from the medicines round to perform other tasks. We observed one person, who required anti-epileptic drugs at '08.00hrs' according to their Medication Administration Record (MAR), did not receive their medicine until 10.50am. There meant that people did not always get their medicines on time.

We saw that where corrections had been made to MARs and hand written entries added, the information was confusing and difficult to follow. For example, there was no evidence over a six day period that one person's pulse had been taken prior to the administration of Digoxin, a medicine used to treat certain heart problems which works by slowing down the rate at which a heart beats. Therefore, we could not be sure that this medicine had been administered safely. We found prescribed topical medicines in three people's bedrooms that were beyond their use by date, but were still being used. A topical medication is a medicine that is applied to body surfaces, such as the skin. The registered manager could not explain our findings.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2010, which corresponds to a breach of Regulation 12(f) and (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had assessed risks related to the building. For example, regular fire and health and safety checks were carried out and also checks on the safety and suitability of equipment used in the delivery of care, such as hoists and specialised bathing equipment. Risks related to the evacuation of people from the home during an emergency had also been assessed. However, there was no evidence to show that the electrical installation within the home was safe and subsequently the registered provider could not be certain that the premises were safe.

We looked at seven staff files in order to assess if recruitment procedures were appropriate and protected the safety of people who lived at the home. We saw application forms were completed including previous employment history, staff were interviewed, their identification was checked, references were sought from previous employers, Disclosure and Barring Service (DBS) checks were obtained before staff began work. There was evidence within staff files that the registered provider had checked nurses employed were appropriately registered and that their registrations were current and valid. This meant that the registered provider had systems in place to ensure that people's health and welfare needs could be met by staff who were fit, appropriately qualified and physically and mentally able to do their job.

We asked people whether they thought there were enough staff to meet their needs. One person told us, "Sometimes they come when I ring the bell, sometimes they don't." Another person said, "Staff are stressed out and this transfers to the patients. You sort of feel so sorry that you have to ring the bell as it then gives them another job to do." A third person told us, "They (staff) always seem to be around." We noted that during our inspection call bells were answered within a reasonable period of time. We reviewed staff rotas and the numbers of staff permanently employed by the provider at the home. We saw that where there were gaps in shifts, the registered manager had mainly covered these shortfalls with agency staff and bank staff. However, on two of the days that we inspected there was only one nurse on duty, who told us, "You're forever chasing your tail. You just finish one thing and then think of another thing you have to do. I'm on my knees. I cannot work any harder. I'm worried that I will miss something or make a mistake."

We observed staff working on each floor and found that at times, on both the middle and upper floors it was difficult to locate staff. People in lounge areas were left unobserved for long periods of time, which meant staff could not be certain people remained safe and that all of their needs were met in a timely manner. On the third day of our inspection the only nurse on duty advised us they had not

Inadequate

Is the service safe?

had a break all day. In addition, we saw that some staff were having their lunch break at 4pm. The registered manager told us that she had recently employed two more nurses and nine care staff to ease staffing pressures, some of whom were awaiting the results of DBS checks before starting work.

Requires Improvement

Is the service effective?

Our findings

The people we spoke with told us that overall, staff met their needs. Some of their comments included; "Well so far they have. I think that I just need watering and feeding, as long as I am well fed"; "Some staff are alright. The girls are generally ok"; "They look after me well"; and "If you ask them for something they usually do it. There is one (staff member) I don't like". We asked people if they thought that staff were well trained and competent in their roles. One person told us, "As far as I am aware. I don't go into their training, so as far as it appears they do and they look after me perfectly – not that I take a lot of looking after. There are people far worse off than me in here."

Staff told us they received regular training but that a large proportion of this training was computer based and not face to face, which some staff indicated they would prefer. We looked at a sample of staff files and found that training in a number of key areas such as safeguarding, moving and handling, infection control and fire safety was up to date. In addition, staff had completed courses within the last three years appropriate to the needs of the people to whom they delivered care, such as, diabetes care and dementia awareness. However, we found that although staff had completed training, they did not always apply the skills that they had learned in practice. For example, whilst we saw safe moving and handling practices took place when staff moved people from their wheelchairs to comfortable lounge chairs, we also saw unsafe practice when people were asked to keep their feet raised, rather than footrests being used, whilst being moved around in their wheelchairs. There was a risk that people may injure their feet, ankles or legs during these manoeuvres.

We discussed elements of dementia care with some of the care staff working with people with dementia. We found that their knowledge was very basic, despite the complex dementia care needs of these people. Staff told us that they had completed a workbook through a local college and also undertaken an online E-learning course. One member of staff who had worked at the home for over a year told us that they had not completed dementia awareness training, despite working in the dementia unit on many occasions. There was no evidence that staff associated how people behaved, with the communication techniques they used when they engaged with them. We saw one member of the care staff team spoke to a person in an abrupt manner and the person's behaviour escalated as a result. A visiting healthcare professional told us, "Staff are not proactive enough in meeting people's emotional needs, which leads to them experiencing more challenging behaviour." Staff appeared to have limited knowledge about the value of emotional support, sensory stimulation, validation of feelings and reminiscence when supporting people with dementia. They did not sit at eye level when speaking to people and did not adjust their non-verbal communication to match the person. The pace of staff interactions was quite fast and not always adjusted to people's cognitive abilities. We did not witness any use of therapeutic touch. This showed that whilst staff had received some training in dementia care, this was not extensive, effective or appropriate enough to meet the needs of the people living with dementia within the home.

We discussed staff training with the nominated individual and the registered manager. They told us that a large proportion of training in the home had been computer based, but that there were plans to change this and training was currently being reviewed across the organisation.

Supervisions and appraisals were in place and were completed regularly. We saw that these were a two-way feedback tool and staff confirmed this. Inductions were also completed when staff commenced employment at the home and there were different induction booklets which were role specific - one for the deputy manager, one for nurses and one for care workers.

We looked at the environment within the home where people living with dementia were accommodated. We found most of the corridors were painted in the same colour with few visible features to aid orientation. In addition, there were few tactile objects around and the main activity across the day seemed to be the television, which nobody was watching. The registered manager told us that the registered provider has plans to refurbish the dementia unit in the forthcoming months and consideration would be given to the environment at that time. The National Institute for Health and Care Excellence (NICE), The Alzheimer's Society and The Thomas Pocklington Trust have all issued guidance about how to create beneficial environments for people with dementia.

Requires Improvement

Is the service effective?

We recommend the registered provider explores relevant guidance such as this, about how to make environments used by people living with dementia, more 'dementia friendly'.

Information in people's care records indicated consideration had been given to people's levels of capacity and their abilities to make their own choices and decisions in respect of the Mental Capacity Act 2005 (MCA). Assessments of people's ability to make day to day decisions about their care were evident in some people's care records. In one case, we saw that a person had been involved in discussions about their end of life care and this was documented. However, records did not always fully explain who had been involved in the decision making process and what discussions had taken place. There was evidence that some people's families had lasting power of attorney (LPA) over their financial affairs and/or health and care interests. However, copies of health and welfare related LPA documents were not always held within people's care records. This meant the provider could not be certain that they were acting in people's best interests and in line with the MCA and the law.

We saw that some people had "Do not attempt cardio pulmonary resuscitation" (DNACPR) forms within their care records indicating their preference, or a best interest decision, about whether an attempt should be made to resuscitate them in the event that they stopped breathing. We saw that decisions about whether CPR should be attempted were made communally by people's general practitioners, family members and nursing staff, where they did not have the capacity to make this decision for themselves.

Staff told us they had completed training in the MCA and Deprivation of Liberty Safeguards (DoLS). DoLS are part of the MCA. They are a legal process that is followed to ensure that people are looked after in a way that does not inappropriately restrict their freedom. For example, a DoLS application would be necessary where a person with limited capacity needs to remain under constant supervision to protect their safety and wellbeing. These applications and decisions are made in people's best interests by the relevant local authority supervising body. The deputy manager told us that 16 applications for DoLS had been made to the local authority and that applications would continue to be made in line with guidance from the Northumberland safeguarding team. We considered that whilst there was evidence that elements of the MCA were applied, records needed to be improved to ensure that best interest decisions were appropriately evidenced in line with legislation.

We looked at how people's general healthcare needs were met and found evidence that healthcare professionals such as doctors, physiotherapists, speech and language therapists and psychiatrists were involved in people's care whenever necessary. One person told us, "If you need the professionals, then yes they get them for you." A person's relative said, "I used to take him to the hospital to have his feet done every two or three months, but they come here now.

People gave us mixed responses when we asked them about the food they received. One person said, "No the food is not good. It's awful - we went to a sister home in Whitley Bay and it was gorgeous. I like the jacket potato with cheese and butter but you can't eat them all the time – there's not a lot of choice." In contrast to this another person told us, "The food is very good, you get enough and there are choices." Other comments made were, "It is ok, it's adequate" and "There is ample food it is nice". We saw that people's care records contained information about their preferences and nutritional needs. For example, there was information if people were vegetarian, if they disliked certain foods, and where they were diabetic, or they needed a soft food diet due to swallowing difficulties. We found information in care plans which contradicted what actually happened in practice. For example, some care records stated that people's food and fluid intake was monitored, but this was in fact a historic instruction that no longer applied and records had not been updated.

We saw there were plentiful supplies of food and drink within the home and food menus were in place which worked on a rotational basis. At lunch one day we observed the dining experience and heard people complaining about the soup amongst themselves. One person told us later in the day, "We had some soup at lunch time and it was just awful, it didn't taste of anything. It wasn't very nice." One person was presented with a jacket potato and small pieces of ham cut up on the side of the plate. People who needed assistance to feed themselves were given this support, but at times we saw people had to wait.

Inadequate

Is the service caring?

Our findings

People gave us mixed feedback when we asked them about the care that they received and the caring attitudes of staff. One person told us, "I was upset the other day and they stayed and looked after me – I loved that, they didn't just push me in a room on my own." Another person told us, "They do look after me." A third person told us, "One or two of them (staff) say 'Oh I am sick of you ringing the bell, don't ring it unless it's urgent' - of course you don't ring it then. Most of the time they are alright but they weren't the other day. The trouble is I take things to heart and sit and worry about them." Other comments included, "Sometimes they say you are useless" and "They say there is not just you in here you know". One person's relative told us, "On the whole they are very good, but the way they speak to my dad and other residents, the manner is a bit abrupt. It is definitely better than what it was a few years ago though."

We observed care delivery and watched how staff interacted with people. We saw several pleasant interactions when staff were supporting people, for example when assisting them patiently, to drink fluids. We also saw some staff engage with people respectfully. However, we observed staff practice which concerned us and which demonstrated that people were not treated with dignity and respect. At lunch we observed a staff member when they assisted someone to eat and saw that they barely spoke to the person throughout a 20 minute period. We saw staff spoke about people, with no respect for their presence. For example, we saw and heard one care worker say, "She is going to the hairdressers. Just put her in the lounge until they come and collect her." The person the care worker was speaking about was sitting between staff and was fully aware of the content of the conversation. We heard another care worker shout across the dining room to a colleague, "He wants to go to his room." Other comments made by staff in front of people in a disrespectful manner included; "I am feeding her, I will do it when I am finished with her"; "Here, I will help her"; and "Do you need the toilet?" (Said loudly to a person by a care worker in the lounge in front of other people). We gave examples of our findings to the registered manager and nominated individual. They took note of the information that we provided.

We saw that people received care which did not promote and protect their dignity or privacy. We saw one lady with a white substance around her mouth, which we believed to be toothpaste, which had not been wiped off. On the third day of our inspection we saw a blanket had fallen off the lap of a lady, resulting in her baring her thighs up to the top of her groin. We noted several staff walked past this lady and did not notice this. We observed another gentleman in his room in dirty clothing and his body below the waist was exposed.

We also observed that people were not given choices and they were not always involved in their care and decisions made. One person told us, "I don't know why they started bringing my breakfast to me in my room. I would prefer to eat it in the dining room like I used to." We overheard two people talking to one another and one person said, "I asked to have my breakfast in the dining room this morning instead of my room and they weren't very happy about it."

We observed some moving and handling practices and whilst we saw that these were done safely, we saw that people were not given choices. Staff told people, "We are moving you into a comfortable chair" but we saw that people were not asked in advance if they wanted to be moved from their wheelchairs. We observed abrupt interactions between staff and people. For example, we heard one care worker say, "Lift your feet" and another care worker, "Uncross your legs". Neither of these interactions were announced to people in advance. Care workers physically moved people before explaining in advance what they were doing, or how they needed the person to adjust themselves to assist with the manoeuvre. At times we heard people call out with discomfort and surprise when staff moved their legs without prior warning. Some people were sleepy and were abruptly alerted when staff engaged with them loudly, in a sudden, unannounced manner. We discussed our findings with the registered manager and nominated individual who told us they would look into staff practices.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not always display caring and compassionate attitudes towards people, resulting in failings in care delivery. On the upper floor we saw several people were distressed at times throughout our inspection and staff did not always attend to these people in a timely manner. We

Inadequate

Is the service caring?

intervened on two occasions and people settled relatively quickly once they received attention and support. When staff did approach people who were agitated, we saw there were sometimes confrontations as their engagement with people was curt.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and we have taken enforcement action against the provider in relation to this.

Requires Improvement

Is the service responsive?

Our findings

People told us they were involved in their care. One person said, "They do talk to me about things and if there is anything going on." One person's relative said, "They do involve me, yes."

Some staff seemed to know people well. For example we heard one member of staff say to someone, "You used to milk cows didn't you." When we asked staff for a summary of people's needs, they were able to give one. However, in some cases staff gave conflicting accounts of the most current position with people's care and some were unable to answer our direct but basic questions about particular individuals, saying, "The nursing staff would know that, not me".

We saw that some people received person-centred care and other people did not. One person was supported to go outside to smoke but another person told us that they were not 'invited' to the religious services that took place within the home, despite being an avid churchgoer prior to living in the home. Some people had specific instructions in their care plans to avoid social isolation, due to their needs, but we saw that these were not followed in practice. For example, one lady who was visually impaired was left sitting on her own away from other people in the lounge and received very little interaction from staff. We saw that the lady became distressed about her surroundings and who was present in the room on several occasions, and only got reassurance from other people living in the home, who shouted across the room to her.

External healthcare professionals told us that generally staff responded to their instructions. We saw that the nursing staff had involved general practitioners and community matrons in people's care where they had become concerned about their health and welfare. We heard the nurse referring one person to their general practitioner for some exploratory investigations. They also liaised with the community matron about another person, who had lost a significant amount of weight in a relatively short period of time. We saw that this discussion with the community matron, and their resulting instruction to weigh the person more regularly and to introduce fortified foods to their diet, had been recorded in the multidisciplinary notes of the relevant care records.

We looked at the activity provision within the home and found that although there were some activities in place these were not always followed. We saw that a newspaper review session did not take place in the mornings as scheduled and people were placed in their wheelchairs in the lounge with the television on instead. Some people who were not independently mobile sat for long periods in one area with little stimulation or interaction with staff. We spent time with people in the lounge and heard them commenting to each other about the lack of stimulation and activities within the home. One person said, "They just leave you sitting here. It's terrible being left here." Another person commented, "This place is so boring and it's no wonder you feel fed up. I might just go to bed after lunch and not bother with tea." A third person said, "We need a bit of entertainment. It's glum in here at the minute."

We spoke with the activities co-ordinator who worked on a full time basis. She told us that she pursued group activities with people who wished to be involved such as dominos and reviews of current news, but that she had little scope for one to one time with people. She also told us that trips outside of the home happened fairly regularly, but these only involved a small number of people who were physically able to go out in a small minibus and were independently mobile. Several people told us that they felt isolated within their own rooms. One person said, "They never really talk to you much. Sometimes I feel as If I am in solitary confinement – sitting here watching the telly. I would like some stimulation – something to get me interested." A second person told us, "I go out with my family. I have not been anywhere with the home and there is nothing on." A third person told us, "The manager says that I am too impatient but it's so boring just sitting watching the television." This showed that people experienced negative feelings as a result of a lack of activities and social stimulation within the home.

We reviewed the way complaints were handled by the provider and found that formal complaints on record were all dealt with appropriately and the complainant responded to. Documents were in place related to each complaint and any actions taken. However, it was not always clear in the records what actions were put in place, if any, as a result. Some people said they could report concerns or complaints to staff, but one person was fearful of complaining in case of repercussions. They told us, "I wouldn't dare as I think they would hold it against you. You just feel a nuisance really." Other people said they were

Requires Improvement

Is the service responsive?

comfortable with complaining and their complaints had been dealt with appropriately. One person said, "Oh aye – you would get in touch with the head one (Registered Manager). I've not complained before – I've been satisfied." Another person said, "I complained once a few years ago, they listened and they sorted it."

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in post. Our records showed that she had been formally registered with the Commission since April 2011. The registered manager was present on each of the three days that we inspected the home and was supported by the nominated individual of the organisation.

We looked at a total of eight people's care records and found they were not easy to follow and in some cases they contained conflicting information that we found misleading. For example, one person's care records showed contradictory information about how often their blood sugars should be monitored in different records within their file. Another person's care records stated their food and fluid intake was monitored, but we established this was in fact a historic instruction that no longer applied and records had not been updated. We saw failings in care delivery were evident in people's care records, but these failings had not been identified and acted upon. There was no risk assessment for one person who suffered from epileptic seizures. There was a system in place for reviewing people's care records on a monthly basis, but this system was not effective as it did not identify the issues stated above and staff did not have clear information available to them about the most up to date care that should be delivered as a result.

Documents related to health and safety checks were not always in place to evidence that they had been done. For example, the results of the latest electrical installation inspection were not available to inspectors. There were no records to evidence that remedial work had been undertaken in response to recommendations made as a result of the latest safety inspection of gas supplied equipment in the home. The nominated individual assured us that this work had been carried out, despite there being no documentary evidence to support these claims.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the provider did not have a quality assurance system in place to ensure that staff delivered care appropriately. Monitoring tools such as positional change charts or charts recording food and fluid intake were either not in place, or where they were, they were not always completed. Evidence showed there was not an effective system in place to review behavioural monitoring charts, in order to act on any matters that may need to be addressed in a timely manner. This meant the registered manager and registered provider could not be sure that people received the care they needed.

We reviewed the accident and incident records held within the home and saw that these were recorded individually and analysed on a monthly basis in order to identify any important patterns and trends that may need to be addressed. For example, as the result of a falls analysis, one person had been referred for specialist input into their care in order to manage their risk of falling – due to a high number of falls in that previous month period.

We observed care delivery on all floors of the home and identified concerns related to respecting people, their dignity and their privacy. We also identified a lack of skill, knowledge and understanding of how to appropriately support the people living with dementia. There was clear evidence that although staff had received training in equality and diversity and dementia awareness, this training was either not effective, not extensive enough, or staff were not applying the skills they had learned. We noted that the registered manager had not identified these issues.

The registered manager told us and records showed that a range of different audits and checks were carried out to monitor care delivery, such as medication audits, infection control audits and health and safety checks on the building. A system was also in place where an operations manager overseeing the home visited on a monthly basis, to assess the home and care delivery. However, although there were quality assurance systems in place, we found that these were not always effective. For example, we saw there was a medication audit in place but this did not identify medicines kept in people's rooms that were still in use, but that had passed their expiry date.

Action plans were not always drafted where issues were identified, and therefore the registered manager did not have a tool in place to monitor that issues were suitably addressed.

Requires Improvement

Is the service well-led?

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and we have taken enforcement action against the provider in relation to this.

We asked staff, people and visiting healthcare professionals about the culture and leadership within the home. Staff told us that morale was low and people confirmed this by saying that they felt staff were unhappy. One member of staff told us, "Morale is not good. Lots of staff moan and complain. It's not good…all the good staff have left." One person told us, "You just know the staff are not happy, they're grumpy and sometimes say, 'What do you want now, not again'." People's relatives gave differing views of the registered manager. One relative said, "You can speak to the manager, she is very obliging", but another relative commented, "I don't think that she is approachable if you have a problem." A healthcare professional linked with the home told us, "Some charts are not completed and care plans are not kept as up to date as they should be. Ultimately this is down to leadership within the home."

We asked people and their relatives if they were asked for their views about the service they received. One person said, "I can't remember being asked for feedback. There used to be a suggestion box but it made no difference." We saw that meetings took place between the staff team, management, people and their relatives and minutes showed that those present had the opportunity to feedback their views. Staff also told us that they had the opportunity to report issues back to management within their supervision and appraisal sessions.

During our inspection we reviewed the home's log of safeguarding incidents and established that we had not been notified of two cases that we should have been, in line with the requirements of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. The registered manager acknowledged she had failed to make the necessary notifications to us in relation to these two safeguarding incidents and gave assurances that this would not happen again in the future. We were satisfied that the registered manager had notified us of deaths and other serious incidents that had occurred within the home over the last 12 months. Notifications are changes, events or incidents that the provider is legally obliged to tell us about. The submission of notifications is a requirement of the law. They enable us to monitor any trends or concerns within the service.

We found significant and widespread shortfalls in the way the service was managed.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **People were not protected from the risk of abuse because they were not kept safe by staff and procedures were not always followed. Regulation 13.**

Regulated activity	Regulation
Accommodation and nursing or personal care in the further education sector Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **People who used the service were not protected against the risks associated with medicines because they did not always get the medicines they required, when they required them and records were not always well maintained. Regulation 12(f)(g).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **People who used the service were not respected and their dignity and privacy was not maintained. In addition, they were not always involved and given choices over day to days decisions related to their care and treatment. Regulation 10**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **People who used the service were not protected from the risk of unsafe or inappropriate care and treatment**

This section is primarily information for the provider

Action we have told the provider to take

arising from a lack of proper information about them, as records were not appropriately maintained. In addition, other records related to the operation of the service were not available. Regulation 17(2)(d)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People who used the service were not protected against the risks of receiving care or treatment that was inappropriate or unsafe as care was not always planned, assessed and delivered in a way that met people's needs. Regulation 9(1)(b)(i)(ii)(iii).

The enforcement action we took:
We have issued a warning notice in respect of this breach of regulation.

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 People who used the service were not protected against the risks of receiving inappropriate or unsafe care or treatment as effective monitoring systems were not in place. Regulation 10(1)(a)(b).

The enforcement action we took:
We have issued a warning notice in respect of this breach of regulation.