Eldercare (Halifax) Limited

Denison House Nursing Home

Inspection report

Denison House Nursing Home
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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**

Summary of findings

Overall summary

This inspection was unannounced and took place on 8 and 10 March 2016.

The service is registered as a nursing home, however they have not provided nursing care since September 2014 and can accommodate up to 35 people but no longer have shared rooms and so the number has reduced to 30. The service accommodates older people and people living with dementia. It is a large building with communal areas downstairs for people to spend their time. There is a secure garden.

At the time of our inspection there were 25 people living at the service.

The service did not have a registered manager. 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.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

People told us they felt safe. One relative raised a concern about the safety of people who used the service because of the behaviour of a person who lived at the service. However, we found risk assessments and risk management plans did not provide adequate guidance for staff about how to keep people safe. Due to our concerns about the care and treatment we saw we made five individual safeguarding referrals to the local authority.

We saw evidence the manager had made some safeguarding referrals. However, there were other safeguarding matters which had not been referred and this meant the risk of harm remained. In addition to this accidents and incidents were not always recorded accurately and the manager had failed to notify the CQC of a number of serious injuries. This is a requirement by law and the CQC will investigate these matters further.

There were a number of environmental risks such as raised carpets and loose tiles which were trip hazards, the electrical safety certificate was out of date and water tests had not been followed up. We saw evidence of poor cleanliness across the service.

The service was not working in line with the principles of the Mental Capacity Act. Assessments of people's ability to make informed decisions were not completed correctly and were not decision specific. We did not see records of best interest decisions. Some people were being restricted of their liberty without having the

legal authorisation in place.

There was insufficient staff to meet people's needs. Staff told us they felt well supported by the manager but we saw evidence of gaps in training and a lack of supervision which meant the manager could not be assured staff had the required skills to deliver effective care.

Care staff were warm and genuine and we saw some positive interaction between staff and people who used the service. We also saw some skilled interaction with people who had behaviour which placed themselves or others at risk. Despite this we saw evidence people did not receive the care they required to meet their individual needs. We saw evidence of people with complex health care needs and we asked the local authority to consider the appropriateness of the placements for some people.

People told us the food was good. The chef described ways of ensuring people's individual preferences were met. However, we were concerned about the lack of systems in place to ensure people received their meal in a way that reflected professional advice based on their individual dietary needs.

Care plans did not reflect people's current needs, where people's needs were changing we did not see evidence of the service taking robust action to address this. Care plans did not contain information about people's individual preferences or their previous life history. For people unable to direct care staff, due to their health needs, this meant we could not be sure they received care which was in line with their previous wishes.

We found multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, affecting people's safety, well-being and the quality of service provided to service users. We did not see evidence of good leadership with robust policies, systems and record keeping which would enable the provider to assure themselves they were delivering high quality care. CQC is considering the appropriate regulatory response to resolve the problems we found.

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.

Risk assessments were poor and did not contain information for staff about how to protect people from harm. People were at risk of choking and skin breakdown. People had sustained injuries which had not been reported to the CQC. Accidents and incidents were not reviewed.

Safeguarding issues had not always been reported to the relevant bodies and this meant people could not be sure they would be protected from harm. There were gaps in medication administration records which meant we could not be sure people were receiving their medicines in line with the prescribing instructions.

The environment was not safe and was not clean. The service did not have sufficient staff available to meet people's needs.

Staff did not receive adequate supervision to support them in providing safe and effective care. Staff training, related to keeping people safe was not up to date.

Is the service effective?

Inadequate

The service was not effective.

The service was not following the principles of the Mental Capacity Act 2005 when planning and delivering people's care. As a result staff could not be sure they were delivering care which was in a person's best interests and in line with their previous wishes. Some people had their liberty restricted unlawfully because they lacked capacity and the required DoLS were not in place. This meant the provider did not have the necessary safeguards in place.

The environment was not dementia friendly and the recent re decoration did not provide stimulation or support people living with dementia to find their way around the service.

People told us the food was good and we saw people enjoyed lunch. However, we were concerned about how the chef knew

about people's specific dietary requirements.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Care staff were kind and compassionate and knew people well. People told us they felt well cared for. Staff described some examples of person centred care. Relatives told us they could visit whenever they wanted.

Despite this we saw evidence of poor care. We could not be sure people's care needs were being met.

Is the service responsive?

Inadequate

The service was not responsive.

Care was not assessed, planned or delivered in a person centred way. Reviews were not effective and when people's needs changed this was not reflected in their care plans or risk management plans.

People and their relatives told us they knew how to raise complaints. We reviewed complaints and saw the service had not followed their own procedures for investigating and informing people of the outcome.

The service had an activities co-ordinator and we saw some people who lived at the service enjoyed the activities on offer.

Is the service well-led?

Inadequate

The service was not well-led.

People told us the manager was approachable and there was evidence of people, relatives and the staff team being encouraged to contribute to the development of the service. However they were inexperienced and did not always understand their responsibilities as registered manager. They were not registered with the CQC.

Records in relation to the service overall and for individuals were poor. The gaps in individual record keeping meant we could not be assured people were receiving the care and support they required.

The manager had not made notifications required by law to CQC. There were no robust systems in place, at either the manager or

provider level, to audit the care people received and this meant the provider could not be assured people were being provided with safe and effective care.

Denison House Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 8 March 2016 and was unannounced; we continued the inspection on 10 March 2016. The provider was aware we would be returning on the second day.

The inspection team consisted of two inspectors, a specialist advisor who was a nurse and had experience in care of older people and dementia care, and an expert by experience. The expert by experience had personal experience of caring for older people. On the second day one inspector returned to the service.

Before the inspection we reviewed all of the information we held about the service, this included reviewing notifications we had received. A notification is information about important events which the service is required to send to the Commission by law. We contacted the local authority social work and commissioning and contracts team for their feedback. They provided us with positive feedback about the service.

During the inspection we spoke with the manager, the new and previous area manager, clinical lead, and two care staff. We spoke with two people who used the service and because not everyone could tell us their views we spent time observing interaction between people and care staff. We spoke with four relatives.

We carried out a tour of the premises which included communal areas and people's bedrooms. We reviewed nine people's care plans and associated records. We looked at medicine administration records for eleven people.

Following the inspection we spoke with three members of staff, we tried to contact a further four members of staff but they were unavailable. We contacted the district nursing team. We also spoke with the local authority social work team manager who provided positive feedback about the service. We contacted the commissioning and contracts officer for the service, they not undertaken a formal assessment visit recently. However, they told us the manager was proactive and keen to learn but that environmental issues had previously been identified at the service.

Inadequate

Is the service safe?

Our findings

People we spoke with told us they felt safe living at the service. Comments included, "Yes, well looked after in my case especially," "Yes, if you ask them [care staff] to do something they will do it," and "It is alright, people are friendly." One relative we spoke with said, "Yes [he is safe]. There are carers on, and at night, I think he is safe, he can't get out." However, one relative we spoke with expressed concern about people's safety and said they thought their relative was safe, "most of the time." They expressed concern about the impact of people's dementia and associated behaviour on the other people who used the service, and referred to staff and visitors being at risk.

Since our last inspection the manager had made five safeguarding referrals to the local authority and had made the notifications, required by law, to the CQC. Following our inspection we made five safeguarding referrals to the local authority. These were about the care and treatment of five people who used the service. The concerns were as follows; pressure area care, one person had been assessed as needing thickened drinks due to the risk of choking and we saw an unthickened drink had been left with them, one person had sustained a fracture whilst being transferred by care staff and there was a lack of risk management plans for people with behaviour which posed a risk to themselves or others. We have asked the local authority to investigate these matters and to consider whether people are placed in the right environment based on their care needs. We will continue to monitor the situation.

We also identified a further four safeguarding matters which had not been referred to the local authority. The manager advised they were not aware of one of the incidents but was not able to offer any explanation as to why the other two referrals had not been made. These related to incidents involving a person whose behaviour had resulted in harm to other people who used the service, an injury a person had sustained and another person who was at risk of harm due to their own mental health issues. There were incidents of known abuse which were not acted upon and this meant service users continued to be at risk of significant harm.

We requested a copy of the Safeguarding policy. The policy was dated August 2014 and was due for review in April 2015. We asked the manager if they had a more up to date safeguarding policy and we were told they did not. The policy did not make reference to the Care Act 2014 and changes this legislation had brought into practice. This meant the provider had not taken steps to ensure managers and their staff team were working in line with current legislation.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One relative we spoke with raised concerns about the safety of people because of the care needs of another person who lived at the service. The manager told us care staff, residents and relatives were 'frightened' of this person. The risk assessment which was in place in relation to the behaviour the person presented with, as a result of their dementia, was inadequate. It failed to protect the person and others. There was no guidance for staff about how to recognise any signs which may indicate the person was becoming

distressed, or techniques about how to intervene to keep the person and other people safe.

The manager explained they had made safeguarding referrals about this person and they were awaiting a re-assessment of their needs by the local authority. The person was also under the care of the community mental health team. However, during our inspection the person was distressed and agitated and we saw three instances which indicated the person was a risk to themselves and others. We concluded the manager had not been proactive in contacting health and social care professionals to raise the level of concern. It appeared the behaviour had become accepted, and although care staff were kind and compassionate with the person and tried their best to reduce the risk of harm this was not sufficient and the person was not receiving the care and support they needed to keep them safe and to preserve their dignity.

Risks were not always assessed and plans not put in place to mitigate identified risks. We saw one person remained in bed on both days of the inspection. The manager told us this person had been spending more time in bed recently and had, "day and night reversal." They had lost weight and had been referred to the doctor with a request for dietician input. At around 4 pm on the first day of the inspection we saw they had two small sandwiches, a bun and a beaker of fluid left on the bedside table. They had only taken one bite from one sandwich. The manager removed these and said they should not have been left there because this person was at risk of choking. The person was fast asleep. We reviewed their care plan in relation to nutrition. It stated, '[Name] does not always want to get out of bed but should be encouraged to get up for meals as is at risk of choking in the bed.' We asked the manager about this who said there had been no choking incidents but the risk was because they were laid down. However, the person was using a profiling bed so could have been raised to an upright position to eat if they were awake. Despite the issues of weight loss being identified there was no care plan or risk management plan in relation to this.

Another person could not have food or fluid orally and had a percutaneous endoscopic gastrostomy (PEG) in place. This is a tube that allows nutrition, fluids, and medicines to be fed directly into the stomach. We observed a member of staff carry out safe care in relation to this. However, when we asked to see a care plan for PEG management and risk assessment we were told by a senior member of care staff there was not one in place. Although the member of staff we observed appeared competent we were concerned about the lack of guidance in place for staff. This meant the person was not protected from the risk of harm associated with PEG care management.

Another person had sustained fractures and the moving and handling risk assessment had not been updated to ensure staff were following safe practice when supporting the person to move.

We observed one person, who ate their meal in bed, spitting out bits of food. The person had been seen by the speech and language therapist due to swallowing difficulties and their care plan stated they were on 'thickened fluids and pureed meat with other food mashed up'. We saw the person had a beaker of thickened fluid but on the bedside. However, in addition, there was a beaker and a jug of liquid on the cabinet that had no thickener added. We highlighted this to the manager immediately. The manager removed the jug and beaker and accepted it should not have been there. At lunchtime on the first day of the inspection we saw the person was spitting out small pieces of meat and vegetables and we saw that their meal had not been provided in line with the speech and language therapists instructions. This meant the person was at risk of choking. We made a safeguarding referral to ask the local authority to investigate the matter and also to consider whether the service was able to meet the person's care needs.

We found accidents and incidents were not consistently recorded and reported correctly. We saw three incidents where people had injured themselves which had resulted in fractures to people's bones. These had not been recorded on accident forms and so we could not see what action had been taken immediately

after the incident or what the service had done to try and prevent accidents happening in the future. Accidents and accidents had not been thoroughly investigated and so there were no measures put in place to protect people from similar events.

The environment was not safe. The provider had not completed the required safety checks which meant people who used the service, staff and visitors could have been at risk of harm. The five year electrical safety certificate was out of date. This electrical test was due in January 2016 but had not taken place. On the second day of the inspection the manager told us they had booked an electrician to complete this safety check.

In May 2015 two water samples had raised concern and the provider had received a letter requesting further samples be sent for analysis. This had not been done. The manager explained that they had requested a follow up visit from the company to re: check water samples on 16 March 2016.The manager had requested this following the inspection because the required action had not taken place in May 2015 and they wanted to ensure people were not at risk.

We found uneven flooring and carpets which were not fitted correctly on a corridor upstairs, where there were bedrooms. These were trip hazards. Two windows had incorrect window restrictors in place. Window restrictors are required to keep people safe and the Health and Safety Executive (HSE) provides specific guidance about the requirements of these. This is to prevent people from climbing out of or falling from windows. We asked the manager to ensure all of the window restrictors within the service met the HSE guidance and on the second day of our inspection we could see new restrictors had been fitted.

The manager told us the call bell system needed replacing and a quote for a new system had been sent to the provider. They were not aware of the timescale for a new system to be installed. One of the call bells, in an unused bathroom, did not work. Call bells which sounded downstairs could not be heard by staff upstairs. A member of night staff explained they had put a system in place involving one member of staff staying downstairs and all night staff carrying their mobile phones so they could be sure they could summon support in an emergency. They told us the manager was aware of this and that they believed the manager had been proactive in alerting the provider about this matter. This meant the provider could not be assured there were safe systems in place to ensure people who used the service and staff could summon assistance in an emergency situation.

The service had a current vacancy for cleaning staff on a weekend. The manager explained they had covered some of these hours or extra care staff had been brought in to cover. We could see a complaint had been made by a family member on 7 March 2016 about standards of cleanliness in their relative's room and ensuite bathroom. The service had been closed from 1 until 7 March 2016 due to an outbreak of diarrhoea and vomiting which had affected 12 people who used the service and five members of staff, including the manager. The manager told us they were unsure about the source of the outbreak but confirmed they had been following the advice of the infection control and prevention team.

There were issues with the cleanliness of the environment. There was a strong odour in a number of areas within the service. The manager said, "Lots of rooms with smells first thing." However we noted the odour problem was evident later in the day as well. In one person's bedroom the odour was strong and this remained on the second day of the inspection, the manager told us they had checked the room and thought a new carpet was required. The person remained in the room on both days of our inspection, this meant they were living in an environment which smelt unpleasant.

The environment was outdated. On a downstairs corridor we saw radiators which were broken, and

uncovered. These posed a risk of injury to people should they fall, both in terms of sharp edges which were uncovered and also the risk of burns if people fell next to the radiator.

The service had a main kitchen and a serving area. The serving area was a walkway for staff to ensure they could access the managers office, care plans and the staff room. We observed people walked through this area without wearing personal protective equipment. The kitchen had a food hygiene rating of three. This meant the service was meeting the food hygiene standards required.

We looked at eleven people's medicine administration records (MARs) and found gaps in four people's records. This meant we could not be sure people were being provided with their medicines in line with the prescribing instructions. We did not see evidence of an effective medicines audit.

We observed a senior member of care staff administer medicines on the first day of our inspection and found they completed this in a patient and kind manner, explaining to people about their medicines and offering encouragement to take them. There were records of room and fridge temperature checks and we could see medicines were stored safely. There were systems in place for ordering medicines and returning unused medicines to the pharmacy. We saw controlled drugs, these are prescribed medicines which are liable to misuse, were stored safely and records were accurate.

We concluded the service was not providing safe care and treatment to people. Risk assessments and risk management plans were inadequate. Accidents and incidents were not recorded accurately which meant they were not analysed effectively. There were gaps in medicines records which meant we could not be sure people received their medicines correctly. The environment was unsafe and not clean which meant people were not protected from the spread of infection.

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

All of the relatives we spoke with expressed concerns about the service having insufficient staff to provide the care people needed. Comments included, "No, I see people wanting attention," "No, but there are staff around" and "No, there has been an occasional 15 minute wait [for staff to respond to the call button], but I know staff are busy."

We observed care staff to be busy. There were four care staff on duty supporting people with significant care needs. There were periods of time when we saw people were in lounges without members of staff supervising or being available to deliver care. This was a significant risk because of people's care needs and the impact they could have on other people who used the service. An inspector asked for support for one person because they had concerns about them getting out of the chair and walking without support or supervision and were at risk of injuring themselves.

Staff told us they felt well supported by the manager, they said the manager was available for informal support and they had supervision. However, we did not see records of regular supervision for staff. Supervision is an opportunity for staff to discuss any training and development needs any concerns they have about the people they support, and for their manager to give feedback on their practice. This meant the manager and provider could not be assured the staff team had the skills required to deliver safe and effective care.

One member of staff explained the service had previously had significant issues with shortages of staff and that the current manager had worked hard to recruit new staff. They said, "In the last three months staffing

levels have improved and we are using less agency staff which means we can give people more consistent care."

Training records showed some essential staff training linked to the provision of safe care was out of date. We discussed this with the manager. They told us that induction training was undertaken at head office. However, we reviewed the training matrix which showed refresher training was overdue. For example six members of staff were overdue infection control training, four members of staff were overdue first aid training, three members of staff were overdue safeguarding training, five members of staff were overdue fire safety training and five members of staff had not received updated moving and handling training. The manager showed evidence of training undertaken in dementia awareness on 22 September 2015 and managing challenging behaviour on 14 September 2015.

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

The service had personal emergency evacuation plans in place for each individual. These were kept in people's care plans and we suggested the manager may wish to add these to the emergency fire folder. They discussed this with the area manager and had taken the suggested action when we returned for the second day of inspection.

Inadequate

Is the service effective?

Our findings

People we spoke with said they felt the staff caring for them provided effective care. One person said, "They're good are the staff, I won't criticise them, I get on very well with them." Another person said, "I used to be a Nursing Sister so I know, yes they are skilled." However, during the inspection we did not always find this to be the case.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The service was not applying for DoLS authorisations in line with current legislative requirements. The manager told us two DoLS had been approved by the local authority and they had submitted a further five applications which were awaiting approval. The manager had identified a further five applications which were required, but these had not been submitted. Three of these people had restrictive measures in place to keep them safe such as motion sensor alarms to alert staff when they moved from their bedrooms.

We saw one person had a sensor mat in place to alert staff should they move. Their care plan recorded this as being necessary as they were unable to maintain their safety due to their dementia. A mental capacity assessment had been completed in December 2015 and reviewed in January 2016. However, the assessment was not decision specific and there was a box ticked which said the person was, 'unable to consent or make decisions.' The MCA refers to assessments being made about people's ability to consent to specific decisions and instructs staff making decisions on people's behalf to use the least restrictive option. There was no clear best interest decision recorded to show what other options had been considered. The manager had not yet applied to the local authority to authorise this DoLS. This meant the service was not working in line with current legislative requirements.

We saw one person had repeatedly declined to have support with their personal care. The person had a strong odour and this was not a dignified way to be supported. The manager told us this person did not have the ability to consent to personal care due to their dementia, and said they were 'resistant' to care. We reviewed their personal care records and could see they had declined to have personal care since 8 February 2016. A mental capacity assessment record indicated they lacked capacity to make complex decisions, there was no best interest decision recorded. However, their care plan in relation to 'hygiene and personal appearance' referred to the person being reluctant to accept support and needing encouragement from staff. It provided staff with ideas about how they could support the person to have a bath or shower. It did not provide guidance for staff about what they should do if the person repeatedly refused to have a bath or

shower. There was no evidence that this issue had been discussed with the relevant health and social care professionals to determine an appropriate way forward.

We asked the manager whether they had considered holding a best interest discussion with the person's family, the local authority and the community health team. The manager said they had not done this, but told us the community mental health team had been involved in the past. We made a safeguarding referral to the local authority to investigate whether the person had been neglected.

Despite the manager and staff having completed MCA training we found the manager had limited understanding of the legislation and how this should be implemented on a day to day basis to support people. Although we saw staff seeking consent from people around day to day matters such as choices of meals, clothing and where to spend their time the manager did not demonstrate understanding of the legislation about more complex matters related to people's care and treatment. They told us they had done some training, but said they needed more knowledge and support on the subject. The new area manager provided some guidance for the manager on the day of our inspection and agreed to offer ongoing support in this area.

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

There was inadequate signage to assist people living with dementia to find their way around the service and to help them to orientate themselves. The downstairs corridor was being redecorated whilst we were inspecting the service. The manager told us they had some good ideas for making this area more dementia friendly but had been told by head office that the 'Eldercare colours' had to be used. A new wet floor shower room was being fitted. We asked the manager whether there was an environmental action plan or redecoration plan and were told there was not. This meant it was difficult to establish who had oversight of the required improvements, whether they had shown consideration to the needs of people living with dementia and what the anticipated timescales for improvement would be.

People provided positive feedback about the food. One person said, "I get lovely food and plenty of drinks. It is grand." Another said, "It is nice, I enjoyed the steak and kidney pie today. We get a choice of two things." And, "If I wanted a sandwich later at night I could have one, I am always offered drinks." The chef explained one person had told them how much they enjoyed a spicy curry so they had cooked them a curry separately and added additional spice to it. This demonstrated a personal approach to meeting people's nutritional needs and preferences.

We observed lunch on the first day of our inspection. People were offered the choice of pork casserole or steak and kidney pie. 14 people ate in the dining room. People were offered clothes protectors and those who needed it had adapted cutlery and plate guards which supported them to eat independently. One person was being assisted to eat by a member of staff, they did this patiently and at the person's pace but they kept getting up to assist other people. This meant the person was left without support and it was not a dignified way to enjoy a meal.

Kitchen staff did not have guidance about the specific diets people needed. We asked the manager how staff knew what people's specific dietary requirements were. They told us people's individual care plans would need to be checked. This meant the service did not have a robust system in place to ensure people were provided with food and drinks which were not suitable for their individual needs. The risk was heightened as there was a vacancy for a chef and so different members of staff were cooking. On the second day of the inspection we saw a chart had been put up in the kitchen with specific needs, this meant the risk of people

being given incorrect meals was reduced.

We saw some people had lost weight and we could see referrals had been made to the doctor to request specialist advice from the dietician, supplements and speech and language therapy.

The service does not provide nursing care, however some of the people who use the service had input from the community nursing team. We contacted the nursing team after the inspection to request their view on the care provided to people at the service. The nurse we spoke with told us they could not comment as they were not in the service for long but said if they had any concerns they would make a safeguarding referral. We shared with them our concerns about the care and treatment provided to one person they supported.

Requires Improvement

Is the service caring?

Our findings

Throughout our inspection we saw staff demonstrated a kind and caring manner towards the people they supported. People told us staff were caring. One person said, "They [care staff] are all good." Another said, "They are lovely." All of the relatives we spoke with said staff were caring. Comments included, "Yes, they are nice with him, treat him as part of the family," "[Name] is shaved, he is clean, he is looked after. The girls [care staff] are all very kind." "Yes, I have no problems with the staff they are great, they give him a hug. They are very caring." Relatives told us they were welcome to visit the service anytime.

One person told us care staff helped them to be independent. They said, "I am encouraged to do as much as I can for myself." We saw evidence of the service providing adapted cutlery and crockery for people to enable them to eat independently. We saw staff respected people's privacy and dignity, a relative said, "They knock on the room door."

We saw one person being supported with their medicines in their bedroom. Their bedroom was homely and member of staff had a positive rapport with the person. They respected the person's dignity and listened carefully to ensure they were able to communicate effectively with the person.

One person became upset during lunch and was verbally distressed towards another person at the dining table. Staff intervened and re directed the person, when they became distressed again a member of staff distracted the person by showing them some flowers. We saw some skilled interaction with care staff and people who used the service. Staff told us they cared about the people who used the service. One member of staff said, "I love my job. We support people to do what they want to do and we always make sure we offer care about all of the person's needs not just practical care." They went on to describe a specific example of providing person centred care to one person in relation to their morning personal routine.

We saw a number of people walking around the service wearing socks and no other footwear. This meant people could be at risk of falling. Other people were seen wearing slippers but were not wearing socks. There were no records within people's care plans to indicate whether this was their individual choice.

Although we saw warm and kind interaction with staff and people they cared for we also found some examples of poor care. Some people needed specific support in relation to their dietary and fluid intake and pressure area care. On the first day of the inspection, we reviewed the care records for one person who was nursed in bed. We were provided with two different 'turning charts' which gave contradictory information. The records did not reflect the position we saw the person to be in. We raised this with the manager and area manager who agreed to investigate this matter.

Inadequate

Is the service responsive?

Our findings

We found care was not assessed, planned or delivered in a person centred way. Person centred care means ensuring the person is at the centre of everything which is done for or with them. This involves taking into account people's individual wishes and needs. Care plans were difficult to follow and did not contain detailed information to enable care staff to know how the person should be supported. Care plans did not reflect the person's current needs and we could not see evidence of regular reviews or updates to care plans.

For example one person's mental health had recently deteriorated. The care plan and risk management plan had not been updated to reflect these changes and the advice provided by the community mental health team had not been added to the person's care plan. Although care staff told us they were following the advice of the community mental health team this was not recorded. The lack of updated risk assessment and risk management plan meant the person remained at risk of harm.

None of the care plans we looked at contained information about people's previous life experiences. This information is essential for care staff to enable them to have meaningful interaction with people living with dementia. Care plans we reviewed did not contain information about people's preferences. We did not see any evidence of people or their families being involved in the development of people's care plans or reviews. This meant people who were no longer able to express their views to staff could not be assured their care was based on their previous wishes. We would expect to see involvement of the person, and or their families in reviews of their care, as this would enable people's previous choices and wishes to be taken into account when staff were providing care.

Care plans contained contradictory information. We saw one person had been in hospital on a number of occasions and they were discharged with a letter which provided staff with guidance about a significant change in the person's care needs. However, we saw three care plans related to the support the person needed with nutrition and diabetes management and they all contained different information. They were undated and this meant the did not provide staff with clear direction about the support the person required to remain well.

Daily records we reviewed contained basic information about people's needs, but they were repetitive. Daily records provide staff with key information about a person's wellbeing. Reviews of care plans were not effective. The evidence of reviews we saw was minimal.

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

It was difficult to track the number of complaints the service had received over the last 12 months. The CQC were aware of one complaint involving a service user on a short break allegedly being pushed over by another service user and sustaining a head injury. The manager had notified the CQC and safeguarding authority about this incident. The manager told us this was being addressed by head office. However, the complaint was not recorded within the complaints file.

Relatives told us they knew how to make complaints and that the manager was approachable. There were three written complaints in the file from December 2015 to date, but we could only see one had been formally responded to and this involved the manager investigating a complaint about themselves in relation to the cleanliness of the service. The complainant was not given details of who they could contact if they were unhappy with the response given. The complaint folder contained guidance notes on investigating a complaint but these had not been followed. The manager told us another complaint had been resolved by a meeting with the complainant, the manager and the previous area manager but there was no written outcome provided.

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

The service employed an activities co-ordinator who works four hours a day between Monday and Friday. We saw they interacted well with people and there were a variety of activities on offer such as, arts and crafts, dominoes, colouring and on the afternoon of the first day of our inspection we saw they were supporting people to decorate marshmallows with chocolate and sweets. The service also had an external person provided an exercise class each fortnight and a drama group that came in and staged a play every month.

Inadequate

Is the service well-led?

Our findings

The service did not have a registered manager. This is a breach of Care Quality Commission (Registration) Regulations 2009 (5). The current manager had been in the role for the last 12 months, and had worked at the service for a number of years as a member of senior care staff. It was their first management position. They had applied to register with the CQC, however at the time of our inspection the application had been returned to the manager as it was not correctly completed and had not been re submitted.

People and their relatives told us the manager was approachable. One person said, "I have seen the manager, they are lovely, they ask me if I am alright and I say yes." Two relatives said they had raised issues at a residents meeting about the lack of activity and had seen an improvement since then. This demonstrated the manager was keen to listen to the views of people and their relatives. The manager told us they had sent out a satisfaction survey six weeks ago. So far they had received 12 responses. The manager explained to us it was important to them to listen to feedback about the service and to use this information to make improvements in the service.

The service was providing care to people with complex physical and mental health needs. The inspection team spoke with the manager, area manager and the local authority about whether people were being cared for in the most appropriate environment. In addition to this care plans were not person centred and did not contain enough information to support staff to deliver compassionate care, the leadership within the service and at a more senior level within the organisation did not provide sufficient governance to ensure people received a good standard of care.

The manager told us they were aware the staff team needed to improve record keeping and documentation. They said they had asked the previous area manager for more training in this area however this had not been provided. We could see these matters had been discussed by the manager at a staff meeting. We found record keeping an area of concern throughout the inspection. This was in relation to individual records for people who used the service and wider service records.

Record keeping for individual people was poor. It made it difficult to assess the care people had received, and whether this was meeting their needs. For example we asked to review the care and support provided to one person who remained in bed during our inspection. We were told they had been supported to have their personal care and meals, and that they had been spending more time in bed during the day. The manager advised there was no record of the care delivered because care staff wrote these records at around 6.30pm. This meant care records were not a reliable contemporaneous record. The person had an hourly record check document in their bedroom. At 10am we saw the record in place for this person had not been completed since 4am. This meant we were uncertain whether the person had received care during this period.

The manager told us they completed regular audits which included; infection control, medicines, care plans and accident and incident analysis. They used a quality management system to audit the service. The manager described spending up to six hours a day in the office, and said they felt, "isolated."

We concluded the audits were not effective as they had not identified the multiple issues we found during the inspection. An example of this was that the care plan audits had not identified that care plans contained conflicting information with poor direction for staff about how to support people. None of the care plans we saw contained information about people's life history or future wishes in relation to their care. Not all of the care plans we reviewed were signed or dated. Effective audits would have identified issues such as these and we would expect to see an action plan to identify how the improvements would be made, by whom and within a specific timescale.

Accidents and incidents had not been reported correctly and therefore the audit was not able to be effective. The manager told us they reviewed accidents and incidents within the service and then sent the information to head office where a further review took place. The systems in place for analysis were not effective as the service was not reporting accidents accurately. This meant the manager and the provider were not learning from incidents or looking at what was needed to prevent accidents happening in the future. One example of this was a person who had sustained three fractures over the last 12 months, they had underlying health problems but a review of the accidents may have resulted in the provider considering whether the person's needs could be met at the service.

The provider has a legal requirement to notify the CQC of serious injuries. The manager told us they had checked with their previous area manager whether they needed to notify the CQC and had been told they did not need to. We are investigating these matters further.

Environmental audits had taken place but these were not effective in identifying issues or concerns which needed to be rectified. For example the maintenance person completed weekly audits of window restrictors but had failed to identify two of these did not comply with HSE guidance.

We spoke, on the telephone, with the previous area manager during the inspection. They also contacted us following the inspection and told us they had completed provider visits. They said the manager had been involved with these, however, they had never been written up and sent to the manager in the form of an audit. This meant the manager was not provided with a baseline of the situation within the service or an action plan to resolve any issues which may have been identified. The area manager told us they had been asked to send these retrospectively which they did before they left the organisation.

Overall we found governance arrangements were poor. There was no robust system in place, either by the provider or the manager to audit the care people received. This meant the numerous areas of concern and multiple breaches of regulation we found during the inspection had not been identified by either the manager or the provider. This meant the provider could not be assured people were being provided with safe and effective care.

The manager had not been provided with regular supervision. They told us they had met with the previous area manager and had talked about any queries they had but this had not been formally documented. Supervision is an opportunity for staff to discuss any training and development needs any concerns they have about the people they support, and for their manager to give feedback on their practice. This meant the provider could not be assured the manager had the skills and knowledge required to deliver safe and effective care. Despite this the manager told us they felt well supported by the provider, and they could ring the previous area manager or managing director of the company for advice anytime they needed it.

The manager was not clear about their responsibilities. For example the manager had made some statutory notifications, but had not notified the CQC of eight incidents whereby people had fractured a bone, safeguarding matters or that the service had been closed due to an outbreak of diarrhoea and vomiting.

After the inspection we found the manager had made a safeguarding alert about a medication error and they had not referred this to the CQC. Statutory notifications are required by law to be provided to the commission about significant events which occur within the service. We will investigate these matters further.

The statement of purpose was dated 31 August 2010. It did not contain up to date information about the service and who was legally responsible, the manager told us the person named as the responsible individual no longer worked at the service. This meant that people were not provided with up to date information about who they could contact if they had concerns about the service or needed to discuss any issues with senior managers.

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

The manager was supported by a clinical lead , senior care staff and care staff as well as ancillary staff. The new area manager explained the clinical lead was a nurse professional but was not working as a nurse and took responsibility for nutrition and medicines. We saw records of people's blood pressure being taken but for one person there was no record of follow up when the reading was markedly lower than the usual reading. We asked the manager why blood pressure readings were being taken within a service providing residential care as we would not expect care staff to have the clinical skills to use this information effectively. They were unable to provide an explanation and said they would stop doing it.

We saw records of regular staff meetings. The manager told us this gave them an opportunity to raise any practice issues with the staff team and also meant the staff could share any concerns or give feedback. This demonstrated the manager was keen to promote an open culture within the staff team. The manager told us they had some difficulties with staff completing documentation and we saw the manager had spoken with the staff team about the importance of this at a recent team meeting.

A new area manager had started with the organisation two weeks before; they came to support the manager with the inspection process on the first day. This was the first time they had visited the service, and met the manager. We shared with the manager and new area manager concerns which were raised over the two days of the inspection. The area manager demonstrated a good understanding of the issues and was proactive in addressing our concerns. They sent an action plan to the manager which focused on the most urgent issues and they shared this with the commission. They demonstrated a commitment to support the manager to resolve the issues and make the required improvements within the service.