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Speke Care Home (Residential)

Inspection report

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Date of inspection visit: 19 and 20 November 2014
Date of publication: 25/02/2015

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

Speke Care Home (residential) accommodates older people who do not need nursing care. On the date of our inspection 35 people were living in the service. The service can accommodate up to 49 people. The service has voluntary agreement not to admit any new service users until improvements are made.

We carried out this inspection to check if improvements had been made from the previous inspections of 31 March 2014 and 25 July 2014. We found that some improvements had been made. However there were a number of concerns that the service had not yet addressed.

Summary of findings

This unannounced inspection took place on 19 and 20 November 2014. We had asked the provider to make improvements in staff support, monitoring the quality of the service, meeting people's health and welfare needs, infection control and records. During this inspection we looked to see if these improvements had been made, but they had not all been completed.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

Peoples view's about the service they received were mixed. While some people were very happy, others were not. In addition, our observations and the records we looked at did not always match the positive descriptions some people had given us.

During the inspection, we spoke with thirteen people living at the service, five relatives, eight staff, the registered manager and the registered provider. 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 service was not consistently respecting and involving people who use services in the care they received. For example all the care plans viewed did not show the person's choices and personal preferences. The care plans did not involve the person or their relative when they were written and their views were not reflected in the care plans. People told us they had no input into the menus or activities and we saw that no choice of meals were offered.

Staff members were not always following the Mental Capacity Act (2005) for people who lacked capacity to make decisions. For example people's mental capacity was assessed once only and there was no information available in the service for the staff that helped them support a person with fluctuating capacity. We saw inconsistent approaches from staff with some staff explaining to people before they undertook a care process, other staff failed to give the person any information about the care and support they were about to deliver.

We saw that people's health care needs were not accurately assessed and that risks such as poor nutrition were not correctly assessed. People were not always supported to eat and drink enough to meet their nutrition and hydration needs. We saw that one person had lost a significant amount of weight but this had not been recognised by the service. As a result relevant professionals had not been contacted and appropriate measures to prevent any further weight loss had not been put into place. People's care was not planned or delivered consistently. In some cases, this put people at risk and meant they were not having their individual care needs met. Records regarding care delivery were not consistently accurate or up to date leaving people at risk of not having their individual needs monitored or met.

Neither the registered manager nor the registered provider investigated or responded to people's complaints in accordance with their own policy. Six of the people we spoke with did not know how to make a complaint. Two people told us they had made a complaint but felt that the situation had not improved.

Staff members were able to explain in detail how they reported any safeguarding concerns. When we looked at how staff put this into practice, we saw that three safeguarding concerns had not been recognised by the staff or reported to the registered manager. As a result the registered manager had been unable to appropriately report the concerns or review the incidents to prevent a re-occurrence. The lack of reporting safeguarding concerns appropriately potentially placed people who lived in the service at risk.

People who lived in the service did not consistently receive their medicines in a manner that met their individual needs. Staff did not have the correct information to give medicines when needed and this meant that at least one person did not receive their pain relief when needed.

Staff training had improved however there remained large gaps in the training of staff particularly around dementia care needs, communication and dealing with challenging behaviour. The majority of staff had been appropriately checked before starting work with the exception of one member of staff who had not been checked for their suitability to work in the service. The

Summary of findings

provider did not have a system to assess staffing levels and make changes when people's needs changed. This meant they could not be sure that there was enough staff to meet people's needs.

The arrangements that the provider had in place to check on the quality of the service had improved. Overall there were still gaps in the providers' arrangements which meant service users' views or their relatives did not influence the service provided and complaints were not appropriately addressed or responded to.

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 who used the service were being put at risk because medication was not given correctly. Safeguarding concerns and complaints were not appropriately dealt with.

There were limited arrangements for people to be involved in the decisions about their care. We also found that staff did not always respond appropriately to people if they became agitated or distressed.

The service had improved the arrangements for managing the risks associated with infection.

Is the service effective?

Inadequate

The service was not effective.

We found that care plans to make sure that people's health needs were managed were not individually reflective as a result people did not always receive care that met their personal needs.

Whilst staff had some up-to-date training and supervision, it was not always put into practice. People who had fluctuating capacity and were less able to make a decision did not have arrangements in place to assist them to make appropriate decisions.

People's views about the food were not consistent. Comments about the food included, "Marvellous", "I like the soup", "It's alright", "No, I don't like the food here, I've got my own", "If I like it I eat it, if I don't like it I leave it and wait till teatime". People did not always have sufficient nutrition to prevent them from losing weight.

Is the service caring?

Requires Improvement

The service was not always caring.

We found that staff's approach to people did not always take their individual needs into account. People's views varied about the care they received with the majority feeling happy and well cared for whilst others did not have their pain relief needs meet.

People who lived in the service were asked were staff kind to them comments included, "They are kind and have lots of patience", "No not really" and "Of course they do, my son would go mad if they didn't."

Information for people less able to communicate was not in a format that assisted them. The service did provide support to people at the end of their lives but staff had not received any training for this.

Summary of findings

Is the service responsive?
The service was not responsive.

We saw that care plans did not always reflect up to date information for staff to be able to meet people's needs. Information about people's preferences, choices and risks to their care were not consistently recorded. As a result some of the people had not received care that met their individual needs.

The service did not manage complaints that had been raised. People we spoke with did not know how to make a complaint or raise a concern. In addition two people told us that when they had raised concerns they had not been addressed.

There were not enough meaningful activities for people to participate in as groups to meet their social needs; so some people living at the home felt isolated.

Is the service well-led?
The service is not well led

People were put at risk because systems for monitoring quality were not effective. Audits had been completed that identified concerns but these were not actioned. Communication to the manager was not effective and unexplained injuries such as bruising were not communicated to the manager for her to action.

The culture of the service was not centred around the person but was more around the tasks that the staff had to achieve each day. This approach did not support people's individual needs.

There had been some improvements in response to a previously issued warning notice from CQC with regards to infection control and effective audits were now in place for this aspect of the service.

Inadequate

Speke Care Home (Residential)

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 19 and 20 November 2014 and was unannounced.

The inspection team consisted of an adult social care inspector, an expert by experience, and a specialist professional advisor. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had specific understanding of care and support for older people. A specialist professional advisor (SPA) also attended this inspection. The SPA had expertise and qualifications in managing infection control.

During the visit we spoke to thirteen people living at the service, five relatives, eight staff, a visiting professional, the registered manager and the registered provider.

We observed care and support in communal areas and also looked at the kitchen and all bedrooms. We reviewed a range of records about people's care and how the home was managed. We looked at the care for eight people this included looking at their care records, risk assessments, food and fluid records, turn charts, daily records, professional visits records, diary records, menus, medication administration records and care plans.

We looked at a variety of staff records including training, induction and supervision for all staff and recruitment records for a sample of six staff employed at the home. We looked at other records within the service including quality assurance audits available at the inspection.

We requested additional records following the inspection. These included copies of policies for safeguarding, whistleblowing, medications, complaints, confidentiality, mental capacity, advanced decision making and end of life care. We did not receive the policies for safeguarding, confidentiality, advanced decision making or end of life care. We also requested an updated fire risk assessment and any quality audits other than the medication audit a copy of which was supplied at the inspection. We did not receive any of these.

We requested audits from the provider and the consultant employed to assist the service. We did not receive any of these. We requested copies of the menus in operation during our inspection and we did receive copies of these. Additional to the menus we requested the arrangements for service users to order food, we were informed that there were no formal arrangements for this.

A request was made for evidence of references and police check known as Disclosure and Barring Service record (DBS) for a particular member of staff, none of which was produced. We also requested that safeguarding notification information was sent to us. We did not receive these.

The managers training and supervision records were requested and we received copies of the managers training, but not records regarding their supervision from the provider.

Inadequate

Is the service safe?

Our findings

Relatives told us, "I was amazed when I first came here, they are always on hand". Three relatives spoken with told us that they thought their relatives were "safe" living in the service. One relative told us that they did not think their relative's needs were fully met and did not get all the care they needed but overall they did not think their relative was at any "significant risk". They told us they thought that was because staff really did try to care for their relative.

One person spoken with stated, "They hit my shoulder." When asked who had hit their shoulder they replied, "The man." There was a purple bruise on the person's neck. The person explained in relation to the bruise that it was, "One of them" who had caused the bruise and indicated towards the staff. We reviewed the person's record and saw that there was a body map showing the bruise and describing it as an unexplained injury. In discussion with the manager she had not been made aware of the bruise by the care staff and as such had not been able to address this as a potential safeguarding concern. The manager agreed to make a safeguarding referral following this inspection.

A further exploration of seven other people's care records showed that within the last months, two other people had an unexplained injury resulting in a bruise. These incidents had not been reported to the manager. There was no evidence that the people's doctors had been contacted to review the bruises. None of the staff or the manager spoken with were able to recall what action had been taken, following the three incidents of unexplained bruising.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as the service did not have an effective system in place that recognised potential abuse or took appropriate action when concerns were identified.

We looked at how the service managed medications and found that people were not getting their medications as they should. We saw that a lot of medicines were recorded as refused at night time. The manager spoke with the night time care staff who explained that the people were actually asleep. This recording error meant that the prescriber had not been contacted for advice. One person had received one of their medicines once a day even though it was prescribed as twice a day. As a result the medication had not been effective. Not receiving the medication correctly had resulted in the community matron having to provide additional treatment to that person, which would have been unnecessary, if their prescribed dosage had been given.

On the first day of our inspection we saw that medicines were still being given out to people at 11.30 am in the morning with the next set of medication due at lunch time. The staff told us that they would move the times that they would give the next set of medication to 2pm. However, this still left a gap of only 2 and half hours between medication, which is not suitable for medication that can only be given every 4 hours. This needs to be spread evenly throughout the day to be effective.

There was no information available in the service for people who had medication prescribed "as needed" (PRN). As a result care staff did not have the instructions they needed to give this correctly. One person was complaining of pain but had not received the additional pain relief that they were prescribed as needed. Another person had a note on their medication administration record that stated that they were self prescribing for a cream. The person told us that they had not had the cream for months. The records stated that two tubes of cream had been received by the service. Only once could be located, the second was unaccounted for. The manager spoke with the staff as to why the person had not had the cream applied or where the missing tube was but no explanation was available.

A further person had run out of medication for two days. No explanation as to why the person had run out or what the service had done to obtain their medication in a timely manner was available. There was no evidence that the person's doctor had been contacted to inform them that the person had not had their prescribed medication for two days.

Medication was not correctly stored. We saw that the majority of medication was stored in a room where staff had checked the temperature of the room. The temperature had been recorded as consistently above 24 degrees centigrade and on occasions up to 28 degrees centigrade. The majority of medication had manufacture's instructions that they were not to be stored above 24 degrees centigrade. Storing medication at too high a temperature can affect the effectiveness. We also saw that when staff were giving people their medication in the

Is the service safe?

morning of the first day of our inspection they failed on four occasions to secure the medication trollies, leaving the trolley doors open with no member of staff supervising the trolley.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as the provider was failing to protect the people in the home against the risks associated with the unsafe use and management of medicines.

The provider had recruited a new member of staff to the service. We observed this person to have free access to all areas of the service. We spoke with the manager regarding the appropriate checks for the member of staff to make sure that they were safe to work in the service. The manager explained that she had not been involved in the recruitment and was unaware of what checks has taken place. We spoke with the provider who apologised and said that the checks for the person's recruitment would be made available. We wrote to the provider following the inspection again requesting copies of records that the provider had checked the suitability of the staff member. We did not receive any copies of the records we requested.

This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as the provider was failing to operate safe recruitment procedures.

We looked at how many skilled staff were employed in the service to meet people's needs. People who lived in the service told us that there were enough staff on duty at the inspection, they stated, "Plenty of staff", "I never have to wait long for help." and"I do a lot myself, but if I ring the buzzer they are very quick."

Staff told us that due to not admitting any new people to the service they thought that there were sufficient staff members at "this time". They expressed concerns that as there were less people living in the service the amount of staff available each day would be reduced by the provider. They explained that in the past there had been significant time periods in which there was insufficient staff available.

We spoke to the manager and provider who informed us that there is no means to determine the amount of staff available based on people's needs. The manager also explained that at present staffing levels were suitable on a day to day basis. There were no arrangements in place to replace staff if off sick or increase the numbers of staff available as more people moved into the service. The manager and provider confirmed that the staffing levels available were determined exclusively by the provider based on economics and the amount of people who lived in the service. Additional staff were not made available if people needed to attend pre-arranged medical appointments. As such the provider did not have arrangements in place that made sure that at all times, there were sufficient numbers of suitably qualified, skilled and experienced staff to meet the assessed needs of people living in the service.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.as the provider did not have sufficient arrangements in place to ensure that there were always appropriate staff on duty based on the needs of people who lived in the service.

At the previous inspection the provider and the manager had been issued with a warning notice for Regulation 12 of the Health and Social Care Act 2008 relating to poor management of infection control in the home. The service had been told to improve. We undertook this inspection with a specialist professional advisor for infection control. They reviewed all the arrangements within the service for managing infection control. At this inspection we saw that significant improvements had been made. Potential infection risks such as hard soap in communal areas had been removed. Liquid soap and paper towels where available at all hand wash basins used by the care staff. However the soap dispenser in the kitchen was broken and was informed by the cook "it had been like that for some time".

The home was overall found to be clean and fresh smelling. Equipment such as commodes were also found to be clean.

Inadequate

Is the service effective?

Our findings

People we spoke with had differing views about the food and its quality, comments included, "marvellous", "I like the soup", "It's alright" and "No, I don't like the food here". One person told us that they disliked the food and as a result they did not eat any of the food available, their family brought meals in for them.

We looked at the arrangements in place to support staff to develop the skills they needed to effectively meet people's needs. We reviewed staff training records and saw that staff had not had training or assessments in their competency to give out medication. During the inspection we saw that medicines were not consistently given out safely or in a manner that met the person's needs, this was because staff were not always competent or sufficiently trained.

On the second day of the inspection some staff members received half a day's training which covered dementia care and mental capacity. We spoke with both the trainer and the manager who agreed that this was an overview of both the topics only. However there was no further training in more detail available that would give staff a fuller understanding of how to effectively meet the needs of people who were living with dementia. We saw that the staff's ability to communicate effectively with people who were living with dementia was not consistent.

A review of training records and rotas of staff working in the service showed that there was a total of 48 staff members including those who worked as part of the bank staff, (a bank of staff brought into work as needed) the manager, administrator and ancillary staff such as laundry and cleaners. There was a total of 36 staff undertaking care including the manager. Staff training available was not sufficient to provide staff with the skills that they need. For example 30 staff received safeguarding training this meant that 18 staff had not received the training. We spoke to three staff who were able to describe how safeguarding concerns were to be dealt with. However despite the training we saw instances where staff had not responded effectively to potential safeguarding concerns when raised and had not been put their training and knowledge into practice.

10 care staff had up to date training in supporting people to eat and drink. This is less than a third of the care staff. During this inspection we saw that people's nutritional needs were not always effectively met. We saw that one person had lost weight, this had not been addressed and arrangements to provide a diet to meet the person's nutritional needs had not been put into place.

We looked at training that helped the service maintain people's safety. We saw that 31 of the 48 staff had up to date health and safety training, 39 of the 48 staff up to date training in fire safety and 36 of the 48 staff had up to date training in moving and handling.

There were also gaps in the training for staff given the assessed needs of people who lived in the service. This included assessing nutritional risk, managing pain relief, written care plans, dealing with challenging behaviour and communicating with people.

Staff could demonstrate recent in house training in relation to infection control and records of training in infection control were also available. However there was no consistency in staff awareness of the home's policy and procedures. When staff where asked how to deal with a body fluid spillage, or how to recognise when the home had an outbreak of suspected viral gastroenteritis, staff views varied and in some instances staff were unable to answer.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as the provider did not make sure that staff received appropriate training in order that they had sufficient skills to meet people's individually assessed needs.

Mental capacity assessments to determine if somebody had fluctuating capacity and to determine the best time and way to support them were done once only. Information about people's mental capacity and how to support them to make decisions or give consent was not included in people's care records. The home provides support to people with living with dementia. There was a lack of appropriate arrangements for supporting people with fluctuating capacity as the service did not have arrangements in place to make sure that people living with dementia had their mental capacity needs met.

We observed how staff approached people with variable mental capacity in order to involve them in their care and gain consent. We saw that staff were not consistent in their approach. For example some staff explained to people the meal available that day, others gave people the food without any explanation. We also saw that this inconsistent

Is the service effective?

approach was in place in other interactions; staff did not always gain people's consent or permission before they moved them around the service or placed protective clothing on them for meals. We discussed with staff their understanding of how to support people who lacked capacity and their understanding of the law to support this such as the Mental Capacity Act (2005). Staff member's understanding was also inconsistent with some staff being able to explain clearly how to support people whilst others demonstrated a limited understanding particularly in relation to people living with dementia.

There was no information in the service regarding advanced decision making for people or who had legal power of attorney for people living in the service as applicable.This meant that information about people's legal rights and human rights was not available for staff to be able to give people the appropriate support.

We were informed by staff that one relative did have power of attorney for a person so they took instruction from the relative of the person about the person's choices. However there was no information in the person's care records that detailed which specific legal obligations the relative had or if this was legally correct. We did speak to the relative of the person who told us that they did not have lasting power of attorney that covered the legal obligations to make decisions about the care or treatment on behalf of their relative. As such staff had not have been acting within the person's rights as decisions were deferred to the relative by the staff

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as the provider did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of people who lived in the home.

We looked at how the service supported people to eat and drink and what arrangements they had in place to meet people's nutritional needs.

We observed people during the lunchtimes and saw that support to eat meals was inconsistent. Some staff gave very good support to people to help them eat and drink. One table of people did not receive their sweet following their meal and staff only gave people this part of their meal when they were reminded to do so by us.

We reviewed three care records for people who lived in the home who had a nutritional risk assessment in place known as a MUST score. All three of the scores we reviewed had been incorrectly calculated. We could not find information in the person's care records as to how the service was making sure that they reduced the risks of malnutrition. No records of dietary intake were available or monitored. We saw that the person had been prescribed a supplement to their diet but this had not always been recorded as such the staff would not know if the supplementary food had been given or not.

There was no evidence on file that a dietician or the person's doctor has been contacted for guidance however the manager told us that the person's doctor had been contacted who had prescribed a supplement. We spoke with the kitchen staff who were unclear as to what was a fortified diet and no evidence that a fortified diet was in place for any of the people who lived in the service. Care staff spoken with were not aware that the person needed a fortified diet and had not provided a fortified diet as the MUST assessment stated needed to be available. As such the service did not provide suitable food to meet peoples assessed individual nutrition needs.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as the provider did not ensure that people's individual nutritional needs were met.

We looked at how staff were supported to receive supervision with their line manager in order to promote best practice. We saw that staff supervision had taken place with the last two months and staff had been reminded of their job role and responsibilities. Records viewed also showed that all but two members of staff had received supervision within the last three months. This was an improvement from previous inspections. Staff spoken with confirmed that they received supervision and found this of benefit.

Following our last inspection we asked the provider to make improvements to the environment. At this inspection we saw that improvements had been made. Several areas in the home had been redecorated and maintenance had been undertaken for doors and windows such as replacing cracked glass and making sure that doors met fire regulations.

Requires Improvement

Is the service caring?

Our findings

Feedback from people about the attitude and nature of staff was mixed. Some people spoke positively about the care provided by staff. Comments included, "They are marvellous staff", "They are all so lovely and jolly, we dance with them. Not one of them are nasty.", "I think that I am very well looked after." One person told us, "It can depend on which staff are around they are not all as good as each other".

We saw that interactions between people living in the service and staff were not always consistent. For example one person told a member of staff that they felt uncomfortable. The member of staff adjusted their clothing and moved cushions around to make them comfortable. We observed one person ask for a cup of tea on six occasions. They received no response from staff who were busy doing other things. When staff were asked why they did not respond they explained that the person was often "agitated" in the morning but settled during the day. There was no information in the person's care records that said this was their normal behaviour.

Some interactions appeared task-focused. At these times staff gave no information about what was happening and did not engage people in conversation. For example in one lounge, two members of staff were using a hoist to transfer a person from their chair to a wheelchair. They did not speak to the person as they put them into the sling. They did not offer any reassurance or commentary whilst the person was in the hoist waiting to be lowered into the wheelchair. We also observed staff move another person using a hoist and an animated conversation including reassurance when the person became upset was observed.

We observed that people were not told what the meal was unless they requested information. We saw that in one area of the service there was a notice board stating what the meals were that day. It was not readable from the majority of the tables in the dining room. Another dining room had no information about food available at all in any format that would meet the needs of the people living in the service.

There was information available regarding activities but this was not in an area frequently accessed by people who lived in the service and was not available in other formats such as pictures that would assist those less able to communicate, to know what activities or food was available.

We observed the televisions were turned on by staff with no consultation with people as to what they wanted to watch or listen to. When we asked a person whether they had input into the choice of programme they told us, "The staff decide".

We asked people whether they felt that the staff listened to them. Most told us they did. We asked had they been involved in any "residents and relatives meetings", one person told us "I don't think so." Three other people could not remember attending a meeting. One relative told us no one in the home has asked them their opinion as to how the home was run.

All the care plans we viewed did not have life histories and there was limited information about people's preferences. In discussion with staff they told us they had worked there for a number of years and knew a lot about the people who lived in the service. However this relies on staff remembering information correctly and passing it on to other staff correctly rather than making sure all staff were aware of the same information about people. As our observations showed staff were not always consistent with how to support or interact with people living in the service.

People spoken with reported that their visitors were welcomed into the service. One relative told us that they always felt welcomed and were offered a cup of tea and a meal if they visited during mealtimes.

During the inspection we observed a nurse conduct consultations with people who lived in the home. These were undertaken in private with the person or their family in attendance. People who lived in the home told us that they always saw the doctor or nurse in private.

Inadequate

Is the service responsive?

Our findings

People living in the home told us that they had no input into deciding on the activities or meals available. One person told us, "We have a set routine; nobody has ever asked me what time I would like to go to bed, I go when everyone else goes." Another person told us that they can not have their meal at a different time, "only if people go out (to an appointment)". We observed over lunch time everybody received their meals at the same time. We saw six people seated at the dining table for over 20 minutes before the meal was served, they were not offered a drink during that time. The menu available in the home did not show a choice of food and the manager confirmed that no menu choices were available. The manager confirmed that as yet people had not been asked about their views of the food or what they would like to see on the menu. The manager told us that surveys about food and other aspects of living in the home were to be sent to people within the next few months.

We spoke with people living in the home about how the home supported their cultural needs. We were told by a relative, "Somebody (a church volunteer) takes him to church every Sunday and to the church club on a Monday." We were told that religious support was not available for people living with dementia as they did not have the staff to take them to church if needed. There was no visiting church representative available. Care records viewed did not highlight people's religion or if they required any support to have their cultural needs met. We spoke to people about their preferences to have their personal care needs met by staff of the same sex. None of the people we spoke with could recall being asked what their preferences were. One person told us, "I don't mind male or female, they are very good staff."

We looked at people's care records regarding their personal preferences, choices and wishes. We saw that there was very little or no information available in people care records that would assist staff to help people make choices. We asked for information that showed us how people less able to vocalise a choice such as food or activities were supported to take into account their personal preferences. The manager told us that no information was available. Staff told us that they often made choices for people living in the service as they "know them really well".

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as the provider did not make arrangements for people who lived in the service to be consulted with about their choices.

There were limited activities available during our inspection days. Chair exercises were taking place in the main lounge after lunch on the first day of our inspection and staff encouraged a lot of people to join in. The television was on all morning and nobody appeared to be watching it. A carer then put the radio on instead of the television. People who were able to undertake activities without staff support told us they spent their time "reading as there are no activities," "Just waiting, waiting for them to talk, I watch TV" "Listening to the radio, or doing crosswords, word searches and Sudoku, (in room)." "Sitting here" and "reading, doing puzzles, word search and TV."

We did not see any activities take place that met the needs of people living with dementia. One person who lived on the dementia care unit told us they were "bored". The provider told us that they had recently increased the activities co-ordinator hours. The activities recorded on the notice board included hairdressing and bingo. Bingo may not be a suitable activity for people living with dementia and consideration had not been made as to the appropriateness of the activities in place. The manager stated that the activities co-ordinator had not had training in organising and running activities suitable to meet the needs of people living with dementia.

We looked at how the service responded to people's health care needs and made sure that they received care that met their needs. We reviewed eight care plans in total. None of them were person centred, with the same plans available for different people such as how to support a hygiene need. Plans were "task and medical condition" orientated and not person orientated. People's individual's needs were not in plans, for example one person had behavioural concerns and these were not recorded in their care plan. There was no information available to staff that told them how to respond when the person became upset or was shouting.

We discussed with staff their understanding of people's care and how they accessed care plans to help them meet people's needs. Staff views and their understanding was not always consistent, for example one person required a thickener in all their drinks. All staff were aware that the person needed the thickener, however not all the staff held the same view. We checked the person's care plan and

medication records and found that these recorded two different views. We were unable to locate an assessment from a speech and language therapist (SALT) that would have described what thickness of fluids the person needed.

People living in the service and their families we spoke with were not aware of the contents of the care records and could not recall having been involved in any assessments of care or writing plans of care.

Care plans were cumbersome, repetitive and as a result were not up to date. Staff told us that they thought that there was too much paperwork. Care plans were reviewed monthly but any changes to the person's condition were not reflected in the care plan. For example one person had unexplained bruising that was documented on a body map. There was no update to the care plan that would assist staff to monitor the person's bruise and no investigation was in place that would assess the likelihood of any risks to the person. Another person told us that they were in pain and had not been given any pain relief. There was no care plan available and no arrangements in place to monitor the person's pain. Following the inspection the manager told us that arrangements would be made for all the people who lived in the service who were prescribed pain relief to have their pain monitored.

We spoke with health care professionals who visited the service. They told us that they thought staff did their best but needed further development to respond to people's needs. The professional explained how a person's medication had changed. There were no arrangements made for staff to monitor the change in treatment, the person's assessment or care plans had not been updated to reflect this change and instruct staff to monitor the treatment. There was no feedback given to the doctor that would inform them that the treatment was in place was meeting the person's needs.

We observed that one person had dirty and long nails. Staff stated they had not been able to attend to personal care needs that day as they had refused. The same person had a cut on the side of their face after a member of the care staff cut the person whilst shaving them. There was no information in the person's care records that they had refused personal care or were prone to do so. The dirt accumulated under the person's nails and the length of their nails could not have occurred in one day.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as the provider did not have suitable arrangements to make that peoples health and welfare needs were met.

Previous to our inspection we had received two complaints from a family member. These had been passed to the service for investigation. At this inspection we asked to see how the complaint was being progressed and what the investigation had revealed, if anything. There were no investigation records available and the manager explained that there was no investigation in progress for the complaint. The service's own policy states that all complaints must be responded to and addressed within 28 days of receipt. We had passed on the complaint to the service more than 28 days prior to our inspection.

During the inspection a relative explained to us that they had made a number of complaints about the care of their relative and this had included a complaint that their parents laundry and personal linen went missing. This included the person's underwear and they had arrived in the service recently to find that their parent had no underwear available. They stated that the manager had reimbursed them in the past for missing linen but this had not prevented their relative's personal laundry and linen from going missing. We asked to see how the manager had investigated these complaints and what action they had taken to prevent a re-occurrence. The manager explained that there were no investigation records as an investigation had not taken place.

We asked the manager to show us copies of any investigation that she had taken following safeguarding concerns and after social services had completed their investigations. None were available.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as the provider did not make sure that they responded to complaints in accordance with their own policy.

Inadequate

Is the service well-led?

Our findings

The culture of the service was not based on the needs of the people who lived in the home but was task orientated. This could be seen by the routines in place in the service that were not flexible to meet people's needs, the lack of choices available to people and care that did not meet people's needs as care was not appropriately planned.

A registered manager was in place on the date of the inspection. We found two notifications of suspected abuse which should have been submitted to the Care Quality Commission (CQC) had not been. The systems in place were not sufficient to ensure the delivery of high quality care. During the inspection we identified failings in a number of areas. These included medication, meeting people's choices, stimulating activities for people who lived in the service, nutrition, care and welfare, managing risks to people, dealing with complaints, identifying and managing safeguarding, staff training and staff recruitment..

The majority of the issues had been identified to the provider at previous inspections. The service has in the past addressed concerns but not maintained the improvements. We did see improvements in the way that service had managed infection control arrangements and in the number of staff available in the service. As a result of past concerns the provider had recruited a consultant to assist the manager in improving the quality of the service.

The registered manager had submitted an improvement plan following the last inspection which had been rejected by CQC as there was insufficient detail to make sure the service would be able to meet its regulatory obligations and improve the quality of service. A further plan was submitted and the service was asked to amend the amount of time it would take to complete all the actions as some were over six months which placed people at risk for a significant period of time.

The manager told us that the consultant had written an improvement plan for the provider that she had not seen. Following our inspection we requested a copy of the action plan. This was not made available to us.

The provider did not have a formal system to assess and monitor the quality of care provided to people or to manage risks of unsafe or inappropriate treatment. There was some evidence of recent quality monitoring of medication and an audit had been completed by the manager that identified a number of concerns. At our inspection we identified similar concerns. However, from the manager's own audit no action had been taken to rectify the issues that had been identified.

Care plan audits had not taken place and the manager acknowledged that care records were out of date and did not reflect people's needs. We asked to see a plan as to when the care plans would all be updated and what support the service, manager and staff would receive. There was no plan available and the manager was unable to state when all the people's needs who lived in the service would be assessed and appropriate plans put into place. We found several instances of care not meeting people's needs. These issues could have been identified through a formal system to assess and monitor the quality of care if one had been in place.

Where issues or improvements had been identified, we saw appropriate action had not always been taken to address them. For example unexplained injuries had not been investigated and complaints had not been addressed.

During this inspection, feedback from people confirmed that there was not enough to do and we observed there was limited stimulation for people. A lack of appropriate activities had been raised with the provider both in survey results from families and meetings with families. Although the amount of hours that the activities co coordinator worked had been increased this had little impact on activities appropriate to meet people's needs.

Policies and procedures reviewed in particular the infection control policy and procedures were erratic and a disorganised array of documents, without consistency for subject, content, review and implementation. For example, many policies where repeated, some three times on occasions.

Risks to people's health, safety and welfare were not appropriately reported, managed and analysed. For example, we found accidents or injuries that were recorded in people's care records but had not been reported as an incident to the manager. As a result the manager had not had the information needed to analysis incidents and take appropriate action to reduce any potential risks.

People who lived in the home and staff had not had the opportunity to give their views and opinions of the care provided and any input for improvement. All surveys previously sent from the service had been to relatives only.

Inadequate

Is the service well-led?

The manager had been developing surveys to be sent to people who lived in the service for their input however these had not been sent and the manager was unable to tell us when they would be sent to people and staff.

We asked to see a copy of the audits that the provider undertook in the service. We were informed that the provider did these monthly. None were made available at the inspection and none were sent to us after the inspection, despite being requested.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as the provider did not have suitable arrangments to assess and improve the quality of the service provided.

Records viewed were not accurate. For example medication records had medicines signed for two people that had not been given. External preparations such as creams were signed for as given by a member of staff whilst it was actually a different member of staff that had used the cream. Staff recorded that people had refused a medication when in fact they had been asleep. As a result of the inaccurate records it was not always possible for the service to know that the correct medication had been given.

Records of fluids and food were not always kept up to date. This was particularly relevant for people who were at risk of poor nutrition and appropriate monitoring of their diet was not in place.

Accident and incident records were not always accurately completed, dates or places that the accident or incident had occurred were not completed. Staff did not always accurately record the incident and in some instances accident or incident records had not been completed at all. This prevented the service from monitoring incidents and making sure that appropriate action could be taken to reduce risks.

Daily records and professional visits records did not always record the care that staff delivered. There were no monitoring records such as incidents of challenging behaviour as staff did not fully understand what an incident of challenging behaviour was, and how to monitor in order to make sure that appropriate action could be taken. The same lack of monitoring was in place for people prescribed pain relief and as a result not everyone had received their pain relief as they should.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as the provider did not ensure that records of care were accurate and up to date.

It was unclear as to who should be the registered provider. This is because there is some confusion from the provider as to the role of the registered provider. The service is registered as a partnership that was dissolved several years ago. The provider was informed that they needed to review their registration arrangements and apply to change the registered provider from a partnership. Staff spoken with were also unsure as to who they answered to other than the manager. People who lived in the service told us they had not met the owner and did not know who the home owner was.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services People who use services involvement in the provision of their care and respect was not supported as the provider did not make appropriate arrangements for peoples involvement . Regulation 15 1 (a) (b) (2) (a) (b) (c) (i) (ii) (d) (ii) (e) (f); (g) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs The provider did not protect people from the risks of inadequate nutrition and hydration. Regulation 14.(1) (a) (b) (c) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers The provider did not have an effective system in place that made sure that all staff were appropriately checked before they started working in the service. Regulation 21 (1) (a) (i) (ii) (iii) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	The provider did not have an effective system determine that sufficient staff were available at all times to meet the needs of people living in the home. Regulation 22
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff People living in the service were not protected from the risks of inappropriate care by staff suitably skilled and supported to meet their needs. Regulation 23 (1) (a) (b)
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints The provider did not have an effective in place to address and respond to complaints Regulation 19 (1) (2) (a) (b) (c) (d) (3) (a)(b)
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records The provider did not protect people from the risks of unsafe or inappropriate care by maintaining accurate and up to date records related to the person care and treatment. 20 (1) (a) (b) (i) (ii) (2) (a) (b)
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment

This section is primarily information for the provider

Action we have told the provider to take

Suitable arrangements were not in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them.

18

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The provider has failed to take proper steps in order to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe.** **Service user's needs have not been fully or accurately assessed; care has not been appropriately planned or delivered.** **The provider has failed to meet the service user's individual needs and ensure their welfare and safety.** **The provider has failed to reflect, where appropriate, published research evidence and guidance issued by the appropriate professional and expert bodies as to good practice in relation to such care and treatment.** **Reasonable adjustments in service provision to meet the service user's individual needs have not been made.** **9 (1),(a) (b),(i),(ii),(iii),(iv)**

The enforcement action we took:
Warning Notice to be meet by 15 February 2015

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The provider has failed to protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective systems. A there was no system sin place to regularly assess and monitor the quality of the services provided or identify, assess and manage risks relating to the health, welfare and safety of service.

This section is primarily information for the provider

Enforcement actions

The provider has failed to have regard to the complaints and comments made, and views (including the descriptions of their experiences of care and treatment) expressed, by service users, and those acting on their behalf.

The provider has failed to make sure that where necessary changes are made to the treatment or care provided in order to reflect information that you were aware of.

The provider has failed to undertake an analysis of incidents that resulted in, or had the potential to result in, harm to a service user.

The provide has to regularly seek the views (including the descriptions of their experiences of care and treatment) of service users, persons acting on their behalf and persons who are employed in relation to the standard of care and treatment provided to service users.

10 (1),(a),(b),(2),(a),(b),(i),(ii), (iii), (iv),(c),(i),(d),(i),(ii),(e)

The enforcement action we took:
Warning notice to be meet by 15 February 2015

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse

The provider has failed to make suitable arrangements to ensure that service users are safeguarded against the risk of abuse. Reasonable steps to identify the possibility of abuse and prevent it before it occurs have not been taken.

The provider has failed to respond appropriately to any potential allegation of abuse by not maintaining appropriate records of investigations or referring potential safeguarding allegations to the correct authority.

11 (1),(a), (b

The enforcement action we took:
Warning notice to be meet by 15 February 2015

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The provider has failed to protect service users against the risks associated with the unsafe use and management of medicines. In so far as you did not have appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing and safe administration of medicines. This placed people at risk of receiving medication that was not suitable to meet their needs and placed them at risk of harm. 13

The enforcement action we took:
Warning notice to be meet by 15 February 2015