Care Quality Commission

Embrace Uk Limited

Lake View Nursing Home

Inspection report

Chorley Road
Withnell
Chorley
Lancashire
PR6 8BG
R6 8BG
Tel: 01254 831005
Website: www.europeancare.co.uk

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Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Inadequate**

Overall summary

We carried out an unannounced focused inspection on 9 and 14 January 2015. We did this in response to concerns received by the Commission in relation to care, moving and handling, records and nutrition. We carried out a focused inspection to look at whether the service was safe, effective, caring and responsive.

The service did not have a registered manager in post. The previous registered manager left their post in March 2014. The provider had recruited a new manager who told us they were commencing the process of registering with the Commission. 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 and associated Regulations about how the service is run.

Lake View Nursing Home is registered to provide care for up to 51 people. At the time of our inspection there were 31 people living in the home. The home was providing nursing and personal care for people, including those living with a dementia.

Summary of findings

Prior to this inspection we had previously visited the home on 12 and 13 March 2014 and identified several breaches of regulations. We asked the provider to send us an action plan to tell us how and when they would ensure they met their regulatory requirements. We issued the provider with a warning notice for regulations 10 and 15 and told the provider by what date they needed to meet their regulatory requirements.

We also revisited the home on 6th June 2014 to check whether the provider had met the requirements of the warning notice. However we identified ongoing concerns with regulations 10 and 15 and identified further concerns in relation to regulation 18.

We also revisited home the home on 2 October 2014 to check the provider had met the regulatory requirements. However we identified ongoing concerns and breaches in relation to the regulations.

During this inspection we again found multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

During our inspection staff told us the staffing numbers to cover night duty had changed the week of our inspection. The provider had sent us documentation prior to our inspection detailing the staffing numbers in place however we noted this had changed.

We looked at staff files for currently employed staff members and noted discrepancies that related to their application form and employees references.

We identified some concerns during our inspection that related to five staff members and discussed these with the management. The provider took immediate action in response to our concerns.

We asked staff about people's choice in relation to waking time in the home. Staff told us people had a choice of when they wished to get up. However we noted one person whose care file noted the time they liked to get up was still in bed over one and half hours later than this. During a tour of one of the units in the home. We noted 11 people were still in their bedrooms at 11:55am.

There was evidence of Deprivation of Liberty Safeguard documentation in some people's care files. We noted one of these documented that the person required constant supervision, however we noted in this person was left unsupervised during our inspection.

We looked at fluid monitoring for people who used the service. We noted some evidence of monitoring taking place however there were gaps in actions noted by staff. We observed the care of one person and saw a lack of fluid offered to this person.

During our inspection we observed the care of people who used the service. We saw the staff interactions with one person who used the service. There was evidence of some positive interactions when staff engaged in meaningful conversation. However we observed some episodes where staff offered little meaningful interaction and engaged in personal conversation between themselves. Some staff offered little reassurance when undertaking personal care and failed to respond when the person who used the service appeared upset or distressed.

We observed the lunchtime period in one of the units. Staff were seen to offer support to people engaging in meaningful conversation. People were offered meal choices and we observed snacks were offered to people who used the service in between meal times.

During this inspection we saw evidence the care plans followed a more consistent format making them easier to navigate. Reviews were seen in the care files that related to care plans and risk assessments for people, however some of these lacked consistency.

Two care files we looked at had details that related to bowels checks. There was evidence of some recording taking place, however we identified inconsistencies in the recording and a lack of actions noted where concerns had been identified.

We observed the care for another person who used the service where we saw they had not been moved on several occasions for several hours over a period of days. We checked this person's record and saw staff had completed positional change records for these days over the time period where omissions of care relating to positional changes had occurred.

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.

We looked at the duty rotas and noted that staffing numbers in the home had been changed the week of our inspection. We saw there was only one qualified staff member that covered both floors in the home on the night shift. The number of staff on duty was insufficient to meet the needs of people living in the home.

We found during the recruitment of staff, discrepancies in records had not always been fully explored and documented.

Is the service effective?

Inadequate

The service was not effective.

Staff told us they had been given instructions about the rising times however they were unable to provide us with the rationale behind this.

Care file we looked at relating to Deprivation of Liberty Safeguards had some evidence of documentation in place. However we saw evidence of incomplete documentation in relation to DoLS

Food and fluid charts identified people who used the service had not achieved expected fluid intake and these had not been acted upon.

Is the service caring?

Inadequate

The service was not caring.

People responded positively to staff when they engaged in meaningful conversation and supported them in a kind a caring way. However one person appeared distressed and upset when staff offered little meaningful conversation, reassurance or support when carrying out personal care.

Records of fluid intake indicated some people did not achieve required minimum amounts of fluids intake. One person we observed had no jug or glass in their bedroom.

We undertook a SOFI observation during the lunchtime period on one of the days of our inspection. SOFI is a tool to help us assess the care of people who are unable to tell us verbally about the care they received. We saw staff were kind, engaging in positive interactions and offering encouragement and support to people who used the service during their mealtime.

Is the service responsive?

Inadequate

The service was not responsive.

We identified inconsistencies in recording and actions in two care files that related to bowel checks.

Summary of findings

We saw evidence that care plans followed a more consistent format and were easier to navigate. Reviews were seen in the care files that related to care plans and risk assessments however some of these lacked consistency.

We observed the care for another person who used the service where we saw they had not been moved on several occasions for several hours over a period of days. We checked this person's record and saw staff had completed positional change records for these days over the time period where omissions of care relating to positional changes had occurred.

Lake View Nursing Home

Detailed findings

Background to this inspection

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

We undertook a responsive, focused inspection to look at whether the service was safe, effective, caring and responsive on 9 and 14 January 2015. This was because we had received some concerning information that needed to be acted upon quickly. The inspection was an unannounced inspection which meant the provider and staff did not know we were coming.

The inspection was carried out by a lead inspector, five additional inspectors and an inspection manager. During our inspection we spoke with 13 staff members; these included, the registered nurses, care staff, activities coordinator, operations director, regional manager, and the home manager. We spoke with two registered agency nurses who were on duty in the home during our inspection. We also spoke with three people who used the service, two visiting family members and one professional.

We undertook two Short Observation Framework for Inspection (SOFI) observations. SOFI is a tool to help us assess the care of people who are unable to tell us verbally about the care they received.

We spent some time observing care and staff interactions with people who used the service in the communal areas. We looked at the care records for eight people who used the service and other documents which included, policies, accident reporting and duty rotas.

Inadequate

Is the service safe?

Our findings

At our inspection on 12 and 13 March 2014 we identified a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because people were not adequately protected against the risks associated with medicines because appropriate arrangements were not place in relation to the safe administration and recording. We asked the provider to send us an action plan.

At our inspection on 12 and 13 March 2014 we found evidence of a breach of regulation 22. This was because the provider was unable to demonstrate there were sufficient numbers of care staff to meet people's needs at all times. We asked the provider to send us an action plan. We revisited the service on 2 October 2014 to check whether the provider had met the breach of the regulation.

At our inspection on 2 October 2014 we found evidence of a breach of regulation 13, 22 and 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We revisited the service on 9 and 14 January 2015 in response to concerns that had been raised relating to care delivered in the home.

We asked people who used the service and visiting family members about the staffing numbers in the home. One person told us, “There is not enough staff,” another said, “It depends on what day you come in. Yesterday was chilled but on other days the patient to staff ratio needs to be more.”

Staff we spoke with about the staffing numbers in the home told us, “We were worried about the safety of people when we only had one carer (named floor in the home),” We could do with extra staff. We had a twilight member of staff to watch the floor, observing while we were doing suppers. This week they have changed it to one nurse. It takes an agency nurse a long time to do medication, people are waiting until midnight for their medicines” and, “We are still using a lot of agency staff, downstairs there is only one nurse.” However one staff member told us, “There are enough staff to meet people’s need we only have 15 (people who used the service).”

We looked at the duty rotas and noted that staffing numbers in the home had been changed the week of our inspection. We saw there was only one qualified staff member that covered both floors in the home on the night shift. The manager told us this had been introduced the week of our inspection. We checked documentation that had been sent to the Commission from the provider that related to staffing numbers. The provider had confirmed in correspondence to the Commission prior to our inspection that the night shift would be covered by two nurses and two care staff. They also confirmed there was a twilight staff member who would be working until midnight each evening. Because these assurances were not reflected in what we found, the provider had therefore failed to ensure staffing arrangements in the home were appropriate and in line with information they had sent to the commission.

We spoke with all the night staff on duty and asked them if the management team undertook checks of the service during the night. None of the staff we spoke with could confirm management in the home carried out spot checks during the night. One person told us, “We don’t see the manager up here. None have come in at night. We have an on call manager in case of an emergency.” Spot checks enable the management of the home to monitor care delivery and support staff during out of hour’s shifts to ensure people who used the service received safe, effective and appropriate care. We spoke with the manager about the arrangements for night checks in the home. We were told they had not yet commenced night check in the home and that they had been working late over the handover period when the night staff commenced their shift. We could not be confident systems to monitor and support night staffing the home were in place.

During the first day of our inspection we arrived at 06:00am to the home. This was so we could speak with the night staff on duty. We noted there was five staff on duty to cover both floors three of these were agency staff who told us they had done three and four shifts prior to this shift. The third agency staff member told us they had worked at the home some time ago and had done three shifts that week. When asked did the staff have limited knowledge of the residents’ needs or if not asked perhaps say there was an increased risk they would not be fully aware of residents’ needs Although the provider was working to recruit new staff, we found there was a significant reliance on agency care and nursing staff. This meant there was an increased risk staff would not have sufficient knowledge to care for

Inadequate

Is the service safe?

people in a safe and effective manner. Systems to ensure people who used the service were cared for by a staff team who were knowledgeable of the home and peoples individual needs were lacking.

There was a breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because the provider did not ensure that at all times there were sufficient numbers of suitably qualified, skilled and experienced people employed.

We asked the manager about the recruitment arrangements in the home. We looked at the files for five currently employed staff members. One staff file we looked at contained references for previous employment however these did not correspond with the dates documented by the staff member on their application form. We could not see evidence these discrepancies had been explored by the management in the home. We saw the application form had not been signed or dated by the staff member to confirm it was a true and accurate record. A second staff file we looked at had no interview notes in place to provide evidence of the recruitment process being fair and robust. A further staff file had details of references and interview questions, however the documentation received did not correspond with the current positon of the staff member which meant their competency to carry out their new role had not been explored formally.

This was a breach of regulation 21. (a) (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because systems to ensure safe and effective recruitment procedures were not in place.

During our inspection we observed concerns around care and safety for one person who used the service due to the care and support provided by several staff members. We discussed these during our inspection with the home manager, the interim manager and the operations director. The provider took immediate action in response to our concerns.

Inadequate

Is the service effective?

Our findings

At our inspection on 12 and 13 March 2014 we found evidence of a breach of regulation 15. This was because people who used the service, staff and visitors were not protected against the risks of unsafe premises. We asked the provider to send us an action plan. We revisited the service on 6 June 2014 and found evidence of an ongoing breach of regulation 15. This was because people who used the service, staff and visitors were not protected against the risks of unsafe premises. We revisited the service on 2nd October 2014 to check whether the provider had met the breach of the regulation.

At our inspection on 6 June 2014 we found evidence of a breach of regulation 18. (2) (b) (ii) This was because the Care Quality Commission was not being informed of notifiable incidents and accidents in the home.

At our inspection on 2 October 2014 we identified a breach of regulation 15, 14, 18, 11and, 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We revisited the service on 9 and 14 January 2015 in response to concerns that had been raised relating to care delivered in the home. We had been made aware of concerns that related to moving and handling of people who used the service prior to our inspection. We asked the management in the home to provide us with evidence of training undertaken by staff. We were shown evidence of training in basic life support, equality and inclusion, safeguarding, deprivation of liberty, fire safety at work, infection control and moving and handling. However, we noted six of the 18 nursing and care staff had not completed training in moving and handling. Eight of the 18 nursing and care staff had not completed training in basic life support and only one of the 18 had completed safeguarding in health and social care. Systems to ensure staff received up to date relevant training for their role was not in place. This meant there was an increased risk of people receiving care not was unsafe or effective.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the registered manager. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken. We looked at care files for eight people who used the service. The nurse in charge and the regional manager confirmed all documentation relating to people would be located in their care file only. We saw some evidence of documentation that related to Deprivation of Liberty Safeguards (DoLS). One care file we looked at contained details of the use of bed rails; this included a mental capacity assessment and a bed rails risk assessment. However we could not see any documentation that related to bed rails in the DoLS documentation in their care file detailing that their use was the least restrictive way to keep the person safe and were used in the persons best interests.

Another care file we looked at had a DoLS application in place which detailed the person required constant supervision due to their healthcare history and needs, however we noted that this person was unsupervised in their bedroom during our inspection for over one and a half hours. This meant the care provided for this person did not reflect their documented needs. Systems to ensure people who used the service had relevant and up to date documentation and guidance in their care file was lacking.

We looked at how people's care preferences were identified and supported. We asked staff to tell us what choices people who used the service had in relation to their of care. One staff member told us, "Ladies don't mind a man here. There is only one person who can say if they mind having a man." Another told us, "(Named person who used the service) doesn't like male carers. (Named person who used the service) does not get carers so much now." The staff member told us they thought this was documented in their care plan. However another staff member told us gender preferences were communicated to staff verbally. This meant the communication systems within the staff team were unclear.

One staff member told us people who used the service were given a choice when they would like to get up in a morning. However one staff member told us they had been instructed to get two people who used the service up but could not give an explanation why this was taking place. Another staff member told us two people who used the service were, "Washed and dressed and left on the bed by

night staff." They told us one of these people would say if they wanted to get up but the staff member could not be confident this person would want to get dressed. They told us the second person who used the service, "Probably would want to stay in bed if they were given the choice. Sometimes night staff help us by getting (named two people who used the service) dressed." Another staff member told us "We try to get people to bed by 10:00pm and start getting people up between 4:00am and 5:00am." They went on to tell us "They are really trying hard to bring them (the home) up to a standard that is acceptable. Everything is in place for it to be a good service." We found people's preferences were not always clearly documented and staff could not provide clear explanations about these. This meant people who used the service were at risk of inappropriate care that did not meet their specific requirements.

We looked at the care files for people who used the service in relation to involvement and decision about their care. We saw evidence of signed consent in two of the eight care files we looked at. We saw evidence of people choices, likes and dislikes recorded however we could not see any gender preferences documented in any of the care files we looked at. We observed several care interventions for one person who used service. We did not see evidence of staff discussing the care with this person or asking permission from them before carrying out any care or activity. This further showed people who used the service were at risk of inappropriate care because choice and decisions relating to them were not in place.

This was a breach of Regulation 17. (1) (b) (2) (c) (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because the provider failed to ensure people who used the service were not enabled to participate in making decisions relating to their care or treatment.

We looked at the arrangements in place for food and nutrition in the home. A visiting professional we spoke with told us, "There are a lot of people on fortified drinks. They are constantly referring to the dietician." We asked staff about the arrangements in the home in relation to meals. We were told, "We were doing boiled eggs at 11:00 am and they (people who used the service) loved it but this has now been stopped."

A staff member told us the home had not had a permanent chef for about three months however the cover provided was with the same agency chef. We saw meal choices on display in the dining room for people who used the service and we observed people being offered meal choices by staff. Staff we spoke with told us food in the home was fortified in the kitchen by the chef.

We undertook a SOFI observation during the lunchtime period on one of the days of our inspection. SOFI is a tool to help us assess the care of people who are unable to tell us verbally about the care they received. We saw staff were kind, engaging in positive interactions and offering encouragement and support to people who used the service during the mealtime. Staff were seen assisting people to eat their meals offering one to one support engaging in positive communications with them. Staff were heard to be discussing nutritional intake with people who used the service. However during our observation we saw one person who used the service had food debris on their clothing and their chair was stained and unclean.

We observed people who used the service were offered snacks and crisps in between meal times. One person who used the service we spoke with told us they were offered choices in relation to their meals and said, "I am just having my second cup of tea. I asked for it."

We observed one person in their bedroom had no access to a water jug or glass. We looked at this person care file which detailed their daily fluid requirements. We looked a food and fluid charts that related to this person and saw six occasions over a 14 day period where the minimum amount of fluid had not been achieved. We could not see any concerns recorded by staff on the fluid chart that related to this. People who used the service were therefore at risk of dehydration because staff had failed to respond to concerns related to people's low fluid intake.

We looked at the food and fluid charts for seven people who used the service and saw evidence of some recordings of diet and fluids in two records. However one person's records identified gaps in fluid intakes on three separate occasions. For example one record identified no fluids had been consumed by this person for nine and a half hours. There was no evidence in their care file that related to the need for monitoring this area of need.

A care file that related to one person who used the service identified on four out of 10 occasions where a person's fluid

intake had also not been achieved. Again there was no evidence of actions staff had taken as a result of these results. Therefore people were at risk from dehydration with inadequate fluid intakes.

We observed the care of one person who used the service that related to food and fluid intake and noted concerns about the amount of food and fluid they were offered whilst in their bedroom. We saw two occasions where staff were kind and attentive assisting this person's with this nutritional support. However on three occasions we saw staff failed to engage in positive communication with them. On one occasion we observed little evidence of staff responding the person's request to not have any more food or staff offering reassurance. We saw two staff supporting this person with a drink which was identified as ready brek (a breakfast cereal). Two staff members were seen discussing that they offered cold porridge to people who used the service as an evening snack. Systems to protect people who used the service from the risks associated with inadequate nutrition support were inadequate.

The food and fluid charts and eating and a drinking support plan that detailed this person's expected fluid intake was in place, however we noted on all of the 13 fluids chart we looked at that this amount had not been achieved. A further record we looked at had no details relating to the person's food and fluid intake. During our observations we noted that this person was only offered a drink by staff on two occasions. People who used the service were at risk because systems to ensure accurate records were in place and to ensure staff responded to concerns that related to their fluid intake were lacking.

We checked the records relating to nutritional assessment and weight monitoring. There was evidence of some weights being recorded, however we noted gaps and inconsistencies in the care files we looked at. We saw in one person's care file that weight loss had been identified over a two month period. However we noted conflicting information on another document that detailed a weight gain over this same period. Records also indicated the previous weighing scales used were faulty. We looked in the care file of another person and saw evidence staff had documented a considerable weight loss, however there were no details or actions that had been taken noted in them. Systems to ensure accurate and consistent monitoring were lacking.

There was evidence of nutritional risk assessments including advice relating to weight monitoring in one of the care files we looked at. Another care file detailed likes and dislike and how best to support this person during mealtimes and we saw evidence of a recent diet support plan in place in another care file we looked at. Monitoring of some weights were taking place however although one person's record identified regular monthly weights, the care plan stated weights were to be obtained weekly. We discussed the risks associated with this person with the manager who was unable to confirm any risks associated with them. One staff member told us, "If I notice people have lost weight I would look for underlying illness. People are put on diet and fluid chart. I would contact the GP and dietician if I was concerned." Staff we spoke with told us some people who used the service would be offered drinks overnight. Overall we found people who used the service were at risk of inappropriate care because records failed to be consistent in their detail.

Staff lacked consistency in their knowledge of people's needs in relation to food and fluid monitoring and records required. One staff member told is, "All apart from one resident (Person who used the service) are on food and fluid charts". In contrast another staff member said that the home had "Diet and fluid checks but they were not required for everyone." And, "Three people need full assistance with meals. A couple of diet and fluid checks have been stopped as people have put weight on," and, "People have supplementary drinks. (Named person who used the service) gets the most monitoring in relation to food and fluids."

There was a breach of regulation 9. (1) (b) (i) (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because the provider did not take proper steps to ensure that people who used the service were protected against the risks of receiving care or treatment that was inappropriate or unsafe.

There was a breach of regulation 14. (1) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because the provider failed to ensure the people who used the service were protected from the risks of inadequate nutrition and dehydration.

Inadequate

Is the service caring?

Our findings

At our inspection on 12 and 13 March 2014 we found evidence of a breach of regulation 9. This was because incomplete and inconsistent information about the delivery of care and treatment meant there was a risk people's needs were not being met, and the welfare and safety of individuals could not be ensured. We asked the provider to send us an action plan.

At our inspection on 2 October 2015 We identified a breach of regulation 17. (1) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because the provider did not have suitable arrangements to ensure people who used the service were enabled to make, or participate in, decisions relating to their care or treatment.

We revisited the service on 9 and 14 January 2015 in response to concerns that had been raised relating to care delivered in the home.

During this inspection we asked people who used the service and visiting family members about the care people received. We were told, "Nurses and cares are brilliant. We've always felt the basics like the care are good. They have accommodated all of (named persons) needs. Staff bend over backwards" and, "The staff treat me well and the carers are lovely. Everything is fine." A visiting professional told us, "The regular staff know the service users (people who used the service), bank staff are a waste of time. General day to day care, the regular staff seems quite good." Staff we spoke with told us, "I know I do a good job. I care to the best of my ability. You will never find anything wrong with my work."

During our inspection on 14 January 2015 we undertook a tour of one of the units in the home to identify how many people who used the service were in their bedrooms. We noted that 11 of the 13 people who used the service on this unit were still in their bedrooms at 11:55am. Of these one person was dressed lying on their bed and two people were in the process of 'getting up'. We asked a staff member on duty on the day of our inspection what support people needed with their care. We were told all but two people on this floor needed the support of two staff with their care needs. One person still in their bed during our observations was noted to be shouting and asking for help. We checked the care file for this person and saw they liked to get up between 10:00am and 11:00am. We observed the staff assisted this person to get up at 12:45pm. One staff member we spoke with told us one person who used the service was assisted with their personal care by night staff and left on their bed, however when discussed further we were told that this person would 'probably would want to stay in bed if they were given a choice. People who used the service were therefore at risk of inappropriate or unsafe care because staff failed to follow care plans for them.

We checked another person's bedroom during our observations at 11:55am. We noted this person was asleep, and there was a lack of appropriate bedding in place for them. Records we looked at indicated this person had not been checked since 3:00am. We observed a staff member entered their bedroom at 1:45pm.

We observed the care of a third person who used the service and noted that some staff appeared kind, caring and attentive to this person's needs. During this time we noted the person responded positively, chatting and singing with the staff. However we identified some concerns in relation to the care that was delivered to this person. We observed this person was at times distressed and shouting. We noted that on several occasions personal care was undertaken by one staff member. During positional changes staff at times appeared rushed and demonstrated inappropriate moving and handling techniques with them. Staff also were seen to be engaging in hurried personal care with this person. People who used the service were at risk because staff failed to provide appropriate care to people in a timely manner.

We observed one staff member undertaking a positional change for one person who used the service on their own. We checked this person's care file and saw documentation to instruct staff that this person required the support of two staff for positional changes. We noted this person had been positioned on their back, however documentation signed by staff stated this person had been placed on their side. People who used the service were at risk of inappropriate or safe care because staff failed to follow care plans for them and carried out inappropriate and unsafe care practices.

We spoke with staff about the staffing requirements to assist this person. All staff we spoke with told us they required two staff to support them with their personal care needs and requirements. We checked this person care file and identified one occasion where two staff had signed the

Inadequate

Is the service caring?

position change chart, however we noted only one staff member had carried out the personal care at that time. We noted another occasion were care was provided to this person by one member of staff, however we saw two staff had signed the documentation for that time. Systems to record in peoples care files accurately were lacking.

During our inspection we spoke with 11 staff about people's requirement for moving and handling and the frequency of checks on them. We received conflicting information from the staff team in relation to people's needs and staff did not provide consistent details in relation to people's specific positional needs and checks that were required. One person told us, "Everyone is checked two hourly and four residents (people who used the service) are on four hourly turns." Another staff member told us two people were checked one hourly and 'three people needed two hourly turns.' We were also told, "If people are in bed I go in numerous time but these checks are not recorded; we only record if you change a pad." People who used the service were at risk because staff did not have consistent knowledge of people individual needs to ensure effective delivery of care.

We observed the care of one person in the home. We observed staff engaging in personal conversations between themselves showing little regard for the person. There was little meaningful conversation and staff offered no guidance or explanation of the care being carried out for the person who used the service. We noted staff using inappropriate language and discussing the care of other people who used the service in the home in this person's presence. This meant the staff demonstrated a lack of consideration for the dignity of the person and the confidentiality of others.

There was a breach of regulation 9. (1) (b) (i) (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because the provider did not take proper steps to ensure that people who used the service were protected against the risks of receiving care or treatment that was inappropriate or unsafe.

There was a breach of regulation 11. (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because systems to ensure that people who used the service were safeguarded against the risks of abuse because they took reasonable steps to identify the possibility of abuse and prevent it before it occurs were not in place.

Inadequate

Is the service responsive?

Our findings

At our inspection on 12 and 13 March 2014 we found evidence of a breach of regulation 9. This was because incomplete and inconsistent information about the delivery of care and treatment meant that there was a risk that individual needs were not being met, and that the welfare and safety of individuals could not be ensured. We asked the provider to send us an action plan.

At our inspection on 2 October 2014 we found evidence of a breach of regulation 9. (1) (b) (i) (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because the provider did not take proper steps to ensure that people who used the service were protected against the risks of receiving care or treatment that was inappropriate or unsafe. There was also a breach of regulation 20 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because the provider did not ensure people who used the service were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them.

We revisited the service on 9 and 14 January 2015 in response to concerns that had been raised relating to care delivered in the home.

During our inspection we looked at the care files for eight people who used the service. We saw evidence that care plans followed a more consistent format and were easier to navigate. There was evidence of reviews in relation to care plans and risk assessments for people, however some of these lacked consistency. We saw in one person's care file that they were at a high risk of falls, however we could not see a care plan to guide staff on how to care for this person safely to reduce the risk of falls. Another person's care file detailed a person had an assessment for their risk of pressure ulcers that had identified a score that was 'high risk'. The records indicated that further care planning was required to support the risk assessment. There was no support plan in place for staff to follow to ensure this person received care that was safe and reflected their current needs. We asked the manager about this, who told us the risk assessment was for tissue damage risk and not a pressure risk. People who used the service were at risk because records relating to them did not accurately reflect their needs.

We looked at what monitoring and checks were taking place for people who used the service. We saw evidence of some checks taking place however we noted inconsistencies and gaps in the records.

We looked at the records that related to positional changes for four people who used the service. We saw evidence of some records that related to positional changes, however we noted there were gaps in three of the records we looked at. We looked at the care records for one person who used the service and we checked this person charts relating to positional changes. Records indicated four days where there was no record of a 'pressure care daily check' taking place over a 33 day period. Another person's record indicated a pressure prevention assessment had been undertaken recently, however we noted this had not been completed in full, calculated or signed. Systems to ensure people who used the service had detailed records that identified checks and assessments were completed by staff were inadequate.

We observed the care for another person who used the service where we saw they had not been moved on several occasions for several hours over a period of days. We checked this person's record and saw staff had completed positional change records for those days over the time period where omissions of care relating to positional changes had occurred. These records were not reflective of our observations. For example we saw records that noted two checks over a period of six hours had been recorded by staff, however evidence we observed suggested this had not taken place. On another record staff indicated four separate checks and position changes over a period of eight hours for this person; however evidence indicated no checks by staff had taken place. A third record indicated again that records for four separate occasions were staff had indicated and positional change and checks, however evidence suggested no checks had taken place. We checked this person's care file and noted documentation to instruct staff that this person needed two hourly checks. Therefore we found the provider failed to ensure people who used the service were cared for by a staff team who adequately monitored their positional needs or recorded them accurately.

One occasion we noted that a person who used the service had remained in their bedroom for several hours. We observed this person did not receive a positional change for eight hours. We checked this person records which

Inadequate

Is the service responsive?

confirmed no positional changes had been recorded. This meant this person did not receive the care they needed. The provider failed to ensure people who used the service were cared for by a staff team who adequately monitored their positional needs or recorded them accurately.

During our inspection on 14 January 2015 we undertook observation of the checks that were carried out on two people who used the service on one of the floors. We looked at one person's care record that related to this persons observation checks. We saw that records indicated some checks had taken place, however we saw there was no record of checks for this person for over nine and half hours. People who used the service were at risk because there was a lack of regular monitoring and checks in place for them. Another record that related to regular checks by staff identified checks had taken place, however we could not see a care plan to direct staff as to the frequency and rationale for them. Records to protect people who used the service by ensuring care planning was relevant and reflected their current needs were therefore not in place.

We were shown a chart the staff completed for people who used the service who were receiving, 'pad checks'. There was evidence of regular forms in place, however we saw these had not been completed in full and we saw three people had not had a pad check for seven and half hours. Another person we saw had not had a pad check for 13 hours. Two charts we looked at had limited records of checks for people who used the service. The last time noted for pad check for people was 7.10pm and 7.40 pm. One of the records had no details of the date it had been completed. We could not be confident that people who used the service received regular continence care and prompt help with personal care because documentation had not been completed fully and showed lengthy delays between checks.

Two care files we looked at had details that related to bowel checks. There was evidence of some recoding taking place, however, as with other records we looked at, we identified inconsistencies in the recording and a lack of actions noted where concerns had been identified. One person's record detailed six days where there was no record of bowel movements. We looked at the care plan that detailed this person's continence needs and we noted daily needs in relation to continence. We looked at the diary entries relating to this person and saw there was no reference to concerns in relation to their continence other than on one occasion where there was a record of a medication given. A second care file for one person who used the service identified there was no bowel movement for nine days, there was a record of medication given but no details on actions taken by staff. Ineffective systems to monitor and record peoples need in relation to their continence were evident.

There was a breach of regulation 20 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because the provider did not ensure people who used the service were not protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them.

There was a breach of regulation 11 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because systems to ensure that people who used the service were safeguarded against the risks of abuse because they took reasonable steps to identify the possibility of abuse and prevent it before it occurs were not in place.

There was a breach of regulation 9 (1) (b) (i) (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because the provider did not take proper steps to ensure that people who used the service were protected against the risks of receiving care or treatment that was inappropriate or unsafe.

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.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing There was a breach of regulation 22. of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because the provider did not ensure that at all times there were sufficient numbers of suitably qualified, skilled and experienced people employed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers There was a breach of regulation 21. (a) (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because systems to ensure effective recruitment procedures in order to ensure that no person is employed for the purpose of carrying on a regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records There was a breach of regulation 20. (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because the provider did not ensure people who used the service were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs

This section is primarily information for the provider

Enforcement actions

Treatment of disease, disorder or injury	There was a breach of regulation 14. (1) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because the provider failed to ensure the people who used the service were protected from the risks of inadequate nutrition and dehydration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse There was a breach of regulation 11. (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because systems to ensure that people who used the service were safeguarded against the risks of abuse because they took reasonable steps to identify the possibility of abuse and prevent it before it occurs were not in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services There was a breach of regulation 9. (1) (b) (i) (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because the provider did not take proper steps to ensure that people who used the service were protected against the risks of receiving care or treatment that was inappropriate or unsafe.