Minster Care Management Limited

Attlee Court

Inspection report

Attlee Street
Normanton
WF6 1DL
Tel: 01924 891144
Website: N/A

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Ratings

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

Overall summary

This was an unannounced inspection carried out on the 25 June 2015.

Attlee Court provides accommodation and nursing care for up to 68 people. The home is located close to local amenities in the residential area of Normanton. Accommodation is based over two floors accessed by a passenger lift. All of the bedrooms are single occupancy and have en-suite toilet facilities. Communal lounges, dining rooms and bathing facilities are provided.

The home had a registered manager, however, on the day of our inspection the registered manager resigned from the home with immediate effect. 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's safety was compromised in many areas. There were not always enough staff to meet people's needs and keep them safe. People were not kept safe from harm as some incidents of abuse were not recognised or reported. Standards of cleanliness, hygiene and infection control

Summary of findings

practices were not consistent across the home which put people at risk. People's medicines were not always managed safely. Individual risks had not always been assessed and identified.

Recruitment records evidenced recruitment practices were thorough and included application forms, interview notes, references from previous employers and checks to ensure staff were suitable to work with vulnerable people. We found some staff training was overdue. Staff received appropriate supervision and appraisal.

We observed some staff practices which showed a lack of respect for people and did not promote their privacy and dignity. We found care plans contained conflicting or essential information was missing about people's care needs. We found people had access to appropriate healthcare professionals.

Whilst we saw people who used the service taking part in an enjoyable activity this was not available to everyone.

The mealtime experience was not good for some people and we found in some areas it was chaotic.

We reviewed complaints about the service and found the provider's policy had been followed. Leadership and management of the home was ineffective and poor communication systems meant those in charge were not always aware of what was happening in the home. There were inconsistencies in how care was delivered throughout the home. The processes for monitoring the quality of care were ineffective and had not picked up the significant problems we found.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special Measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action.

Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

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 being put at risk as cleanliness and hygiene standards were not maintained, there were insufficient staff to meet people's needs and medicines were not managed safely.

People were at risk of harm as suspected or actual abuse was not adequately identified or reported appropriately. Individual risks had not always been assessed and identified.

Prior to commencing employment robust checks were carried out.

Is the service effective?

Inadequate

The service was not effective in meeting people's needs.

The provider was unable to demonstrate they had acted lawfully and followed the principle of the act in seeking Deprivation of Liberty Safeguards authorisations. Staff were not following the Mental Capacity Act (2005) legislation for people who lacked capacity to make certain decisions.

Staff supervisions and appraisals were carried out in line with the supervision matrix.

People received appropriate support with their healthcare, and nutritional needs, however, people's mealtime experience was not positive.

Is the service caring?

Requires improvement

The service was not always caring.

Staff did not always treat people with dignity and respect. We saw examples of where people's dignity was not respected.

We saw some good interactions between staff and people who used the service.

Is the service responsive?

Inadequate

The service was not responsive to people needs.

We found care plans did not contain sufficient and relevant information. People were not protected against the risks of receiving care that was inappropriate or unsafe.

People were unable to regularly take part in meaningful and stimulating activity.

Complaints we reviewed were dealt with appropriately.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well led.

The processes for monitoring the quality of care were ineffective and had not picked up the significant problems we found. People were put at risk because systems for monitoring quality were not effective.

Leadership of the home was ineffective and this impacted on the running of the home.

Meetings allowed staff to have an input into the running of the service.

Attlee Court

Detailed findings

Background to this inspection

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

This inspection took place on 25 June 2015 and was unannounced. The inspection team consisted of three adult social care inspectors, a specialist advisor in dementia, a specialist advisor in governance and an expert by experience in people living with dementia and older people. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

At the time of our inspection there were 52 people living at the home. During our visit we spoke with 10 people who lived at Attlee Court, three relatives, one visiting health professional and 11 members of staff, the registered manager and the regional manager. We observed how care and support was provided to people throughout the inspection and we observed breakfast and lunch in the dining rooms on both floors. We looked at documents and records that related to people's care, and the management of the home such as staff recruitment and training records and quality audits. We looked at 11 people's care plans and five medication records in detail.

Before our inspection, we reviewed all the information we held about the home. We were aware of concerns the local authority and safeguarding teams had and their on-going investigations at the home.

Inadequate

Is the service safe?

Our findings

On arrival at Attlee Court at 6:00am we were concerned at the number of staff available to assist people. On one unit we found there was just one member of staff to assist 16 people throughout the night. On another unit we found two members of staff to assist 16 people throughout the night, however, we were told by staff everyone on that unit required the assistance of two members of staff and one person needed three people to assist them. On the residential unit there were two members of staff. There was also one nurse who assisted people throughout the home. We spoke with the registered manager who said, "If someone was taken ill during the night we would not be able to send a member of staff to hospital with them."

We spoke with eight members of staff about staffing levels at the service. We were told there was a problem with high sickness levels which led to the service being short staffed at times. One member of staff said, "Today one person rang in sick this morning and now someone has had to go home. It really is a strain." Another staff member said, "We even have to work as cleaners and clean up the dining areas after each meal. And we have to do activities, all on top of our care work. It's ridiculous." On the day of our inspection staff told us they were still helping people to get out of bed at 12:15pm. We were told this was because the person needed two members of staff to assist them and staff had been busy assisting other people. We looked at the person's care plan and found they preferred to be up and out of bed between 7:00am and 10:00am.

We spoke with six people who lived at Attlee Court and asked them if they thought there were enough staff to keep them safe, one person said, "They are very short of staff here, when people leave; they take a long time to replace them. Sometimes I have to wait a long time for assistance, but not always." Another person said when they used their call bell, "They do not come quickly; I have to wait for staff." Someone else said, "I think there is enough staff to meet my personal needs as I am fairly independent." One person said, "On the whole I am not sure, they have more staff on some days."

The regional manager told us the dependency assessment tool was updated monthly in the care plans and then inputted into the overall home 'residential forum tool', they told us this was "Randomly based on occupancy." We were told staffing levels were based on 'one staff member to five nursing people and one staff member to eight residential people'. Therefore, people's actual dependency needs were not taken into account.

We concluded there were not sufficient numbers of staff deployed to meet the needs of people who used the service. This was a breach of regulation 18(1)(staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed a staff member shouting at a person when we entered the 'high dependency' dementia unit. The person was upset that they couldn't access their bedroom due to the decoration at the service. The staff member raised their voice and said, "What do you expect me to do about it?" They went on to say, "You will just have to get on with it." We reported this to the regional manager who agreed to make a referral to the local safeguarding unit.

We sat and observed in the communal area of the high dependency dementia unit. We saw a person go into the small lounge area and attempt to sit on the floor at 11:30am. We had previously observed this person try to sit down in the corridor and on top of other residents as they did not appear to have spatial awareness.

We saw this person become very agitated as he was told by a staff member not to sit on the floor in a loud and forceful voice. The staff member shouted the person's name repeatedly. We saw the person lashed out at the staff member and struck them a number of times on the arm. We then saw another staff member enter the room and stand by the door blocking the exit. This made the person more agitated. The staff would not let the person sit on the floor as they wished. We saw the interactions were negative towards the person.

We spoke to the regional manager about this incident. She told us the person often sits on the floor and was safe to do so and this usually calmed the situation. We looked at the persons care plan for maintaining a safe environment. It told us the person was at a 'very high risk' of falls but did not have information about how they liked to sit on the floor or their lack of spatial awareness. However, we saw this person had a 'risk management plan' in place that stated 'staff to be non-confrontational in their approach' and 'staff to speak in gentle tones clearly indicating what they are going to do'. We saw an additional management plan around placing themselves on the floor. This told us

the person gets clearly agitated if staff attempted to get them up before they were ready and that each incident should be recorded onto an ABC chart. This is a chart that details behaviours that are observed.

We checked this person's daily file at 3:00pm and found that no ABC chart had been completed. We also checked the hourly observations that were completed for this person. We found this incident had not been documented and that staff were not following the person's care plan when caring for this person. However, it did say '[person's name] put himself to the floor but got himself back up' This entry was timed at 14:15pm.

We saw the same person walk into a wall and hurt their nose at 2:00pm. We asked staff how they report accidents and incidents. They told us that accident forms go on a written form and then to the manager and any incidents go into ABC charts. We checked at 5:00pm and found no accident report had been completed and that no entry was made in the daily notes about the accident.

Staff we spoke with were able to confidently describe what they would do should they suspect abuse was taking place. We were told they would speak with their unit manager and they said any kind of allegation would be taken seriously. However, we saw 20% of staff's safeguarding training was overdue.

One person we spoke with said, "Staff are usually nice but there is one that can be sharp with you and I reported her." Another person said, "They are fond of telling me off." When we asked why they were told off and they said for all sorts of things."

We concluded the provider had not taken appropriate steps to ensure people were protected from abuse and improper treatment. This was a breach of regulation 13 (safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at a care plan for someone with a pressure ulcer. We saw a care plan was in place for this ulcer dated 14 June 2015. The person had a risk assessment called a 'waterlow' score completed monthly. This was last reviewed on 15 June 2015. We looked at how the record had been completed and saw it was scored incorrectly and did not reflect that the person had a current wound. The care plan stated 'staff to offer pressure relief e.g. air mattress or cushion when necessary'. We asked staff what this meant. They did not know. We could not access the person's bedroom to check what equipment was in place as they were asleep during the day. The care plan was not detailed enough to inform staff how to offer any pressure relieving equipment or what type they should use.

We looked at a care plan for someone who had bed rails to stop them falling from their bed. We saw a risk assessment had been completed for this on 6 October 2013. The risk assessment stated it needed to be updated monthly; however, we could not see it had been reviewed. We could not see that consent had been gained to use these bed rails.

A person we spoke with told us they liked to go outside to smoke, when we looked at their care plan we could not see a risk assessment for this.

We found risk assessments were not always reviewed or updated.

We looked at various areas of the building and found most windows had restrictors in place which opened no further than the recommended distance; however, we found two windows on the first which opened fully which meant people were at risk of falling or climbing out of the windows. We informed the regional manager about this who ensured this was corrected the same day.

People's 'personal emergency evacuation plans' were within people's care files only, therefore, in the event of a fire staff and emergency services would not easily be able to obtain information about people's evacuation requirements.

Attlee Court was in the process of being refurbished, we asked if a risk assessment had been completed to ensure the refurbishment did not impact on people's safety and we were told by the registered manager and the regional manager that a risk assessment had not been carried out.

During our inspection we observed hot food being carried on trays between units and dining rooms this was a result of only two hot trolleys being available; therefore we concluded this increased the risk of harm.

We concluded the provider did not do all that was reasonably practicable to mitigate risks. This was a breach of regulation 12(2)(b) (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service safe?

We saw some bathroom areas of the home were unsafe, floor surfaces were undulating and in one bathroom the floor covering had lifted. We saw in one person's care file they had fallen as a result of the undulation which had resulted in a skin tear. One bathroom on the first floor was decorated with plastic fish and an under the sea theme which was not age appropriate.

There was no clear signage to orientate people who used the service. Bedroom doors were all the same colour and they had no pictorial signage to enable people to recognise their bedroom. There were few ornaments/pictures and general furnishings to make the communal rooms more appealing, welcoming, comfortable and to stimulate memories. The lighting was poor in some areas as some of the strip lighting was not working. This was especially noticeable on the ground floor corridor.

Some areas of the rear garden was overgrown, neglected and dirty with a large amount of cigarette butts on the floor next to the door. We looked at the monthly maintenance and grounds audit checklists and which recorded the gardens were 'well maintained and in tidy condition'.

We concluded the provider did not ensure the premises were safe for use for their intended purpose. This was a breach of regulation 12(2)(d) (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked staff if anyone was taking early morning medication. All the staff we spoke with said no. We looked at one person's medication administration record (MAR) and saw they had been prescribed alendronic acid which was to be taken at least 30 minutes before breakfast. We looked at another person's MAR who had been prescribed Levothyroxine which needed to be taken at least 30 minutes before breakfast and caffeine. As staff told us people did not require early morning medication prior to breakfast we concluded staff sometimes failed to follow the prescribers' direction fully and people were not given their medicines correctly.

We observed the medication round started at 8:30am and was not completed until 12:00pm. We saw the next medication round commenced at 2:15pm. We asked the staff member how they could be assured medication was being administered within the correct prescribed timescales and they said they just remember.

We saw one person's MAR stated chloramphenicol eye ointment was to be applied four times daily. The MAR showed the person refused to have the eye ointment administered saying they did not need it as their eyes were not red. We saw they had also refused the eye ointment on a second occasion. We looked at the person's professional visitor's record which stated 'to stop the eye drops' and 'at 15.30 call to stop eyes drop because they make a mistake eye drops it was for one lady upstairs I stop the eye drops the pharmacy come in afternoon after eye drops'.

We found there was out of date medication in an unlocked drawer in the locked downstairs medication room. For example, we saw there levomepromazine with a person's name on which had expired in April 2015. There was also water for injections which had been dispensed in September 2013 and hypodermic needles which expired in 2011. There were alcohol wipes which had expired.

We found cefalexin 125mg/5ml SF oral suspension which had been dispensed and administered from 28 May 2015. On the day of our inspection we found the bottle was nearly empty. The instructions on the bottle stated dispose after 10 days of opening. Therefore, the medication should have been either returned or destroyed as it was out of date.

We looked at medication stock and found it was not possible to account for all medicines. Staff had not accurately recorded when medicines had been administered and new stock was delivered. For example, we found on one person's MAR for amoxicillin the number of tablets carried forward had not been documented. On another person's MAR for tamsulosin hydrochloride, warfarin, spironolactone, codeine phosphate and furosomide we found the number of tablets carried forward had not been documented.

We saw people's MAR charts did not contain a photograph. One staff member we spoke with said there were no photographs on people's medication administration records because in the last month the service had changed their pharmacy. We looked at the quality and compliance monthly medication audit completed by April 2015 for ground floor which stated photograph was needed for nine medication administration records. We looked at the quality and compliance monthly medication audit completed April 2015 for the upper floor which stated a photograph was needed for 21 people. We saw a medication audit for May 2015, in the criteria statement it

Inadequate

Is the service safe?

said 'there is a sheet containing the resident photograph, name, date of birth and allergy status held in front of each residents MAR sheet for identification purposes'. This was ticked yes.

We found that care and treatment was not provided in a safe way for people using the service because there was no safe management of medicines. This is a breach of Regulation 12(2)(g) (Safe care and treatment); Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found several areas of the home were unclean and had a malodour. We looked at the majority of people's armchairs and found they were stained and under each seat cushion was dirty with debris. We found debris behind radiators and a puddle of unidentified liquid next to an armchair.

There were unidentified stains on doors and some door handles. Food dispensing trollies were stained. We found stained mattresses and bed frames. On one unit we found a large square area of damage to the wall which had been caused by the removal of a handrail. This had been left with heads of screws exposed and the dust and dirt from the damage. It would not have been possible to ensure this was clean. We found there was debris on floors and light switches were unclean.

There was a simulated telephone box on one unit and again we found this was dirty with what appeared to be remnants of cement dust.

In the downstairs dining room we found the tables had been laid with tablecloths and cups and saucers. We found some of the cups and saucers were stuck together as they had not been washed properly and some cups were sticky and stained.

We spoke with staff about the cleaning of the home and we were told the registered manager had told staff to stop deep cleaning.

We looked at one daily bath cleaning record and found this had not been completed daily. We found a mop bucket and sweeping brush stored in a kitchenette which was dirty and a red mop which was used for cleaning bathrooms and toilets had been left in a the mop bucket.

We found the provider did not assess the risk of infection control and prevention. This was a breach of regulation 12 (2)(h) (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke to a visiting health professional who raised some concerns about the service. They told us they had concerns about staff being abrupt, poor manual handling techniques, poor falls management and felt the service did not manage weight loss well.

We reviewed the recruitment records for five members of staff which evidenced recruitment practices were thorough and included application forms, interview notes and references from previous employers. The provider had checked with the disclosure and barring service (DBS) whether applicants had a criminal record or were barred from working with vulnerable people.

Inadequate

Is the service effective?

Our findings

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom." We spoke with staff about their understanding of the DoLS and if they knew if anyone who used the service had an authorisation in place. Some staff were unsure of what this meant and said they would have to ask a nurse.

A member of staff we spoke with told us there had been some DoLS requested, however, there had been no mental capacity assessments carried out. Another member of staff told us there had been some DoLS authorisations requested and that a team of professionals carried out the mental capacity assessments.

The provider was unable to demonstrate they had acted lawfully and followed the principle of the act in seeking DoLS authorisations. We concluded this was a breach of regulation 13 of the Health and Social Care Act 2010 (Regulated Activities) 2014.

We saw one person had a 'MCA-1' form that recorded some elements about the person's capacity; however, this was not a two stage assessment that looked at best interest. The form stated that it should be reviewed monthly but we saw it had not been reviewed since March 2014.

We saw in some people's care plans they had consent for photographs forms but in some cases it stated n/a in the signature section. There was not a mental capacity assessment for these people we were therefore, unable to ascertain why the signature section would be n/a.

In one person's care file we saw a mental capacity assessment form that recorded some elements about the person's capacity. There was a tick box for what decisions it related to, washing, showering, changing incontinence pads and dressing were ticked. In the 'detail action you will be taking' section it stated, 'to ensure dignity is preserved by changing clothing if wet or dirty. To ensure health and safety of resident by assisting/supporting them into a safe area' and that the person did not require pressure relief as they were mobile. The latter two statements did not relate to the day to day decisions highlighted in the tick box section. Therefore, we concluded this was not an effective decision specific capacity assessment.

A member of staff we spoke with told us people who used the service did not have mental capacity assessments. We looked at how many members of staff had received Mental Capacity Act (2005) training and found 20% of staff were overdue their training in this subject.

On one unit people were not offered choices of what they wanted to eat, staff made the decision for them. We saw staff put sugar on the cereal without asking the person if they wanted it. However, on another unit we observed people were asked what main meal they would like and were given choices. This meant that people could have whatever combination they requested.

Staff we spoke with told us they gave people choice, one member of staff said, we always give people a choice of what they want to wear.

The care plans we looked at did not contain appropriate and decision specific mental capacity assessments which would ensure the rights of people who lacked the mental capacity to make decisions were respected. We concluded this was a breach of regulation 11 of the Health and Social Care Act 2010 (Regulated Activities) 2014.

One person we spoke with said, "This cup of tea is horrible, it's cold." We heard another person say to staff, "Can I have a drop more tea?" We saw staff did not follow up this request.

We saw a person who was very sleepy during breakfast and slouched over their chair. A bowl of porridge was put in front of them. They did not wake up despite staff trying to wake them. We saw this person did not eat or drink anything at breakfast. Staff took them back to bed later in the morning.

We observed lunch on the high dependency dementia unit. We saw tables were not set and napkins were not available. People were put in blue plastic aprons to protect their clothes. One person told us they found the aprons very hot. We saw people were taken into the dining room a long time before lunch. Some people got up and walked away as they had nothing to do. A person told us, "I wish they would give us a drink of pop, I'm thirsty."

Inadequate

Is the service effective?

We saw people were given a visual choice of meal and a choice of hot and cold drink. We saw one person requested a jacket potato and we noted this was served to them at 1.05pm; most people had finished their main meal by this time. Initially, there were no drinks put out on the tables and it was only after someone requested a drink that it was served at 1.05pm. People who chose sandwiches for their lunch were not given the option of brown or white bread or what filling they preferred, the sandwiches were just given to them, even though there where different options available.

Staff told us it was difficult to manage lunch as the hot trolley was on the other unit. We saw staff had to constantly walk to the other unit to fetch items which disrupted the service for people. We saw lunch was chaotic. There did not appear to be a member of staff in charge which resulted in staff not knowing who had eaten what. Staff were struggling to support the more dependent people in their care as they were very busy.

We asked staff what they thought about the food available to people. One staff member told us, “There is no variety. They get lots of pasties, fish fingers and beans. It’s like kids food.” Another staff member told us, “We have told the management about the food quality before but nothing gets done. We have to make the most, especially for residents on a soft diet.” We asked one person who was eating a pasty and beans for lunch if they liked it. They said, “No.”

We saw staff removed the crumble topping from the rhubarb crumble to give a person plain rhubarb who was on a soft diet. We asked staff why they did this and we were told they did not agree with just giving people yoghurt or mashed banana. One staff member told us, “We have to be imaginative to make sure people can have something a bit different.”

Staff told us people who used the service had access to snacks during the day such as biscuits and crisps if they needed them.

Staff we spoke with told us they had received regular supervisions. We saw there was a supervision matrix for 2015 which included one to one’s and appraisals. We looked at five staff files and found evidence of supervision and appraisal notes.

We reviewed the staff training matrix and found staff had the opportunity to attend various training courses. With the exception of Mental Capacity Act (2005) training we saw generally staff training was up to date.

People we spoke with told us they were able to access healthcare professionals when required. One person had their feet raised; they told us the Dr said they needed to do it to reduce the swelling in their legs. We spoke with a senior member of staff who said this was what the Dr had advised and staff ensured it was done. Another person had a dressing on their leg, they said, “The Dr and nurses come in to check my leg and redress it.” Another person had recently had a toe amputated and staff told us they were helping them to adjust by supporting them to walk on different floor coverings to help improve their balance. We spoke with the person who told us they had a hospital appointment and a member of staff would accompany them.

Requires improvement

Is the service caring?

Our findings

We observed how staff interacted with people living with dementia. We found when staff walked with residents they outpaced them and staff did not have the skills to effectively communicate with people who were not able to communicate.

We observed people's privacy and dignity was not respected. We saw one person on the high dependency unit without any footwear. We asked staff if the person had any slippers, they said they were unable to find a pair. We also saw one person who had got themselves out of bed and was sat in the communal corridor area in just vest and pants with a urine leg bag. Staff told us the person did not like to wear a dressing gown and it was a struggle to get them to wear one. After speaking to staff they assisted the person to their bedroom and ensured they were dressed appropriately.

We also observed one person asleep alone at the dining table with their head on the table after lunch and two other people asleep in the lounge bent double with their head on their knees.

We saw the high dependency unit handover book was stored in the kitchenette area of the dining room which was easily accessible to service users, visitors and relatives. The handover book contained information about one person who used the service that was not appropriate and compromised the person's dignity.

A staff member we spoke with told us people's bedroom doors were locked during the day because people wandered and moved things. They told us people living in the home would have to ask a member of staff to unlock the door. One person we spoke with told us they put a piece of tissue between the door frame and the door to enable them to get back into their room during the day.

We saw one person knocked their drink over and it was spilling onto their trousers. A staff member told us they would change the person after lunch. We noted by mid-afternoon a towel had been placed on the chair seat and the person still had the same trousers on.

One person we spoke said, "All of the girls and staff are nice but I don't like to have to ask and have bits of kids talking down to me."

We observed breakfast on the first floor low dependency dementia unit and saw tables were not set. There were no curtains on the dining room window for privacy.

We heard two staff members talking in the communal atrium on the high dependency unit. One staff member said they had put a person's sandwiches in their soup and mixed it all around. This was in front of two people who were sat on the sofa.

One person we spoke with said, they thought people should be able to go to the toilet when they wanted to but they had to wait for staff to take them.

A relative we spoke with told us their family member could be a lot cleaner to look at and sometimes they were dressed inappropriately by night staff.

We concluded that people were not treated with dignity and respect. This was a breach of regulation 10 of the Health and Social Care Act 2010 (Regulated Activities) 2014.

One person told us, "Staff are good to me, we have a laugh sometimes." "One member of staff (staff member name used) is especially nice and he is a good lad. He will always help you, he never pushes you off." Most of the people we spoke with said that they were happy with the care they received.

We observed a hoist being used and the two members of staff made the person feel safe by explaining each step to them in a kind and considerate manner.

A relative we spoke with told us they had never seen their relative's care plan and had no involvement with their care other than issues they raised on a day to day basis. We did find evidence people were involved in their care planning and files we reviewed did not contain a signed consent to care document.

Inadequate

Is the service responsive?

Our findings

The care plans we looked at contained conflicting information, sections were missing, sections were not up-to-date and did not reflect people's current care needs. For example, one person's care plan index detailed 13 care plans, falls risk, smoking, communication hearing and vision, communication confusion, eating and drinking, elimination, washing and dressing, mobility, pressure sore risk, working and playing, sleep, dying and prophylactic antibiotics. We saw the care plan only contained three of the care plans listed in the index which were for falls risk, washing and dressing and profalictic antibiotics. This meant the person was at risk of receiving unsafe care.

Another person's physical and social assessment stated they used a zimmer frame and wheelchair. However, their relative told us they did not use a zimmer frame.

We saw one person had been seen by a dietician who had recommended that food was fortified and that they received increased drinks, including milky drinks made with milk powder. The person's dietary intake records did not show that fortified food had been given and did not show the amount of fluid the person was receiving daily. The records were confusing and did not reflect what they had actually eaten.

We saw from one person's care plan they had lost 7kg since they were admitted to the home. We saw from the person's professional visits record they were not referred to a health professional with regard to weight loss until mid-June 2015. This meant the person's weight had not been effectively monitored and timely advice sought from health professionals had not been obtained. One health professional we spoke with said they had concerns that the service did not manage weight loss well.

In another person's care plan it was difficult to establish how often they should be turned as the care plan stated different times from every hour to every two to four hours.

One person's risk management plan stated 'Resistive to care. Staff find that if he is taken out for a cigarette before commencing any intervention then this helps'. However, the person did not smoke.

A relative we spoke with said that initially a lot of the staff had not known their family member was blind and they had been putting DVDs on for them to watch. It was only when they told staff; they admitted they did not know the person was blind.

We saw one person was given a newspaper to read at breakfast. They told us they had it delivered every day. We saw the paper had their name on it. The person told us, "I don't know why they make me read this; I don't like it, its politics. It was their choice."

We did not see any meaningful activities taking place. We saw little staff interaction with most people who used the service. Staff were policing people rather than supporting them. We saw five people sat in the main atrium, three were asleep and there was no stimulation for people who were awake. This continued for over an hour. One staff member then started to colour with one resident in a 'Micky Mouse' book which was not age appropriate. We saw this person did not have the dexterity to hold a pen and became quite frustrated by this activity.

We were told the activity coordinator had left and staff we spoke with told us they were having to try and find time to organise activities but this it was very difficult due to staff numbers. One person told us they sat in their room all day as they did not like sitting in the lounge as people were asleep all of the time and therefore they could not make conversation with anyone.

One person we spoke with was extremely upset as the one thing they wanted was to be able to have was a cigarette but staff were too busy to take them. They told us they were not allowed out by themselves and had to wait for staff to take them in their wheelchair. The person said they asked in the morning but often could wait hours before someone could take them.

This meant the provider was not taking proper steps to ensure that each person was protected against the risk of receiving inappropriate or unsafe treatment. This was in breach of regulation 9 (Person-centred care); Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was an activities board which displayed on the day of our visit a singing duo had been arranged on the ground

Inadequate

Is the service responsive?

floor residential unit. It was clear people really enjoyed this as they were singing and playing tambourines. We spoke with people who said they had liked the entertainment and it was very enjoyable.

We saw the complaints policy, dated February 2014 which was referred to in the statement of purpose booklet which was made available to people when they came to live in the home. This ensured people had written information available to them to make them aware of their right to complain and they were supplied with information as to how any dispute would be handled within the organisation.

We did not see a complaints summary however; we saw the complaints file which contained one complaint. This complaint had been dealt with in line with the provider's complaint policy.

Inadequate

Is the service well-led?

Our findings

We found the leadership of the home was inconsistent and systems designed to enable the registered person to regularly assess and monitor the quality of the service were not effective. The registered manager told us they were unwell and during our inspection they resigned with immediate effect.

We spoke with staff about how the service was managed. One staff member told us, "My unit manager is nice and so is the regional manager. The home manager is never here." Another staff member said, "We get plenty of training but some of it is on DVD. If I have an issue, I see my unit manager." Other comments included, "The registered manager would often 'run upstairs f'ing and jeffing' at staff when she was not happy with something", "Do not reckon much to the manager, the management team are weak" and "The weakest point is the manager."

Whilst we saw the results of a recent relative survey, the regional manager told us there had not been a recent staff or resident's survey.

We reviewed the quality monitoring of the service. This was a 'tick list' and we did not see evidence of the follow up action being taken by staff. We were told by the regional manager that there was not an audit chart with the percentage of achievement, together with the actions to be taken as they would have expected from home managers.

We saw the regional manager's three monthly audit for May 2015. We noted the areas for improvement were identified; however, there was no accompanying action plan to show how these areas were going to be addressed. For example, in the caring section it stated: 'staff need to be more empathetic with regard to care delivery – whilst this doesn't apply to all staff it has been observed with some, monitor levels of care, staff guidance, supervision, additional training, not all residents have a family history available for the staff to peruse to be completed, greater emphasis needs to be placed on involving residents and their families in the care planning process this requires more documentation'.

We saw decoration was being undertaken on the high dependency dementia unit. We asked the regional manager how the service had decided on the colour scheme that was being introduced. She told us that residents had been involved in this process however; we could not see any evidence to show this had happened.

We saw that walls had been painted in two-tones of peach. One resident told us, "I wouldn't have that colour in my house." We couldn't see that the service had used any research to ensure that their decoration was in line with best dementia care practice, for example, two tone wall colours could sometimes create a tunnelling effect for some people living with dementia and that could increase the risk of falls. We also saw the decoration was causing some anxiety to people on the high dependency unit. We asked if an environmental audit had been completed as there were workmen and tools in the area, however, the regional manager was unsure if an audit had been completed.

The registered person did not have effective systems in place to assess and monitor the quality of the services provided or to identify, assess and manage risks to the health, welfare and safety of people using the service and others. The processes in place had not identified the serious concerns we found during the course of our inspection. This was in breach of regulation 17 (good governance); Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw the minutes of the June 2015 staff meetings, we found meetings had taken place for 'senior carers and nurses/unit managers' there was one for nurses/unit managers', 'senior carers', health care assistants, and domestic/laundry/kitchen staff. We saw the agenda items were very similar with extra items that were role specific.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **We concluded there were not sufficient numbers of staff deployed to meet the needs of people who used the service.**

The enforcement action we took:
We are progressing with our enforcement action.

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 **We concluded the provider had not taken appropriate steps to ensure people were protected from abuse and improper treatment.**

The enforcement action we took:
We are progressing with our enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12(2)(b) We concluded the provider did not do all that was reasonably practicable to mitigate risks.**

The enforcement action we took:
We are progressing with our enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12(2)(d) We concluded the provider did not ensure the premises were safe for use for their intended purpose.**

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
We are progressing with our enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12(2)(g) We found that care and treatment was not provided in a safe way for people using the service because there was no safe management of medicines.

The enforcement action we took:
We are progressing with our enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (2)(h) We found the provider did not assess the risk of infection control and prevention.

The enforcement action we took:
We are progressing with our enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The care plans we looked at did not contain appropriate and decision specific mental capacity assessments which would ensure the rights of people who lacked the mental capacity to make decisions were respected.

The enforcement action we took:
We are progressing with our enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

This section is primarily information for the provider

Enforcement actions

Treatment of disease, disorder or injury	We concluded that people were not treated with dignity and respect.

The enforcement action we took:
We are progressing with our enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care This meant the provider was not taking proper steps to ensure that each person was protected against the risk of receiving inappropriate or unsafe treatment.

The enforcement action we took:
We are progressing with our enforcement action.

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 The registered person did not have effective systems in place to assess and monitor the quality of the services provided or to identify, assess and manage risks to the health, welfare and safety of people using the service and others. The processes you did have in place had not identified the serious concerns we found during the course of our inspection.

The enforcement action we took:
We are progressing with our enforcement action.