Dharma Limited

Orchard Lodge Care Home

Inspection report

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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
Is the service well-led?	Inadequate

Overall summary

The inspection at Orchard Lodge was undertaken on 27 November 2014 and was unannounced.

Orchard Lodge provides care and support for a maximum of 44 older people, some of whom may have physical disabilities or sensory impairment. At the time of our inspection there were 31 people who lived at the home. Orchard Lodge is situated in a residential area of Blackpool. It offers single and shared accommodation over two floors. In addition there is a dining room and communal lounge. Garden areas to the front and rear are accessible for wheelchair users via a ramp. Communal space is accommodated in three lounges and a dining room.

There was a registered manager in place. 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.

Summary of findings

At the last inspection on 25 April 2013, we asked the provider to take action to make improvements to how people's nutritional needs were maintained. At the follow-up inspection on 13 August 2013 we observed improvements had been completed and the service was meeting the requirements of the regulations.

During this inspection we found the registered manager had failed to properly maintain people's safety and freedom. There were limited or no risk assessments in place to ensure people were protected against harm. We saw one person's safety was compromised. We were also told by relatives about concerns they had with another person's safety. There were concerns with how the registered manager safeguarded people in relation to infection control and environmental health and safety. For example, we saw some areas of the home were dirty and door closures were positioned in a way that put people at risk from injury.

We observed several incidents of people's liberty being deprived. Sliding bolts were in place on the outside of bedroom doors and bed rails were widely used throughout the home. There were limited or no risk assessments or best interest decisions in place. This demonstrated the registered manager had failed to ensure some people were not deprived of their liberty.

We have made a recommendation about the appropriate use of bed rails within the home.

Staff were continuously rushing from one duty to the next and they told us there were not enough staff on duty. Call bells were not answered in a timely manner and people told us they often had to wait to have their needs met because staffing levels were poor. We were unable to properly assess staffing levels because the registered manager did not send us requested, related information and told us that there were more staff on duty than we found to be the case during the inspection. This meant people were at risk from unsafe care because the registered manager had not ensured adequate staffing levels to meet their needs.

People did not always receive their medication safely because there were periods during the week when there were no trained staff on duty to monitor those who had received medicines. Staff did not always follow recorded instructions and did not concentrate on one person at a time, which placed people at risk from harm.

We observed staff were caring and supportive towards people who lived at the home. However, we noted staff did not always engage with people who had limited capacity in an appropriate manner. People's welfare, dignity and privacy were not continuously maintained throughout our inspection. For example, the ground floor communal toilet had no lock on it and people's confidential information was not held securely.

We were told staff had a good understanding of people's individual needs. However, we observed people's recorded preferences were not always followed. There was limited evidence that people or their representatives were involved in their care planning and review. Care records had missing information and were not regularly reviewed. This meant people were at risk from inappropriate care because the registered manager had not ensured care records were adequately maintained.

People's health needs were monitored and any changes were acted upon. The home worked with other providers to ensure continuity of care.

Staff told us they were adequately trained and received formal and informal supervision and support from the registered manager. However, we were unable to fully confirm this because related staff records were poorly maintained and indicated staff had received minimal training. This included training in food hygiene. We found an identified risk associated with malnutrition was not responded to in a timely manner. Associated records were incorrectly completed and the kitchen was dirty.

Some staff and people who lived at the home told us the registered manager was not always open and visible within the service. People were not enabled to make formal complaints because information was out-of-date and identified issues were not always followed up by the registered manager. There were a range of quality assurance audits in place. However, we found the management team did not have a clear picture of monitoring the quality of care delivery, recording processes and individual responsibilities.

Audits to check the standards of care provided for people did not pick up issues we identified with care records, health and safety, infection control, food hygiene and training. There was no documented evidence to confirm issues identified from staff and service user surveys were acted upon. The service's gas and electric safety

Summary of findings

certification were out-of-date. This meant people were at risk from unsafe and inappropriate care because the registered manager had failed to effectively monitor the quality of care provided and act upon issues identified.

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

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.

Staff demonstrated an understanding of their responsibilities with regard to safeguarding people from abuse. However, we observed a breach of one person's safety and were told by relatives about their concerns of another person's safety.

Risks to people who received care were not always safely managed. For example, there were limited or no recorded risk assessments in place and accidents and incidents were not followed up to minimise their re-occurrence.

We observed the registered manager had failed to properly maintain infection control and environmental health and safety procedures. We found several areas of the home to be dirty and related records were poor. We identified health and safety concerns that compromised people's safety.

We were unable to properly assess staffing levels because the registered manager did not send us requested, related information and told us there were more staff on duty than was the case. People told us they did not always have their needs met in a timely manner because there were not enough staff on duty.

Medication was not always administered safely. There were frequent periods during the week when there were no trained staff on duty to monitor people who had been administered medication. Staff did not always concentrate on one person at a time when they gave people their medicines.

Is the service effective?

Inadequate

The service was not effective.

Staff told us they had received training and supervision to assist them in their role and responsibilities. However, related records were poorly maintained and indicated staff had limited training, the majority of which was facilitated by untrained staff.

We observed the registered manager had failed to ensure some people were not deprived of their liberty. For example, we found bed rails were widely in use and sliding bolts were fitted to the outside of bedroom doors. CQC had not been notified of a DoLS in place, the conditions of which had not always been followed by staff to protect the individual. We noted staff did not fully have a good understanding of how to engage with people who had limited capacity.

People's food preferences were checked, but they were not supported to eat hot food in a timely manner. An identified risk associated with malnutrition was not responded to in a timely manner. Records were incorrectly completed. We saw poor food hygiene practices in the home. For example, the majority of staff did not have related training and the kitchen was extremely dirty.

People's changing health needs were monitored and external services were accessed for additional support where this was necessary.

Summary of findings

Is the service caring?

Inadequate

The service was not always caring.

We observed staff were caring and supportive towards people who lived at the home. However, we noted the registered manager had failed to maintain people's welfare and general well-being because the ground floor toilet had no lock on it.

We found the management team had not safeguarded people's privacy. For example, personal information and care records were not stored and held securely.

People were not fully involved in their care planning and review. One person told us they did not know if they had a care plan. People's recorded preferences were not always followed by staff.

Is the service responsive?

Inadequate

The service was not always responsive.

Care was personalised and people were supported to maintain their independence. However, we found care records were inconsistent and important information was missing. A review of people's care was not regularly undertaken.

We found the complaints policy and related information for people was out-of-date. There were no timescales for managing complaints and there was no recorded evidence to show they were properly addressed.

Is the service well-led?

Inadequate

The service was not always well-led.

Comments from staff and people who lived at the home indicated the registered manager was not widely seen as open and visible within the home.

There were a range of quality audits in place. However, these did not pick up issues we found with care provided for people, care records, health and safety, infection control, food hygiene and training. Some audits were not fit for purpose. There was no documented evidence to confirm issues identified from staff and service user surveys were acted upon.

The service's gas and electric safety certification were out-of-date. The management team did not have a clear picture of monitoring the quality of care delivery, recording processes and individual responsibilities.

Orchard Lodge Care Home

Detailed findings

Background to this inspection

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

The inspection team consisted of three adult social care inspectors; a specialist advisor, with social worker experience of older people and people with dementia; and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience for the inspection at Orchard Lodge had experience of caring for older people.

Prior to our unannounced inspection on 27 November 2014 we reviewed the information we held about Orchard Lodge. This included notifications we had received from the provider, about incidents that affect the health, safety and welfare of people who lived at the home. We checked safeguarding alerts and comments and concerns received about the home. At the time of our inspection there were ongoing safeguarding concerns being investigated by the Local Authority in relation to people's safety at Orchard Lodge.

We routinely ask providers to complete a Provider Information Return (PIR). 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 did not ask the provider of Orchard Lodge to complete a PIR because this inspection was carried out quickly in order to check the safety of people who lived at the home.

We spoke with a range of people about Orchard Lodge. They included the registered manager, six care staff, the cook, eight people who lived at the home and three relatives. We discussed care with a visiting GP, two district nurses and an external staff trainer. We also spoke with Healthwatch Blackpool and the commissioning department at the local authority. We did this to gain an overview of what people experienced whilst living at the home.

We also spent time observing staff interactions with people who lived at the home and looked at records. We checked documents in relation to eight people who lived at Orchard Lodge and three staff files. We reviewed records about staff training and support, as well as those related to the management and safety of the home.

Inadequate

Is the service safe?

Our findings

A relative told us, "My [relative] has escaped from the home 4 or 5 times and on each occasion was injured. She had broken her wrist twice due to falling when escaping." We were told the family or friends visit every day to ensure the individual concerned was safe. The relative told us they were unhappy about their safety and the care received. We reviewed this person's care records and noted there were no risk assessments in place.

During our inspection we found serious concerns in relation to one person who lived at the home. This person was distressed and had dried, cracked lips with only a cold beaker of coffee on their bedside table. The call bell was out of reach, the room was cold and the individual was half undressed, with only a sheet to cover them. Inappropriate equipment had been put in place that restrained their movement and prevented them from getting out of bed. The person told us they had been asking to get up for over two hours. This request had not been facilitated by staff.

We asked for this person's records and found information specifying they did not like tea or coffee and preferred to get up at 9 am. Fluid monitoring records did not correlate to how we found this individual because they indicated good levels of hydration. When we checked other charts at 15:45 we noted entries had been completed for 16:00. This was a serious breach of the individual's safety. Related records meant the person was at risk from unsafe and inappropriate care because staff had not followed care plans and incorrectly completed monitoring charts. We reported our concerns to the Local Authority safeguarding vulnerable adults team.

Our discussions with staff showed they had a good understanding of how to report safeguarding issues. A staff member told us, "I would report any concerns to the manager. We have a whistle-blowing policy in place. It's about having respect and discipline as a worker." Staff told us they had received updated training to underpin their knowledge and understanding. However, we were unable to confirm this as training records and certificates we reviewed were not up-to-date.

This is a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because suitable arrangements were not in place to protect people against the risks of abuse.

We reviewed how staff recorded and responded to accidents and incidents within the home. We found an effective accident and incident reporting system was not in place. The accident book had perforated sheets and we noted some pages had been removed. We asked the registered manager about this, but we were not given a suitable explanation. We observed 45 accidents had been recorded since 02/07/2014. There was no formal documentation about how accidents and incidents would be investigated and analysed to minimise their re-occurrence.

The registered manager was unable to provide us with records about how incidents were managed in the home. We found in one person's care record a document that highlighted they were involved in an incident with another person who lived at the home. There were was no other information about what the incident was or subsequent actions. We discussed this with the management team who were unable to provide any additional details. This meant risks to people who lived at the home had not always been recorded and followed up effectively to ensure their recurrence was minimised.

The gate at the top of the main staircase was extremely low and did not deter people, who may be deemed unsafe to do so, from accessing the stairs. We saw no reason why this was in place and it put people at risk from serious injury if they fell over it down the stairs. There were no environmental risk assessments in place to safeguard people in relation to this gate. We observed two main ground floor thoroughfares were very dark due to inadequate or absent lighting. This posed a slip, trip and fall hazard to people accessing their bedrooms.

We found bedrooms were cold and people did not always have ample bed linen for their warmth and well-being. Not all windows had restrictors in place to prevent people from falling out. The fire door by the main staircase was blocked with wheelchairs. Several ground floor bedroom doors had no closures in place to ensure they closed automatically when people entered or left the room. This posed a fire risk because doors may remain open in the event of a fire. Where door closures were in place some closed so quickly that people were at risk from being injured. This meant people's safety was compromised because the registered

manager had not ensured adequate health and safety measures were in place. We have informed the local fire authority and the Local Authority health and safety officer about the concerns we found.

We checked the majority of the home's bedrooms and found pull cords were not attached to the nurse call system or they were located away from where beds were placed. This showed people were not always protected in an emergency because the registered manager had not ensured a means of urgent contact was made available to them.

We checked how the registered manager maintained the security of people who lived at the home. One person told us, "Oh, I feel safe. I wouldn't be anywhere else." Another person said, "I feel safe in the home." However, although we were asked to sign in the visitor's book on our arrival, staff did not, at any time, ask to check the identity of any member of the inspection team. Failing to fully check visitors' identity at point of entry to the home is a lapse in people's security.

These are breaches of Regulation 15 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because people were not being protected against the risks associated with unsafe or unsuitable premises.

We noted there were signs around the home to highlight the importance of maintaining infection control. This included information about safe hand-washing techniques. We saw ample products were in place to assist with infection control, such as soap dispensers and paper towels.

However, we found failures in how the registered manager controlled the spread of infection and maintained cleanliness. Cleaning records kept in toilet areas, which were designed to be signed by staff when tasks were completed at regular intervals, were left blank throughout our inspection. The ground floor communal toilet was raised on a plinth that was extremely dirty. The light pull cord and flooring had ingrained dirt on it and the positioning of the toilet roll was inaccessible to people who used the facility. Several rooms had offensive smells in them that did not enhance people's well-being. Windowsills and carpets were dirty with debris and some flooring areas were sticky when we walked across them.

Some en-suite toilets did not have toilet rolls in them, whilst others had toilet role holders that were positioned in such a way that made them inaccessible to people who lived at the home.

The registered manager was unable to provide us with cleaning schedules designed to outline how infection control was maintained and how areas within the home should be cleaned. One person told us, "My room is vacuumed when I ask. I don't think they just do it." A relative stated, "I have complained that the cleaning is never done and [my relative's] bathroom was untidy."

We were told a member of the domestic staff had not received training in infection control. A staff member said, "There are no cleaning schedules in place. I know cupboards have to be locked and stuff stored properly. I've not had COSHH [Control of Substances Hazardous to Health] training. I don't know what this is." This meant the provider had not ensured the staff member had received information about an important aspect of their role. This indicated people may be at risk from inappropriate infection control measures.

This is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because people were not being protected against identifiable risks of acquiring an infection.

Care records contained an assessment of people's needs. However, we saw limited or no evidence this then led into a review of any associated risks. Potential risks of harm or injury and appropriate actions to manage risk were not always identified. This meant the registered manager did not protect people from unsafe care because documentation was missing or where this was in place records were inadequate, incomplete or had missing information.

This is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because people were not safeguarded against the risks of receiving inappropriate or unsafe care.

We observed there were insufficient staffing levels at the home. For example, we observed staff went about their duties in a hurried way and people's needs were not always attended to in a timely manner. People were still being assisted to get up at 11 am, although their records

Is the service safe?

indicated they preferred to get up earlier. We noted call bells rang for long periods before being answered and we had to wait for up to ten minutes before staff answered the front door to admit us into the building.

People told us staffing levels were inadequate. One person told us, "Sometimes there are not enough staff on duty, especially at lunchtime." Another person said, "There does not appear at times to be sufficient staff on duty." A third person stated, "I'm very unhappy as I have been wanting to get up for ages and no-one has come to see me. I haven't got my buzzer so I can't call for help. I've been waiting for ages to get up." A fourth person told us, "The staff say they will come back and help you, but no-one ever comes back." This showed there were not enough staff to sufficiently carry out duties and meet people's needs.

The registered manager told us there were more staff on duty at the time of our inspection than was the case. We were told nine or ten staff were on duty, but we only saw seven staff working during our inspection, including two staff who did not provide personal care. Staff feedback from the survey in October 2014 consistently raised concerns about poor staffing levels. A staff member told us, "We need more staff as it can be very hard work. Sometimes we have to wait a while for another staff member before we can hoist somebody, for example." Another staff member said, "People are not looked after properly here. Staff care, but we don't have enough time. We want to do it right, but we have to cut it short."

We were unable to properly assess staffing levels the provider had in place on the day of the inspection. The registered manager gave us only current and planned staff rotas. She told us past related records were kept off the premises. We requested these be sent to us within 48 hours of the inspection, but we did not receive this information despite this request.

This is a breach of Regulation 22 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because there were not, at all times, sufficient numbers of staff to meet people's needs.

The management team had in place suitable recruitment processes. We checked related records of three staff members and found correct procedures had been followed when staff had been employed. This included reference and criminal record checks, qualifications and employment history. This showed the management team had ensured people were protected against the employment of unsuitable staff by the completion of proper recruitment processes and checks prior to their employment.

We observed medication being dispensed and administered to people. This was not always done in a safe, discrete and appropriate manner. Staff did not always follow the home's policy and procedures. A staff member told us, "I've been told I'm in charge of meds, but feel I've been dropped in the deep end."

There was a clear audit trail of medicines received, dispensed and returned to the pharmacy. Related documents followed national guidance on record-keeping. Medication was stored safely and work areas were clean. However, we noted there were limited numbers of staff trained to administer medication. We were told off duty staff frequently had to come in to the home in order to give people their medicines if there was no one on a shift trained to do so. This meant there were frequent times when people who received medication were not monitored by trained and experienced staff. People were not protected against unsafe medication processes because the registered manager had not ensured trained staff were on duty at all times.

The registered manager had not ensured staff were kept up-to-date about current information on individual medicines. Guidance available was out-of-date and medicine information leaflets were not retained for reference purposes. We found one person's records identified they were allergic to morphine. However, medication forms showed this person was prescribed Diamorphine on 14/10/2014. Diamorphine contains morphine. This demonstrated staff had not checked this person's medical history and had placed the individual at risk of harm.

Staff did not always complete medication administration records in line with the National Institute for Health and Care Excellence (NICE) guidelines for managing medicines in care homes. NICE guidelines provide recommendations for good practice on the systems and processes for managing medicines in care homes. For example, hand written records did not always give clear instruction and were not consistently signed and dated by staff. Directions recorded on people's documents were not always followed. We saw one example where a person had been prescribed

Inadequate

Is the service safe?

night sedation with instruction to administer sparingly. However, this had been recorded as being administered every night since 07/11/2014 up to the date of our inspection.

We observed one staff member dispensing seven people's medication at the same time. There was further risk, until we intervened, when the staff member proceeded to take all this medication through to people they were prescribed for. This showed people were at risk from unsafe medication procedures because staff did not administer medicines to one person at a time.

This is a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because people were not being protected against the risks associated with the unsafe use and management of medicines.

Inadequate

Is the service effective?

Our findings

Staff told us they had received training in infection control, movement and handling, medication, catheter care, end of life care and safeguarding. A staff member told us, "We have lots of training and the manager is very supportive of this. I am doing my level 3 [National Vocational Qualification (NVQ)]." Another staff member said, "I've recently done a dementia course. People with dementia need special attention and care. I try my best to give this." Staff told us they had undertaken qualifications, such as NVQs in healthcare.

However, training records did not indicate when staff had completed updated training. We found it difficult to assess staff training levels because related documents were poorly maintained. This showed the registered manager was not able to track when staff training was missing or out-of-date. The management team reassured us this would be addressed.

We looked at four staff training records. We found one staff member had received information on only movement and handling and infection control. Another staff member only had training in fire safety and safeguarding in March 2011, as well as recent movement and handling guidance. The other two staff files indicated nutrition and first aid had been provided for one staff member and health and safety, end of life care and first aid to the other individual. A visiting District Nurse told us, "I think there's a real issue with training and staff experience and continuity of care. Some staff are good, some not so good. I often have to repeat information to make sure staff understand. Even basic care tasks some staff don't understand. So the training needs to improve."

Training records did not match the training matrix in place at the home. Files indicated the majority of training had been delivered by staff employed at the home, such as the handyman and senior staff. We were unable to confirm what accreditation they had received in order to provide this training. This meant people were at risk from inappropriate care because staff had not consistently received adequate, up-to-date guidance from a suitable training provider.

This is a breach of Regulation 23 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because staff were not adequately trained to effectively meet people's needs.

The Local Authority had recently carried out a safeguarding investigation into how the home had dealt with a medical emergency. Poor staff training was identified as a contributory factor to failures at the home. The registered manager told us the external company used to deliver training for staff was no longer able to do so and another training provider was urgently being sought.

Staff told us they received regular supervision and appraisal to support them to carry out their roles and responsibilities. Supervision was a one-to-one support meeting between individual staff and a senior staff member to review their role and responsibilities. A staff member told us, "I have supervision every month. I find it helpful to raise any issues or concerns. It's good learning to develop ourselves and work better." Records confirmed staff had opportunities to discuss issues they had and to explore their professional development.

We saw evidence that people or their representatives had signed consent to their care and support. Care records contained people's preferences about, for example, daily routines, food and fluid choices, retirement times at night and activities. The registered manager told us, "Care is about improving people's lives and seeing people be free to do what they want to do." A staff member told us, "Everybody has a choice and I have to get to know people and their needs so I can help them." However, we observed some practices where people's preferences were not taken into consideration.

We observed sliding bolts were in place high up on the outside of bedroom doors. The placement of such devices would allow other people or a member of staff to lock the occupant in their bedroom. Under such circumstances people would not be able to leave their bedrooms. We asked staff why these locks were located on people's doors and were informed this process was for the protection of people. However, this potentially placed people's freedom to move about the home at risk of severe and unnecessary limitation.

The management team had ensured policies were in place in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA and

Inadequate

Is the service effective?

DoLS provide legal safeguards for people who may be unable to make decisions about their care. We spoke with staff and the registered manager to check their understanding of the MCA and DoLS. A staff member told us, "This is about not forcing someone. It's about giving residents choice and explaining and encouraging them. If a resident refuses medication, for example, we record this and inform the GP. We would also monitor that person."

We were told there was one authorisation in place to deprive a person of their liberty in order to safeguard them. We were not notified about this and requested the registered manager send us a statutory notification immediately. However, following this inspection we had still not received this information. The registered manager had failed to notify the CQC about the approved application. This meant people were at risk because the provider had not enabled the Commission to fully carry out its regulatory duties.

The DoLS application related to closely monitoring one person who lived at the home to minimise the risk to the individual from falling. However, we noticed on two occasions the person was walking unsupervised in high-risk areas of the home, including the main staircase. There were no records of checks carried out on this individual. The DoLS record highlighted risk assessments should be completed. We found no evidence of this in related care records. This demonstrated staff were not always protecting the individual because relevant aspects of their authorised DoLS application had not been followed.

During our inspection we found a breach of an individual's liberty. This person was distressed and unable to get out of bed because inappropriate bed rails and a commode were in place to prevent them from doing so. The bed rails in place were not designed for the bed they were attached to and placed the person at risk from injury. We saw no records authorising the use of bed rails and the individual was unable to ask for assistance because their call bell was out of reach. We saw an entry in this person's care records stating that they did not wish to have cot sides in place. We found no other documentation demonstrating or updating this person's best interests. We told the registered manager to remove these bed rails and we have reported our concerns to the Local Authority safeguarding vulnerable adults team.

We observed the use of bed rails was widespread throughout the home. Records we checked held no evidence that people who occupied these bedrooms had documented risk assessments. This meant the registered manager had not protected people from serious injury and assessed their potential deprivation of liberty because records did not demonstrate individual risk assessments were in place.

We saw another person deprived of their liberty due to the positioning and type of seat she was sat in. The chair was positioned on carpet that prevented the individual from moving the chair away from the table in front of them. Had the individual attempted to move away there was a risk of the chair tipping backwards. This posed a health and safety hazard to this person.

This is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because suitable arrangements were not in place to ensure people's consent in relation to their care had been sought and acted in accordance with.

We reviewed care records to check how people were assisted to meet their nutritional needs. Records confirmed people were weighed regularly and screening assessments were in place designed to ensure malnutrition risks were monitored. However, we saw monitoring information was not always acted upon. One person's records showed they lost 4 kilogrammes between July 2013 and December 2013, but their nutritional risk assessment reviews consistently stated 'no change'. The concerning information was not acted upon until the person was referred to the GP on 30/09/2014. This meant staff were not always clear about people's nutritional support needs because effective monitoring and associated records had not been maintained. Identified issues were not acted upon in a timely manner.

We saw some people had food and fluid monitoring charts in place. However, we noted some of these were not filled in correctly. For example, we saw one person who had dried and cracked lips, but their fluid chart indicated they had ample fluids. This person told us, "I am so thirsty as I've not had anything to drink."

We were told the service had been awarded a five star rating following an inspection by the Food Standards Agency. However, this was in April 2013 and we saw concerns with the cleanliness of the kitchen. Equipment

and worktops were dirty and sticky residue was found in some areas. The fryers had thick grease around the edges and the cutlery trays, kitchen floor and windowsills contained ingrained dirt and debris. A staff member told us, "Areas are cleaned every week or so." There were no records in place to confirm how food safety and cleanliness was maintained. We found the majority of staff had not received training in food hygiene and safety. This demonstrated people were at risk from poor food hygiene because the registered manager had not ensured adequate numbers of staff were trained and processes were in place. We have informed the Local Authority food standards officer about our concerns regarding the standards of hygiene in the kitchen and the lack of staff training.

The notice board outside the dining room held information that contained a four week menu. This confirmed people were provided with a variety of meals. However, we observed the main lunch was not the same as that indicated on the menu programme. This demonstrated the programme was not followed and may confuse people who were expecting something else.

We joined people for lunch. One person told us, "The food is excellent." However, another person said, "The food is average, not like home cooking, but they do the best with the money they have to spend." We noted the mealtime was not a relaxed and social occasion to aid people's well-being and enjoyment. This was because it was noisy and staff were not well organised to serve and support people effectively.

We observed staff took 15 minutes to serve people their lunch. This meant some people who required support to eat were given a meal that was no longer hot. Food was not always cut up to aid people who struggled to eat. We noted some people's food had gone cold because there were not enough staff to support them in a timely manner. We did not observe staff encouraging or supporting people, where required, to wash their hands. This showed infection control measures were not followed to maintain food hygiene for people who lived at the home.

This is a breach of Regulation 14 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because people were not always protected against the risks of inadequate nutrition and hydration.

Care records confirmed staff engaged with social workers, GPs and hospital services, for example, to enable people to maintain continuity of their care. A member of staff told us, "When someone is not very well we inform the senior staff. We check their blood pressure, temperature, etc. If I'm worried I would ring the doctor and community care co-ordinator team. We record this properly."

Appointments and visits by professionals had been documented along with the outcome of these events. The home ensured people were supported to maintain their health by having access to other services. A visiting professional told us, "The home has improved a lot over the past 12 months and they are open to making improvements. Sometimes I have to repeat information because the staff don't always retain it or take on board what I've said."

We recommend that the registered manager checks and ensures the management team and care staff follow the Medicines and Healthcare Products Regulatory Agency guidance on the Safe Use of Bed Rails 2006 (Revised 2012).

Inadequate

Is the service caring?

Our findings

We observed staff sometimes interacted with people in a caring manner. For example, we saw staff spoke slowly and carefully with people to ensure they understood the information that was given. One person told us, "You couldn't ask for more. The staff are interested in you." Another person said, "The staff are very kind." A third person stated, "The staff are fabulous. I feel very well loved and cared for."

Our discussions about good levels of care with staff demonstrated they sometimes had an appropriate level of understanding. A member of staff told us, "I want clean clothes, nice hair and clean nails. If I want this, I know the residents do too. I make sure I give this to them." Another staff member said, "I enjoy my job. I love looking after our residents and helping them with their needs."

At other times we noticed staff were condescending when they spoke with people. For example, we heard staff using inappropriate language when addressing individuals who lived at the home. One person told us, "I'm so unhappy here." Another person's visiting friend said, "I have complained about [my friend] being left in a soiled pad, but [the registered manager] was negative." A visiting health professional told us, "It's not the best home, especially if I think about whether I would want my family member staying here."

Staff had limited understanding of how to engage with people who had restricted capacity to comprehend information. For example, we observed a person being offered Reiki and meditation. Staff gave an unnecessarily long explanation and the individual's response indicated they did not understand what was being communicated to them. This showed staff had failed to comprehend the best way to engage with this individual, who was not offered support that used a caring approach.

The communal toilet on the ground floor was situated in a main thoroughfare that accessed the lounge and dining area. There was no lock on the door and we frequently observed people and staff opening it and finding other people inside using the toilet, which was not conducive to their well-being. The registered manager had not planned and delivered care that met people's individual needs and maintained their welfare. Reasonable adjustments had not been made in service provision to uphold people's well-being and care needs. When we asked the registered manager why there was no lock on the door we were told that when there was a lock previously in place people with limited capacity often locked themselves in, so it had been removed. However, there had been no consideration of how this impacted upon people's welfare.

This is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because people were not safeguarded against the risks of receiving inappropriate or unsafe care.

We found care files contained an important document entitled 'Preferred Priorities for Care' that detailed people's end of life preferences. This was in easy read format and used descriptive pictures to aid understanding for people who may have limited capacity. These documents had been completed and signed by staff and the individual concerned, or their representative. However, not all forms had been reviewed frequently and we noted one had been completed without re-evaluation for over 12 months. Staff recorded on these documents that they should be reviewed annually. This meant people's wishes at the end of their life may not always be followed because staff had not regularly checked for any changes.

Care records did not always demonstrate people or their representatives had been involved in care assessment, planning and review. When we checked with people how involved they were with their care planning one person told us, "I do not know if I have a care plan." When we discussed ensuring people's human rights were maintained a staff member said, "People have rights and it's about respecting their rights."

We observed people's privacy and confidential information was not held securely. We saw breaches of people's confidentiality when we toured the building. For example, documents about people's weights, diets and pressure area care were held on a notice board in a thoroughfare by the dining room. When we pointed this out to the registered manager this information was removed immediately.

We further noted people's care records were stored in the main office, which was situated in between the main lounge and entrance lobby. We observed the office doors were constantly open, but the area was frequently unmanned. This meant anybody could access the office

Inadequate

Is the service caring?

and read people's personal information without staff being aware. People's confidentiality was not maintained because the registered manager had not ensured their information was securely stored.

This is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because people were not always involved in the planning of their care and did not have their privacy maintained.

Inadequate

Is the service responsive?

Our findings

The service provided care that was personalised to people's individual needs. We observed people were able to individualise their rooms. For example, personal furniture, photo frames and ornaments were in situ in people's bedrooms.

We were told the management team and staff responded to people's changing health needs in order to maintain their independence. One person told us, "The staff meet my needs at present." A relative said, "The staff could do more, but it cannot be perfect. They are doing a lot for [my relative] and are meeting [their] health needs."

People were supported by staff who were experienced and had some understanding of their individual needs. A staff member told us, "I am happiest when I can help people to help themselves." Another staff member said, "We communicate well. We check people's records, at handover and the communication book to make sure we keep an eye on people properly." This showed people's support needs were checked and staff responded to their changing needs.

However, care records we reviewed were not always consistent and held contradictory information about the people they concerned. For example, one person's information stated a preference about not being disturbed at night. However, we saw a form that indicated 15 minute checks were undertaken each night. This meant people were at risk from inappropriate support because conflicting information was contained in their care files.

There were gaps in people's care records. For example, important information about people's funeral requirements was not completed. All files we reviewed held a form that was designed to evaluate causes of falls and to limit their recurrence. However, the sections that recorded actions staff had undertaken were all blank. Record-keeping did not always follow national guidance because documents were not always signed and dated by staff. People were at risk from unsuitable care because the registered manager had not ensured their records were adequately maintained.

Ongoing records of people's progress were limited and not always informative of their general health and well-being. We saw information was missing in another person's daily notes and documentation of their pain management was poor. Records were not always checked and reviewed regularly.

A visiting professional told us, "I bring the tools for the home to make improvements in evidence-based best practice. This includes the Body Mass Index, food charts, falls records, etc." However, we noted staff were not always effective in utilising these important documents. For example, fall charts had important information missing and one person's bowel chart had not been completed since 17/11/2014. The individual's care records stated on 05/11/2014 that bowel movements must be documented. Helpful tools to assist in the monitoring of people's health were not consistently maintained.

This is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because people were not safeguarded against the risks of receiving inappropriate or unsafe care.

The registered manager told us that call bells went on to an emergency ring if they had not been answered by staff after 3minutes. The registered manager said this was, "To ensure staff are answering them as quickly as possible. If people need the toilet I want to know staff are responding to ensure residents are able to go when they want to." However, we observed call bells were frequently ringing for long periods throughout our inspection before they were answered. We noted the system of when the call bells went on to emergency ring occurred regularly whilst we were there. We noted that the registered manager did not act on this during our inspection. We also heard people using alternative methods to seek assistance, such as banging on radiators and shouting out. This demonstrated people had to wait for some time before staff responded to their needs.

Information on the notice board outside the dining room highlighted a daily programme of activities. This included bingo, entertainers, outings, games, quizzes, physical exercise and parties. A poster highlighted staff were arranging a forthcoming Christmas party and external entertainers. We observed Reiki sessions were being provided to aid people's relaxation and spiritual well-being.

People and their representatives did not agree adequate activities were offered to meet their needs. One person told us the Reiki session, "Was a load of rubbish. No-one asked me what I wanted to do. I'm not happy here as there is nothing to do. A while ago there had been a computer course and I had really enjoyed it. I wanted to do another one, but nobody listened to me." Another person said, "I'm not very sociable. It's not always a joyful place down there." A third person stated, "My hobbies and interests are not

Inadequate

Is the service responsive?

met". A relative told us, "The residents never do much. They don't cater for dementia." This indicated some people's mental health needs and well-being were not always maintained because adequate provision of activities was not in place to stimulate people. We asked the registered manager to review this information with people who lived at the home and their representatives.

We looked at how complaints were addressed by the registered manager. One person told us, "I am quite content as I have nothing to complain about really." Another person said, "If we have a complaint we are able to voice it." However, there was no system or formal records in place to demonstrate how complaints were acted upon. The registered manager told us policies were reviewed every year. However, we found the complaints policy had not been updated for ten years. The policy identified the use of complaints forms, which were no longer in use, and referred to the 'Commission for Social Care', which does not exist.

There were no timescales in place for responding to the various stages of a complaint. Information made available to people to explain how they could make a complaint if they chose to was also out-of-date. This meant the registered manager did not have an up-to-date and effective system in place to assist people to comment on the service they received.

We looked at complaints the management team had received. We saw no recorded evidence of investigations carried out or actions taken. We were unable to confirm the management team had undertaken a review of complaints or followed them up to check if issues had been comprehensively addressed.

This is a breach of Regulation 19 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because there was no effective system in place to handle and manage complaints in order to reduce or prevent the impact of unsafe or inappropriate care.

Inadequate

Is the service well-led?

Our findings

On our arrival we noted incorrect and out-of-date information about the service's registration was held on notice boards at the entrance. For example, certificates highlighted the service still provided nursing care, which was no longer the case. This demonstrated people may be misinformed about the type of service that was provided. The registered manager told us, "We've worked towards our registration changes and for me to register as manager with CQC. Now it is about turning the building around and making it into a five star hotel. Standards do need to improve and we recognise this. Our drive now is spending time on personalising care and looking at what our residents want."

We discussed the working culture and atmosphere within the home with staff and people who lived there. We received mixed information about this. One person told us, "I see the manager quite a lot. She's always doing office work. She runs it efficiently as far as I know. You can always talk to her and she's on the ball." However, we spoke with another person who had been admitted to the home over the last few weeks. The individual was not aware of who the registered manager was and referred to a staff member, whose designated role was the floor manager, as the 'boss'.

One staff member told us, "The management are supportive." However, another staff member said, "Management is so-so. New staff don't want to stay long. Staff are not always respected, regardless of whether they are a cleaner or whatever. The floor manager is a very hard worker and very supportive. Some staff are not approached very well by the manager." This indicated the service may not always be well-led because the registered manager was not widely seen as open and visible within the home.

We checked how the management team monitored the quality of the service provided to people who lived at the home. Quality assurance was poor and inconsistent. Audits in place did not pick up issues we found in the care provided for people, care records, health and safety, infection control, food hygiene and training. For example, staff were using another service's infection control audit that was designed for a hospice. Much of this audit was not relevant and the document was not localised or intended for the needs of staff and people who lived at the home. Issues we found with infection control had not been identified by the audit that was in place.

We discussed audit systems with the registered manager and found the management team did not have a clear picture of monitoring the quality of care delivery, recording processes and individual responsibilities. This meant people were at risk from unsafe care because the registered manager did not have effective systems in place to monitor their safety.

The registered manager had sought the views of staff who worked at the home as a way of checking the quality of care provided to people. Comments from the survey dated 16/10/2014 were mixed. For example, some staff said: "I enjoy working with other staff" and "Other staff are very helpful". However, other staff stated: "Sometimes I don't know what job I should do first because I have been asked to do so many things"; "More training"; and "Due to the nature of the job there never seems enough time to finish the required tasks before other problems present themselves." We were unable to check how the registered manager acted upon staff comments as a way of improving the quality of care because there was no documented evidence to confirm this took place.

We looked at how people were enabled to feedback about the service they received. One person told us, "They treat me with respect because I can voice my opinion." We were also told people's views were sought from resident meetings and a comments book was held in the entrance lobby.

We were shown survey forms dated September 2014 from people who lived at the home or their representatives. However, we noted the majority of these were completed in the same hand-writing and asked the registered manager about this. We were told a staff member had spoken with people individually and completed the forms on their behalf as they were unable to do so themselves. This demonstrated people would be unable to feedback anonymously when completing surveys if they chose to. We were unable to check how the registered manager acted upon people's comments as a way of improving the quality of care because systems in place were limited and not always effective.

The registered manager told us the service's gas and electric safety certification were up-to-date. However, she was unable to provide recorded evidence of this at the time of our inspection. We requested these be sent to us within 48 hours of the inspection, but we did not receive this information. The registered manager informed us after the

Inadequate

Is the service well-led?

inspection that electrical safety certification was out-of-date. This meant people were at risk from unsafe care because the registered manager had not monitored and maintained important environmental health and safety processes.

This is a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because people were not protected against the risk of receiving inappropriate or unsafe care by the means of an effective quality assurance system.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse The registered manager had not always ensured care practices and associated records kept people safe. The registered manager had failed to protect people from excessive and unauthorised restraint.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs An identified risk associated with malnutrition was not responded to in a timely manner. People did not receive meals quickly enough to maintain their health and well-being. The kitchen was dirty and there were no cleaning records. Food hygiene was not always effectively managed and staff had limited training.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services One person told us they did not know if they had a care plan. Care records did not always indicate people or their representatives were involved in care planning and review. People's recorded preferences were not always followed. People's privacy was not maintained because their confidential information was not stored securely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints

This section is primarily information for the provider

Action we have told the provider to take

There was no system in place to review and follow-up on complaints. The registered manager had failed to ensure procedures were effective and up-to-date in order to enable people to complain.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff Training records were inconsistent and certificates indicated staff had minimal training. Training was provided by other staff who had no training to do so.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services Records contained limited or no risk assessments and had missing and conflicting information. The ground floor toilet did not have a lock on it, failing to protect people's welfare. People's recorded preferences were not always followed. Staff did not effectively engage with people with limited capacity in a way that aided their understanding.

The enforcement action we took:
We have issued a Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The registered manager did not have effective systems in place to check the quality of the support people received. There was no evidence that the registered manager acted upon identified issues from staff and service user satisfaction surveys. The management team did not have a clear picture of quality assurance and individual responsibility.

The enforcement action we took:
We have issued a Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control We found infection control record-keeping was poor and cleaning schedules were not in place. Related staff training was poor. We found areas of the home were dirty and observed poor hygiene and food safety practices.

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
We have issued a Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines There were not enough staff trained to administer medication. Staff were not kept up-to-date with current information and did not always follow record-keeping guidelines. Staff did not always follow instructions to ensure people were safe and did not concentrate on one person at a time when administering medication.

The enforcement action we took:
We have issued a Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises Accident and incident management was poor. We found concerns with environmental health and safety, fire safety and premises security.

The enforcement action we took:
We have issued a Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment Where people's freedom was restricted, the registered manager had failed to evidence their consent and best interest decisions.

The enforcement action we took:
We have issued a Warning Notice

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Accommodation for persons who require nursing or personal care

Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing

The registered manager had failed to ensure there were enough staff to meet people's needs in a timely manner. People and staff told us staffing levels were insufficient. People who received medication were not continuously monitored because there were insufficient numbers of skilled staff.

The enforcement action we took:
We have issued a Warning Notice