Sycamore Care Limited

Dawood House

Inspection report

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Date of inspection visit:
24 October 2016
25 October 2016
26 October 2016
09 November 2016

Date of publication:
22 December 2016

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This was an unannounced inspection carried out on 24, 25, 26 October and 9 November 2016. We last inspected the service in January 2015 where they were rated overall as good.

Dawood House is situated in the village of Bentley which is approximately three miles from the town of Doncaster. The home provides personal care for 40 older people, some of who may be living with dementia type conditions. Bedroom facilities are provided on the ground and first floor level of the building. Access to the first floor is by a lift. There were communal areas including two lounges, a conservatory and separate dining areas. The home stands in its own grounds and there is a car park at the front of the building. At the time of this inspection there were 31 people living at the home. The service has been in administration since May 2016 and is being run by Carport a company appointed by the administrators

The service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service has been without a registered manager since October 2015. Several managers had been in post since that date but none had been registered with the Commission.

Prior to this inspection we received information of concern from other health professionals that visit the service. They told us the service was not safe. High volumes of safeguarding referrals had been received and were being investigated. Occupational therapists, district nurses and quality monitoring officers from Doncaster council were involved in the service. This was because they had received anonymous calls from people who had witnessed inappropriate moving and handling of people who used the service.

Care records were not always fit for purpose. Some lacked detail, were out of date or contradictory. When care records were reviewed, the reviews did not always result in relevant changes being made to people's care plans or risk assessments. We identified instances where care was not being provided in accordance with people's assessed needs.

Health professionals told us that communication within the home was poor. They told us their instructions were not always followed which meant people's care needs were not always met.

We found staff approached people in a kindly manner. However, most of the interactions we observed were task orientated. The service was using a number of agency staff to cover shifts which meant they did not know the people who used the service. We observed people had to wait for assistance and staff were not always present in communal areas to ensure people's safety. Relatives we spoke with told us that they were concerned for people's safety as they had observed falls because no staff were available in communal areas.

The provider told us systems were in place to guide staff on safe administration of medicines. However, we identified these were not followed and people did not always receive their medication as prescribed. Protocols for the administration of 'as required' medications were not in place which meant people were not given pain relief at the times they required them. Medicines no longer required had not been disposed as they should have been.

People were not always supported to eat and drink sufficient amounts to maintain a balanced diet and adequate hydration. We found the meal time experience did not meet the standards expected by the provider.

Infection prevention and control policies were not always adhered to; therefore safe procedures were not always followed.

The requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) were in place to protect people who may not have the capacity to make decisions for themselves. However we were told by the acting manager that they were unable to confirm who had authorised DoLS in place. This meant we could look at any conditions that may have been put in place for people who used the service. The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including balancing autonomy and protection in relation to consent or refusal of care or treatment.

The systems and processes in place to monitor the quality and safety of the services provided were not effective. There was a complaints procedure; however relatives told us that they were not satisfied with the standards of care. One relative told us they were not satisfied with care provided and had raised concerns about the lack of communication which meant they had no confidence in the provider.

We asked the provider to tell us what immediate action they were going to take to reduce the risks to people. We went back to the service on the 9 November 2016 to check if improvements had been made and that people were safe and receiving appropriate care and treatment. The provider had developed an action plan to identify and implement the improvements required. We looked at records introduced by the provider to check on progress against the action plan.
We are considering what further action we are going to take. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still 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 this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to 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 so there is

still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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 unsafe.

Individual risks to people were not assessed or mitigated.

Staffing levels did not enable people's needs to be met in a timely way or in keeping with their preferences. Most staff were recruited safely but induction, training and supervision required improvement

Medicines were not managed safely.

Infection prevention and control measures were not effective

High number of referrals to safeguarding meant the service was not protecting people from harm.

Is the service effective?

Inadequate

The service was not effective.

Staff lacked understanding on how to meet people's needs when they demonstrated behaviours that may challenge others.

Appropriate referrals had been made using the mental capacity and deprivation of liberty safeguards; however some MCA assessments lacked detail. Care staff had not received training in this subject.

People's nutritional and health needs were not consistently met. Records were poor in relation to what people had eaten and drank.

Is the service caring?

Inadequate

The service was not caring.

Care plans were not always up to date. It was difficult to determine if people's wishes were listened to or respected. There was minimal information available about people's wishes for the end of their life.

Staff were task orientated. However, interactions we observed were kindly.

Is the service responsive?

Inadequate

The service was not responsive.

People's health, care and support needs were not regularly assessed or reviewed. We found some staff were knowledgeable about people's needs; however, most interactions were task led rather than person centred.

People were able to access activities both inside the home and in the community.

There was a complaints system in place; however, relatives told us that they did not feel as though they were listened to.

Is the service well-led?

Inadequate

The service was not well led.

There was no registered manager

There was a distinct lack of communication, leadership and direction within the service which had not been identified by the provider.

The culture of the service was not positive, open and inclusive.

Health professionals told us communication was poor as some information had not been passed on that affected people's care and treatment.

Audits and checks of practice were not effective in identifying and improving services delivered. Systems and processes were not effective to address where improvements were required to be made and ensure regulations were met.

Dawood House

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 24, 25, 26 October and 9 November 2016 and was unannounced on the first day.

The inspection team consisted of two adult social care inspectors and we were joined on three days by a quality assurance officer from Doncaster council. On the first day of this inspection we were also joined by a senior clinical nurse specialist; infection prevention and control nursing and quality, from Rotherham, Doncaster and South Humber NHS Foundation Trust.

Prior to the inspection visit we gathered information from a number of sources. We looked at the information received about the service from notifications sent to the Care Quality Commission by the service. We also contacted Doncaster safeguarding to gather further information about the service. We spoke with the local council commissioners who had recently completed their monitoring of the service. We also contacted the fire safety officer who informed us that the service would be visited in the near future.

During the inspection we spoke with two visiting district nurses and an occupational therapist for their views on the service. We also spoke with the community psychiatric nurse who supported people with their mental health needs.

Prior to our visit we had received a provider information return (PIR) from the provider which helped us to prepare for the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with the registered provider and acting and deputy managers, the activity co-ordinator, a senior care worker, three care staff, two domestic staff and the cook. We also spoke with three people who used the service and ten visiting relatives. This helped us evaluate the quality of interactions that took place

between people living in the home and the staff who supported them.

We used the Short Observation Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We looked at other areas of the home including the outside garden space, some people's bedrooms, communal bathrooms and lounge areas.

We looked at documentation relating to people who used the service, staff and the management of the service. We looked at nine people's written records, including the plans of their care. We also looked at the systems used to manage people's medication, including the storage and records kept. We also looked at the quality assurance systems to check if they were robust and identified areas for improvement.

Inadequate

Is the service safe?

Our findings

We spoke with people who used the service to assess if they felt safe in the home. Because most people were living with dementia some of their responses we have not been able to include. One person we spoke with said, "Some of the staff are very good but others are quite rough when they are caring for me." All of the relatives we spoke with expressed concerns that the care was not safe for their family members. They said the service lacked direction and there always seemed to be a lot of agency staff working who did not know the people who used the service. One relative we spoke with said, "I used to think that the care was very good, but now I would only rate it as four out of ten." Another relative said, "The communication is very poor. Sometimes we can ask three staff members how my [family member] is doing before one of them actually knows who I am talking about."

We spoke at length with two district nurses who also expressed extreme concern about the safety of people who used the service. One nurse said, "I have been coming here for a good period of time but now the communication is poor. I can give feedback to the senior for something to be done and when I return the messages have not been passed on."

Other visiting health care professionals we spoke with told us when they visited they always struggled to find staff and felt there was not enough staff on duty. One professional said, "I always like to hand over to ensure staff are aware of what is required so there is consistency with care. However, I am not very often able to find staff, sometimes I arrive go to my client and then have to go hunting for staff to pass on information."

Throughout the four days of the inspection we carried out observations of people receiving care to assess whether there were staff in sufficient numbers to meet people's needs. We observed that at times people had to wait for assistance from staff, and there were periods where people did not receive support when they required it. For example, we observed one person asking staff to use the bathroom. This continued for 30 minutes before two staff brought a wheelchair to transfer the person to enable them to take the person to use the bathroom. We saw staff were unable to move the person who was unable to stand. Staff returned 15 minutes later with a rotunda (equipment used to aid standing and transferring). It took several attempts to move the person who clearly was unable to fully understand how to use the equipment.

When we returned to the service on the third day of the inspection we saw staff moving the person using a mechanical stand aid. We asked staff if the person had been assessed to use the equipment and the staff member said they had been told the person could use the equipment. We checked this with the acting manager who confirmed the person had not been assessed by the occupational therapist to use the equipment. The care plan did not have a risk assessment for the use of this equipment. This put the person at risk of harm as they had not been assessed to ensure effective measures were in place to move them safely.

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

We looked at nine care plans and found that risk assessments did not provide staff with sufficient information to deliver the care safely. For example, we saw one person was assessed as a falls risk however the risk assessment had not been updated since July 2016. The same person had a risk assessment for the potential of developing pressure sores. This had not been updated since July 2016. The care plan was dated January 2016. This did not identify that the person had any care needs with regard to the management of their skin integrity. The district nurse told us that they had asked for a two hourly change of position for the person to relieve pressure. During the three days of this inspection our observations confirmed staff were not following this instruction. The district nurse told us on the second day of this inspection that the person had developed a grade two pressure sore as a result of not receiving the care they required.

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

We looked at the accident/incident log dated 7 August 2016 through to 18 September 2016. We noted that 26 falls had occurred during this period. The majority were unwitnessed. This was a high number of accidents during a six week period and suggests there were insufficient staff to ensure people were kept safe. Two relatives we spoke with told us that their family members had sustained injuries following falls at the home. One relative said, "We were informed that our [family member] had a fall which resulted being taken to hospital." They said since the fall their family member was unable to walk. This had given them cause for concern as they had been asking staff for the physiotherapist to visit to try to increase their mobility. They were still waiting and staff appeared to be unsure if a request had been made. They said, "When we ask we seem to get a different response from each staff member we ask. So we don't know if they have made a referral."

Another relative we spoke with told us that they had witnessed two people falling while they were visiting their family member. They told us at the time of the falls no staff were present in the lounge area.

We discussed staffing levels with the acting manager. They told us that due to staffing issues, for example, high staff sickness, staff leaving and holidays, they were having to depend on agency staff. On the first day of the inspection we were told that three of the six staff on duty were agency staff. This included a senior care worker who was responsible for the administration of medication. We observed that one agency worker spent their time sitting or standing in the lounge. They did not engage with people who used the service. We asked them if they had been at the service previously and they said they had worked "A couple of shifts," but did not know people's names. They told us they had not read any of the care plans and could not describe people's care needs. On the second and third day of the inspection two agency staff were used and it was their first time at the service. The use of agency staff had impacted on the care being delivered to people who used the service. As only permanent staff actually knew people's needs. It was unclear if the agency staff had the skills and competencies to deliver care safely. The administrator told us that they received telephone confirmation about the training agency staff had undertaken. No written confirmation was obtained prior to the staff working at the service.

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

We contacted Doncaster safeguarding authority team prior to this inspection and were informed that they were extremely concerned about the high numbers of safeguarding that were logged against the service. During this inspection we observed poor practice in relation to moving and handling of people who used the service. We discussed our concerns with the acting manager and informed him that we would be making further referrals following the inspection. For example we clearly heard the district nurse informing both the

senior on duty and the deputy manager instructions about a person who required their legs elevating to help with a condition of their legs. The district nurse also asked one of the permanent carers to find a foot stool for the person. Throughout the first day our observations confirmed that the district nurses instructions had not been followed.

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

We noted that several referrals to the safeguarding authority had been made following medication errors. The acting manager told us that since the referrals staff involved were being retrained in the safe management of medication. They told us that at least three observations would take place before the staff would be allowed to administer medication. This process had begun prior to the inspection. The acting manager also told us that the supplying chemist had carried out an audit of the medication at the service. They had reported that procedures were not being followed and several actions were needed to ensure medication was being administered safely.

We looked at the systems in place for managing medicines in the home. This included the storage, handling and stock of medicines and medication administration records (MARs). We found several errors in the management of controlled drugs (these are drugs that the Misuse of Drugs Act 1971 states should be stored with additional security). For example two people who were prescribed buprenorphine patches to assist with pain relief were not changed on the day that they should have been. This could result in the people experiencing unnecessary pain. We also found end of life medication had not been destroyed in a timely way after the person had passed away. One person who had been discharged from the home in May 2016 we found their medicines were still on the premises and had not been disposed of. This demonstrates that procedures were not being followed and the audits carried out by the home were not effective in identifying where improvements were required.

We saw medication for two people to help with their low moods and aggressive behaviours were not being administered as prescribed. This was discussed with the deputy manager who told us that they were not aware that the two people were not taking their medication. Entries on the medication administration records (MAR) confirmed that they had been refusing to take the medication. We observed both of the people throughout the first three days of the inspection. They both had periods where they were agitated and one person often refused personal care and had nights when they had refused to go to bed.

We found people were prescribed medication to be taken as and when required, known as PRN (as required) medicine. We saw people did not always have PRN protocols, or if they were in place they were very generic and did not give sufficient detail to determine when to give PRN medication or explain how people presented when they were in pain or agitated.

Staff told us people who were prescribed these medications were not always able to tell staff when they were in pain or distressed due to their capacity limitations. This meant that people who used the service could be in pain or distressed and not have medication administered as staff did not know what signs they may present with to determine when it was required.

We observed one person showing signs of discomfort by rubbing their leg. There care notes confirmed the person had sustained a fracture following a fall. When we asked the person on a number of occasions they told us that they were in pain and continued to rub their leg. On the second day of the inspection we asked the senior care worker if they had been given any pain relief. When the senior care worker checked the MAR the person was prescribed pain relief medication. This was out of stock. On the third day of the inspection

the person had not received any pain relief as the senior care worker (agency staff) had ordered medication for the wrong person. No attempt had been made to purchase pain relief as a homely remedy until a new prescription could be obtained.

When we returned to the service on 9 November 2016 to check on the progress of improvements the service told us they were making we found although some improvements had been made, medication errors were still taking place. For example a number of people were without medication to help with their low moods and agitation. The provider told us that they had ordered the medication but it had not arrived into the service. We saw one person's medication had been delivered on the day of this visit. The provider told us that they were planning to return all medication at the service to the pharmacy so that everyone living at the service on 14 November 2016 would have a new prescription to commence on that date. They told us this would enable them to audit from the start date. This was because prior new stocks of medication had not been booked in correctly making it difficult to establish if people had received their medication as prescribed.

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

On the first day of the inspection we were joined by the senior clinical nurse specialist; infection prevention and control nursing and quality, from Rotherham, Doncaster and South Humber NHS Foundation Trust. We looked around the home and found some areas required deep cleaning to eliminate the malodours in several bedrooms and corridors. The medication store needed refurbishment to make sure medications were stored safely. Staff were seen to be wearing jewellery such as stoned rings bracelets and watches and had painted fingernails which was not following good hand hygiene practices. Staff required further training in infection prevention and control and the service did not have an identified member of staff who led on infection prevention.

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

Inadequate

Is the service effective?

Our findings

Relatives we spoke with told us that the care provided was not as good as they would have expected. One relative told us that communication from the staff to the relative was poor. The relative went on to say that they thought standards had fallen over the last few months. Another relative said they thought the regular staff were mostly good at their job but they said a number of good staff had left and they felt too many agency staff were being used and this was not good for people who used the service. This concern was also expressed by other relatives we spoke with.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We were told that the service had authorised DoLS for three people who used the service but the acting manager and the deputy manager were unable to provide us with the records to support this. We were told that most of the remaining people were awaiting outcome from their applications.

We checked whether the service was working within the principles of the MCA. From the care plans we looked at we found the mental capacity assessments were not sufficiently detailed and were generic. There were no best interest decisions documents on any of the files we looked at. This had also been raised by Doncaster quality monitoring officers when they carried out their monitoring of the service.

When we looked at the medications records for two people who were prescribed medication to help with their low moods and mental health problems we found they regularly refused their medication. We observed both of these people over the first three days of this inspection and saw they presented with disruptive and challenging behaviour. We asked the deputy manager if they had sought advice from the GP and community psychiatric nurse to see if it would be in their best interest to administer their medication covertly (hidden in food or drink). This would ensure they received their medication as prescribed which may help with their behaviours that was impacting on other people who used the service. The deputy manager told us that they were not aware that the two people were regularly refusing their medication and had not considered consulting with health professionals to determine what would be in the person's best interest regarding medication.

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

We were told by the training manager that most of the staff had not received training in managing

challenging behaviour. Our observations of staff interaction and staff we spoke with confirmed this. We spoke to staff about training. They told us that most of the training was undertaken using e-learning. From our observations it was clear that staff required updates in infection prevention and control, fire evacuation and dementia care including managing behaviours that may challenge others. We were told that some people required refresher training in safeguarding and although moving and handling training was still required for some staff we observed that staff were not following instructions. For example we saw staff using a piece of equipment on a person that they had not been assessed to use.

We identified that no staff had received regular supervision in line with the provider's policies. The acting manager told us staff should receive supervision every two months. They confirmed that due to the lack of a permanent manager this had led to staff not being adequately supported and supervised. From speaking to several staff it was clear that staff did not feel supported. They told us they could not remember the last time they had received supervision. We found examples where staff were not following policies and procedures which had not been identified or addressed and examples where staff had not received the training to effectively meet the needs of people who use services.

The training manager told us that they did not currently enrol new staff onto the 'Care certificate' The 'Care Certificate' looks to improve the consistency and portability of the fundamental skills, knowledge, values and behaviours of staff, and to help raise the status and profile of staff working in care settings. They told us that she delivered the induction to staff which included all of the mandatory subjects.

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

People were not always supported to eat and drink sufficient amounts to maintain a balanced diet or adequate hydration. Throughout the three days of this inspection we spent time observing mealtimes and we carried out a SOFI during lunch on the first day. We saw people were seated for long periods before being served their meals. Some people ate their meal which was served to them on a small table where they were sat in the lounge. This meant people had moved very little during the time we were present. During breakfast people were brought to the dining areas and left unattended until the kitchen assistant brought their meal. Some people who were left unattended were unable to or made no attempt to eat their meal and staff were not available to encourage or support them to do this. The kitchen assistant returned later and cleared the tables without alerting staff or recording that people had not eaten their meal.

Staff had the responsibility to monitor food and fluid records but this was not possible as they were not present during the meal. This meant the records were not accurate. For example we saw a person given their meal and we noted the meal was later taken away uneaten. We checked the records for this person and it stated that the person had eaten all of their meal and had drunk their entire cup of tea. We also saw one person who was stood over a group of three people eating their dinner. The person was helping themselves to the seated people's dinner. No staff were present to prevent this interaction. The inspector alerted staff to this incident. We saw another person being cared for in bed on the first day of the inspection. Staff told us that they helped to feed the person which we observed. However there were no records in the person's bedroom to records their fluid and food intake. A further person had a care plan to monitor their food and fluid intake. It stated staff were to offer assistance to eat their meal. We observed this person struggling to eat but was not offered help. We saw from the weight chart that the person had lost 1Kg between August and October 2016. Although this did not seem a lot of weight it was significant due to their body mass index score which was only 17.1 This indicates that the person was significantly underweight. Being underweight can damage health and can contribute to a weakened immune system, fragile bones and a lack of energy.

We looked at food and fluid charts for people. They were stored with the daily notes in a file separate to the main file. We noted that one person was being cared for in bed however the food and fluid charts were not with them in their bedroom. This meant staff could not record accurately at the time that drinks and food was offered. The staff told us that they wrote the records at the end of the shift. This meant they relied on their memory of the person's diet and may not be accurate. We looked at a selection of food and food records and noted that they only recorded food and fluid up to supper time. There was no record of the food and fluid consumed during the night time hours.

The current best practice guidance for hospitals and healthcare services from the national patient safety agency states that, although there is no agreed recommended daily intake level for water in the UK, a conservative estimate for older adults is that daily intake of fluids should not be less than 1.6 litres per day. We were unable to confirm if people met their daily target and staff we spoke with told us that senior care workers did not currently check the records to ensure people were receiving enough fluids.

We observed lunch on the third day of this inspection. The service of the meal was task orientated and not person centred. There was no menu available as the meal displayed on the notice board outside the dining area was from two days previous. Even though we spoke at length about the dining experience on the first day of the inspection we did not feel this had improved people's experience two days later.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not always have access to external health care professionals as the need arose. For example, we heard one person ask several staff over the three days to see a doctor as they had a sore eye. Staff responded by telling the person that they would ask the senior care worker to get the doctor. This did not happen. The person told us that their eye was painful and we passed this onto the senior care worker. At the end of the inspection we asked again about the doctor for the person and was told that they would request a visit the next day. We saw several health professionals were visiting people who used the service during our inspection. A district nurse told us that often messages had not been passed from shift to shift and generally communication was extremely poor. On the first day of the inspection the nurse told us that she had been asked to see another patient making five patients in total for the day. The nurse told us that the senior expected her to pick up additional patients without following the correct referral processes. She told us that happened frequently.

The nurse also told us about how a person's hand splint had gone missing. This was an essential piece of equipment to prevent the person getting a pressure sore in the palm of their hand. The nurse told us it had been missing for over a week and although she asked each day if it had been located staff said it must be in the laundry but days later it and was considered lost. Staff had not acted swiftly to replace the equipment. Although we had informed the managers of the service on the first day of our inspection we found they had still not obtained this until we asked again on 9 November 2016 some two weeks later. This may have caused discomfort and pain for the person who used the service which could have been prevented.

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

Inadequate

Is the service caring?

Our findings

We spoke with people who used the service and their relatives about the care they received. People that were able to talk to us in a meaningful way told us that regular staff were nice but they said there were a lot of staff who they did not know. Several relatives said they felt the care had deteriorated over recent months. One relative said, "You can never find staff to ask how their [family member] was keeping." Another relative said, "This used to be a lovely home but things are not very good now. I am considering if it's the right place for my [relative]." Other comments received included, "Staff that have been here a long time know my [family members] but some of the new staff don't care as much," and "There just isn't enough of them [staff] and people living here need the extra support because they are living with dementia."

Some permanent staff we spoke with had a good knowledge of people's individual needs, their preferences and their personalities and they used this knowledge to try to engage people in meaningful ways when they could. However the extensive use of agency staff meant these staff did not have this depth of knowledge so were less likely to strike up a conversation with people who used the service. For example, on the first day of the inspection we observed an agency member of staff standing in various areas of the lounges. They spent much of their time not engaging with people, only speaking to people when they were giving out drinks. We saw them placing cups of tea in front of people without even telling them that they had brought them a drink.

We saw care staff had very limited time to spend engaging with people in a social way because they were busy carrying out physical care. One relative commented, "People are left for long periods without staff being present and I have seen people fall because of that." Some people's rooms were personalised with their own belongings, such as photographs. Other bedrooms were very untidy and not very personalised. A relative told us that they had brought in their family member's own bed to help them settle. However they told us they were very disappointed that staff had not put a mattress protector on the bed even though this was provided by the relative. This had resulted in the bed becoming soiled and required deep cleaning. This had caused their family member a great deal of distress.

During our visit we spent time in communal areas observing people who used the service and talking to relatives and staff. We saw some positive interactions between people and staff. However, a lot of the time staff were not in communal areas and people were left unsupported by staff. We observed one person very distressed as they had wanted to go to the bathroom. We saw the person edging forward in their chair but were unable to stand. Several staff passed the person without acknowledging their request and ignored them. Another person who was visually impaired was seeking reassurance from staff about where they were sitting. Staff responded curtly by reminding the person they were in the lounge. The person asked further questions but by this time staff had left the area. The activity coordinator eventually sat at the side of the person and gave reassurance.

We observed one person living with dementia who constantly wanted to link arms with staff while moving around from lounge to lounge but staff told the person to "go and sit down in the lounge." We sat and observed one person who was quite vocal. This resulted in other people who used the service telling the

person to be quiet. Staff had told us earlier that the person could be quiet disruptive and was often left in their bedroom so that they did not upset other people. This demonstrated that some staff lacked respect for people, compassion and an understanding of how to communicate with people who had complex needs.

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

Inadequate

Is the service responsive?

Our findings

People and relatives we spoke with told us that activities in the home were good. During this inspection over the four days we saw the activity coordinator interacting with people, doing quizzes, painting ladies' nails and doing arts and crafts. This was positive and people who used the service seemed to enjoy the interactions. However interactions with care staff and people who used the service were limited to care tasks which were not person centred. Person-centred is a term used to describe a way of supporting people which puts the person and their individual needs at the centre of all that is done, and considers the care provided from the person's own experience.

We checked care records belonging to nine people who were using the service at the time of the inspection. We found that care plans did not always have sufficient detail or set out how staff should support each person so that their individual needs were met. For example, most had not been reviewed since July 2016. One care plan had not been updated since the persons mobility had changed dramatically. Another person had been diagnosed as having a urinary tract infections (UTI) there was no short term care plan to tell staff how to manage the person's needs during this period of illness.

Another person often displayed behaviours that were challenging to others. There was no care plan to guide staff on how to deal with their behaviours. The person was seen periodically by the community psychiatric nurse (CPN). They had asked staff to record the person's behaviours on a chart so that they could look at the triggers for the behaviours when they next visited. This had not been passed onto staff so were not being completed. This meant staff was not following the instruction of the CPN in monitoring and managing any negative behaviours.

The home was using a high number of agency staff who did not know people using the service therefore it was particularly important that assessments and care plans were up to date and clear so unfamiliar staff would know what support each person required.

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

Permanent staff we spoke with had a good awareness of the support needs and preferences of people who used the service. However only some care records included a personal history and personal details for example, food preferences. We asked three of the agency staff if they had the opportunity to look at a person's care plan before delivering the care. They told us they did not and were led by what permanent staff had told them to do for each person.

A health care professional we spoke with told us they found staff did not always follow advice they gave to ensure people's needs were met. For example one professional told us they had explained to staff on a number of occasions the importance of completing monitoring charts so when they visited they could review these to determine any change in needs. They told us these were still not being completed.

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

There was information about how to make complaints available in the communal area of the home, and relatives we spoke with told us they lacked confidence in the provider and described care as poor. One relative told us about a complaint that they had raised. They said they felt that it had not been resolved to their satisfaction. This had left them feeling that their views had not been listened to or acted upon. Relatives told us they could not recall being involved in planning their family members care or being invited to any reviews. This meant the choices of people who used the service were not always respected.

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

Inadequate

Is the service well-led?

Our findings

We found the service was not well led. There had not been a manager who was registered with the Care Quality Commission for over 12 months. Several managers had been in post for a short period but they had not submitted an application to become the registered manager. The area manager informed us that they would be acting in the capacity of the manager until a new manager could be employed. The deputy manager had only very recently been appointed. A number of permanent staff had left and this meant agency staff were being used to ensure safe numbers of staff were on duty. We found communication was poor and that staff lacked leadership and direction.

The staff told us morale was low as they were uncertain about the future of the service. They told us that they did not feel supported but were trying to maintain the expected standards of care. Staff meetings were infrequent up until recently so staff were not able to discuss concerns. The acting manager told us that supervisions and appraisals of staff were not taking place so staff could not identify, discuss and address any training or performance issues they may have had.

Staff lacked skills and competencies to manage people living with dementia and were unable to manage people who displayed behaviours that were challenging to others. Areas of training such as infection control, moving and handling, fire safety and mental capacity were needed to help keep people safe. This had not been recognised through an effective monitoring system.

Mealtime experiences for people who used the service was poor. People were being left unsupervised and they were not given appropriate support to eat and drink. We raised this on the first day of the inspection and we found things had not improved by the end of the third day of the inspection. Again this had not been recognised through an effective monitoring system and when we fed this back on the first day of our inspection the provider failed to take timely action to address the concerns we raised and make improvements.

People who used the service and relatives could not recall being consulted about the quality of the service, although the registered provider had held a meeting to discuss concerns. Relatives we spoke with told us that they thought the care had deteriorated over recent months. Throughout the inspection the atmosphere within the home was tense. Staff were extremely busy trying to meet people's needs.

Health professionals and Doncaster quality monitoring officers all told us that they felt communication was poor and "Things were not being passed on" which made them anxious about the care being provided. For example, the district nurse described situations where they gave instructions about elevating a person's legs. This had not been followed. They also raised concerns about a piece of equipment had been missing for over a week, but a replacement had not been obtained.

There were high levels of referrals made to safeguarding for investigation. Some involved medication errors. The service had asked and received an audit from the supplying chemist on 3 October 2016. However when we commenced this inspection we found major concerns remained at the service regarding medication

administration. This showed the service had failed to recognise the risk to people and take immediate action to ensure people received their medicine as prescribed.
We saw daily records for all of the people who used the service were kept in padded boxes in the lounge area. These boxes did not have the facility to be locked. This meant that anyone in the home could read confidential information about people. We raised this issue with the deputy manager early on the first day of the inspection. We noted they were still in the same place at the end of the inspection on the third day.

We found there was very little evidence of any effective system to monitor the quality of the service. Where audits had taken place they were not effective in improving the quality and safety of the service and identifying the shortfalls as described in the breaches illustrated throughout this report. Risk assessments were not effective and there were high numbers of accidents and incidents. Most were described as unwitnessed. The provider had failed to analyse these to identify any themes or patterns such as large numbers of falls where most are unwitnessed by staff. This, for example could indicate insufficient staff or ineffective deployment of staff however this had not been considered by the service and the provider had failed to monitor the risk to people who use the service.

We returned to the service on 9 November 2016 to check if people were safe and receiving appropriate care and treatment. We also checked what immediate improvements the service was making to ensure people were safe. We found the service had introduced handover records which gave a brief overview of the care needs for each person who used the service. The handover sheet also gave designated tasks to each member of staff on duty. We found one of these records was left on a table in the dining area where people were having breakfast. This meant confidential information about people who used the service was not kept safe. We had also asked that daily records for people were securely stored to protect their information. These were still in boxes in the lounge area. We again brought this to the attention of the provider.

We asked to see records that had been implemented to monitor a person's behaviours. We were shown one completed record that had been introduced since our visit on 26 October 2016. The rest of the records had not been completed. Some reference to the person's behaviours had been recorded in the daily records which would be more difficult to extract when feeding back to the community psychiatric nurse.

We had raised serious concerns about how people were supported to eat and drink so that people received sufficient to meet their assessed needs. The provider had partly addressed this by adding an extra member of staff on duty, who had responsibility for supporting people in the dining areas during breakfast. However, we saw one person eating a bowl of sugar in the main dining area and this person was a tablet controlled diabetic. We discussed this with the provider and they told us that they would need to consider how to observe the three areas where people ate at breakfast time as clearly the current allocation of staff to the dining area was not working. However the service has failed to recognise this area they felt improvements had been made was not effective.

Communication in the home continues to be a major problem. For example the provider told us that a piece of equipment for one person had been ordered. When further investigation had taken place it was discovered that it had not been ordered as the administrator was waiting for finances to be authorised to purchase the item. This meant the person had been without the required equipment for over three weeks. This meant the provider had neglected to follow up on the purchase of the item which could have led to the person who used the service being in more discomfort that could have been avoided.

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

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 RA Regulations 2014 Person-centred care There was a lack of response in updating people's individualised needs and risks in their care plans and records that would help staff to monitor people's health and wellbeing.

The enforcement action we took:

The service is in special measures and will be kept under review in line with timescales set out in the relevant guidance.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure that care and treatment of people who used the service was only provided with the consent of the relevant person.

The enforcement action we took:

The service is in special measures and will be kept under review in line with timescales set out in the relevant guidance.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use services and others were not protected against the risks associated with inadequate infection, prevention and control measures. Medication procedures were not followed. staff did not have the skills and competencies to meet peoples needs.

The enforcement action we took:

The service is in special measures and will be kept under review in line with timescales set out in the relevant guidance.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to act appropriately where incidents of abuse or suspected abuse were identified. Regulation 13(1)(2)

The enforcement action we took:

The service is in special measures and will be kept under review in line with timescales set out in the relevant guidance.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider did not have suitable arrangement to ensure people who used the service had sufficient to eat and drink to meet their needs Regulation 14 (1)(2)(b)

The enforcement action we took:

The service is in special measures and will be kept under review in line with timescales set out in the relevant guidance.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People who use services were not protected against the risks of inappropriate care by means of the effective operation of systems designed to regularly assess and monitor the quality of the service.

The enforcement action we took:

The service is in special measures and will be kept under review in line with timescales set out in the relevant guidance.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed in order to meet the needs of people who used the service.

The enforcement action we took:

The service is in special measures and will be kept under review in line with timescales set out in the relevant guidance.