Greasbrough Residential and Nursing Home

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Inspection report

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Ratings

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

Overall summary

This inspection took place on 10 and 11 March 2015 and was unannounced on the first day. The home was previously inspected in October 2014 where we found the service was compliant with the regulations we looked at.

Greasbrough Nursing Home is a care home providing accommodation for older people who require personal care and nursing care. The home is a two storey purpose built property situated close to local shops and facilities. It provides accommodation for up to 60 people whose main needs are those associated with old age, including people living with dementia.

The home had a registered manager. 'A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like

Summary of findings

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.

While most people said they were very happy with the service and praised the staff very highly, some also raised a number of concerns. Our observations and the records we looked at did not always match the positive descriptions some people gave us. We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in that people's health and welfare needs were not always met, infection control measures were not satisfactory, people were not always respected or involved in making decisions, we found at times there were not enough staff on duty to meet people's needs and the quality monitoring of the service was not always effective.

People were protected against the risks associated with the unsafe use and management of medicines. Appropriate arrangements were in place for the recording, safe keeping and safe administration of medicines. We found new systems had been introduced but these still needed to be embedded into practice.

People were protected against the risk of abuse. The provider had safeguarding policies and procedures in place to guide practice. Staff we spoke with were aware of procedures to follow including whistleblowing if it was necessary.

There were not always enough staff to meet people's needs. People who lived at the home told us they did not think there was enough staff on duty to meet their needs. One person said, "I have to use my buzzer to get help when I need to go to the toilet. Sometimes I can be ringing for ages before anyone comes. Sometimes it's too late by the time they come and I'm in a right mess."

People were not always protected against the risk associated with infection prevention and control. The systems in place were not effective in ensuring the service maintained standards.

Staff understood the legal requirements of the Mental Capacity Act (2005) Code of Practice. The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including balancing autonomy and protection in relation to consent or refusal of care or treatment. However, during our inspection we saw staff did not always document how best interest decisions were made to assist decision making for people who lacked capacity to be able to make the decision.

Care plans identified people's needs, and their needs had been reviewed, however the care plans were not up to date. They did not clearly detail people's changing needs. We also observed people's privacy and dignity was not always maintained and there was not always evidence that people were involved in making decisions. There was also lack of stimulation and activities.

There were robust recruitment procedures in place; Staff had received formal supervision although this was not in line with the provider's policy. Staff told us they felt supported. Some staff had received an annual appraisal and others were being organised.

The registered manager told us they had received no formal complaints since our last inspection, but was aware of how to respond if required. However people we spoke with told us they had raised concerns, the registered manager had dealt with them but these were not recorded. This did not evidence that the registered manager had responded appropriately and listened to people.

We found best practice guidance was not always followed for people living with dementia in respect of the environment. Although this had been recently redecorated the colour scheme was very neutral with walls and doors very similar colours. This is not conducive for people living with dementia.

There were systems in place to monitor and improve the quality of the service provided. We saw copies of reports produced by the manager and the provider. The audits included infection control, environment, and yearly quality audits. However, the systems were not always effective.

You can see what action we told the provider to take at the back of the full version of the 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.

Appropriate arrangements were in place for the recording, safe keeping and safe administration of medicines. Although new systems had been introduced these needed to be embedded into practice.

There was not always enough staff to provide people with individual support required to meet their needs.

Infection prevention and control measures in place did not always protect people.

There were robust recruitment procedures in place. Staff were knowledgeable on safeguarding procedures and procedures had been followed.

Is the service effective?

Requires Improvement

The service was not always effective.

Mental capacity assessments had taken place in line with The Mental Capacity Act 2005. However best interest's decisions had not been documented to show how decisions were made for people who did not have the capacity to make them.

A well balanced diet that met people's nutritional needs was provided. However, the experience for some people was not pleasant as staff failed to manage situations appropriately when people presented with behaviours that challenged.

Staff had received formal supervision although this was not in line with the provider's policy. Staff told us they felt supported. Some staff had received an annual appraisal and others were being organised.

Best practice guidance was not always followed for people living with dementia in respect of the environment.

Is the service caring?

Requires Improvement

The service was not always caring.

People's dignity was not always maintained and we did not always see people were supported to be able to express their views and involved in making decisions.

Some people and their relatives told us they were not always happy with the care provided. This was mostly regarding lack of stimulation and activities leading to isolation.

Summary of findings

Most people praised the staff and we found they were kind, caring and showed compassion. However some of our observations showed people were not treated with respect and their dignity was not maintained.

Is the service responsive?

Requires Improvement

The service was not always responsive

People's health, care and support needs were assessed and reviewed. However, we found the support plans did not always reflect the person's changing needs. This meant staff were not always aware of people's needs and how to meet them.

The manager told us they had not received any complaints since our last inspection. However, we found a number of concerns and issues had been raised by relatives. We found these were not documented to show any action taken. There was no evidence to show people were listened to and issues resolved.

Satisfaction surveys were used to obtain people's views on the service and the support they received. Residents' and relatives' meeting took place.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a registered manager in post.

People were put at risk because systems for monitoring quality were not effective. For example, audits to monitor infection control had not identified the issues we found.

Monitoring of accidents and incidents was not effective, it had not identified the times of the incidents to identify issues that needed to be resolved.

Staff and residents' meetings took place. Staff we spoke with felt supported and told us the registered manager was very good.

Greasbrough Residential and 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.'

This inspection took place on 10 and 11 March 2015 and was unannounced on the first day. The inspection team was made up two adult social care inspectors 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.

Before our inspection we reviewed all the information we held about the service. The provider had not completed a provider information return (PIR) as we had not requested one. The pre-inspection information pack document is the provider's own assessment of how they meet the five key questions and how they plan to improve their service.

We spoke with the local authority, commissioners, safeguarding authority and Doncaster CCG. The local authority contracts officer also visited the service on the second day of our inspection.

At the time of our inspection there were 56 people living in the home. The service consisted of two floors accessed by a passenger lift.

As part of this inspection we undertook a Short Observation Framework for Inspection (SOFI) SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spent some time observing care in the lounge and dining room areas on both floors to help us understand the experience of people who used the service. We looked at all other areas of the home including some people's bedrooms, communal bathrooms and lounge areas. We looked at documents and records that related to people's care. We looked at six people's support plans. We spoke with 16 people who used the service and 7 relatives.

During our inspection we also spoke with 11 members of staff, the deputy manager, the personal care lead, the registered manager and the provider. We also looked at records relating to staff, medicines management and the management of the service.

We also spoke with visiting professionals, including a district nurse who had been delivering training.

Inadequate

Is the service safe?

Our findings

People who lived at the home and their relatives we spoke with told us they felt safe and did not have worries about any of the staff or other people who used the service. One person told us they did not like the fact that another person was able to enter their bedroom at night. This person did not feel unsafe when this happened, but felt anxious until staff were summoned and were able to lead this person out of their bedroom.

People told us, "The staff are brilliant. They just need more of them." another person said, "I don't like to make a fuss when I have to wait a long time for help because I know all the carers are working as hard as they can."

People were protected against the risk of abuse. The provider had safeguarding policies and procedures in place to guide practice. Staff we spoke with were aware of procedures to follow including whistleblowing if it was necessary. All staff we spoke with told us they had received training and would not hesitate to report any suspected abuse immediately.

Five people who lived at the home told us they did not think there were enough staff on duty to meet their needs. One person said, "I have to use my buzzer to get help when I need to go to the toilet. Sometimes I can be ringing for ages before anyone comes. Sometimes it's too late by the time they come and I'm in a right mess." Another person said they would like to have two showers a week, but often this would only happen once a week, due to staff shortages. This person said "It's happened this morning. I've been told I can't have my shower because they're short staffed, so I've got to wait until my next slot on Saturday. I don't think that's right." Another person said "You have to be patient here. They (the carers) tell you they've got lots of people to look after." Another person we spoke with who was in bed told us they didn't like to stay in bed but had to wait for staff to be free to hoist them up into the chair. They said, "I sometimes have to wait a long time it depends how busy they are, but I am normally up by lunchtime."

Five relatives we spoke with told us they thought there were not enough staff on duty at all times to provide appropriate care for their family member. One relative told us they, or another relative, would assist their family member at meal times as they did not think there were enough staff on duty to provide sufficient support for their family member. This relative said "I feel sorry for the staff at mealtimes because they're all so busy trying to make sure everyone gets fed. I try to help out when I can." Another relative told us they were relieved that their family member no longer needed to eat their meals in their bedroom as they were concerned they would not get appropriate support with their meals in their bedroom. Another relative said "I don't think there are enough staff, especially after breakfast. My relative needs a hoist to get to the toilet, which takes a while and there aren't enough staff to sort them out. I know my relative gets agitated about this and it's upsetting for me."

Staff we spoke with told us at times there was not enough staff on days when short notice sickness occurred and couldn't get the shift covered. However they told us from 7pm when the night shift commenced this could be a busy period as the staffing numbers decreased, but there was still people up. A large number of people required the assistance of two staff for personal care. We discussed this with the registered manager and provider who told us they had been reviewing the staffing and intended to increase the staffing from 7pm until 10pm to be able to meet people's needs. This will commence on 1 April 2015. When we looked at incidents and accidents recorded we found in January and February 2015 a high number of incidents occurred during these hours. Out of 15 incidents recorded in January 2105, 11 had occurred after 7pm and 9 incidents out of a total of 14 in February 2105 had occurred after 7pm. This meant insufficient staff during these hours put people at risk.

Before our inspection, we asked the local authority commissioners for their opinion of the service. They told us they had some concerns and were regularly monitoring the service. The contract monitoring officer also attended the service during our inspection and conducted their monitoring visit the day after our inspection. Following this visit they told us they had met with the local authority commissioners as they had concerns. They said their action plan remained unmet and some of the actions such as a lack staff to provide activities and stimulation for the people who used the service had been on-going for some time without improvement.

They also had concerns that the registered manager worked many shifts and was included in the numbers and therefore did not always have time to fulfil their role as the manager. The registered manager told us that this would

Is the service safe?

be resolved as there was now a new deputy manager, who once their induction was completed would ensure that office hours were covered by either themselves or the deputy.

The staffing rota we were shown recorded for March 2015 that the registered manager was working ten days covering the shifts and had five days to complete the registered manager duties. Although this increased on the rota we were shown for April 2015. The lack of the registered manager or deputy available Monday to Friday put added pressure on other staff when health care professions, GP's or other workers attended the service. There was also no administrator so when no management was available staff who were caring for people would have to always answer the phone, deal with visiting professionals and relatives. This meant people's needs may not be met due to the number of staff on duty.

This was a breach of Regulation 22 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who lived at the home and relatives we spoke with told us they thought they, or their family member, received their medications appropriately and on time. People were not always sure what their medications were for, but told us they trusted the staff to give them what they needed. One person said, "It's the doctor who tells them (the staff) what I need." People we spoke with who lived at the home told us that if they were in pain, the staff would tell a nurse or senior carer and they would be given painkillers.

Medicines were stored safely, at the right temperatures, and records were kept for medicines received and disposed of. The registered manager had recently changed the supplying pharmacy for the medicines. The new systems had commenced three weeks before our inspection. We found people received their medicines as prescribed. However, we saw some errors in recording carried over stock and staff had not always signed to evidence they had checked the amounts received were accurate. The registered manager told us this would be audited at the end of the first cycle, which was the week of our inspection. They told us errors would be discussed with staff to ensure the new systems were embedded into practice. We also found insufficient detail for medicines prescribed for 'as and when required'. For example one person who lacked capacity to be able to verbally tell staff when they were in pain, did not have a protocol in place. This would give staff guidance on how the person presented when they were in pain to be able to give pain relief when required. The registered manager devised a protocol format during our inspection and assured us these would be implemented by staff immediately.

We looked at eight staff recruitment files including one nurse, care staff, cook, domestic staff, and activity co-ordinator. We found that the recruitment of staff was robust and thorough. Application forms had been completed, two written references had been obtained and formal interviews arranged. All new staff completed a full induction programme that, when completed, was signed off by their line manager. We looked at a completed induction which matched the 'Skills for Care' induction standards.

The registered manager told us that staff at the service did not commence employment until a Disclosure and Barring Service (DBS) check had been received. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with vulnerable adults. This helps to ensure only suitable people were employed by this service. The registered manager was fully aware of their accountability if a member of staff was not performing appropriately.

We carried out a tour of the building to determine that people were cared for in an environment that was clean and hygienic. We found the communal areas and bedrooms were all maintained to a high standard of cleanliness. Most bedrooms were well furnished and personal possessions were displayed. Most of the relatives and people who lived at the home that we spoke with told us that their bedrooms were always clean and well presented. One person said "I love my room. It's so bright and clean – and I've got a good view." One relative said "I think my relative's room could do with a good spring clean. I think it's called a deep clean now."

However, we found some areas were not well maintained. We found shower chairs, bath chairs and commodes were dirty and two were encrusted in old faeces on the underside of the chair. We also saw that the cleaning trolleys were engrained in black filth and several wheelchairs being used by people who used the service were dirty and food stained. These issues were actioned immediately by the domestic staff.

Inadequate

Is the service safe?

We found mops were stored in buckets wet so they were unable to dry thoroughly which could cause risk of cross contamination. Mops should be inverted to ensure they dry thoroughly.

We found the cleaning schedules did include these areas and it was not clear who was responsible for the cleaning of the shower and bath chairs. The Housekeeper added this onto the domestic's cleaning schedule and assured us these would be cleaned every day by the domestics. The registered manager told us that staff would be told they needed to ensure after every use they were also cleaned.

We found the cleaning schedules lacked detail; they did not describe what needed cleaning in each area, how to clean them or what do if they were unable to be cleaned. The housekeeper agreed they would be written with more detail to ensure all areas were cleaned and maintained so people were protected from risk of cross infection.

We also found there was no colour coded equipment used for different areas. For example different colour clothes for clean and dirty areas to prevent cross infection. We also found bleach was used; this was decanted from the large container into a small spray bottles this put staff at risk of injury. We found the bleach was also stored on the cleaning trolleys, which were left unattended at times in communal areas available to people who used the service. People living with dementia may not have the capacity to understand the risk associated with bleach and could put them at risk of harm. This practice stopped immediately when it was discussed with the registered manager and the housekeeper.

We identified the service did not have a mechanical sluice, used to wash and disinfect commode pots. The staff told us these were washed by hand in the sluice rooms. When the staff were asked how they cleaned them they said they just used water. This will not clean them effectively and put people at risk of cross infection. There was also no rack in the sluice to ensure the pots and urine bottles dried effectively.

When we spoke to the housekeeper regarding cleaning fluids they told us they used one chemical, it was not clear if this was suitable for all cleaning required in a care home. We were also not able to ascertain from the information shown if the chemical was effective for the use when a person had a known infection.

We also saw that in bathrooms and toilets there were no paper hand towel dispensers. The hand towels were stored on top of the toilets. This meant they could be contaminated from spray when people used the toilet and wash hand basin.

This was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (1) (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

People who lived at the home and relatives we spoke with told us they thought the staff were well trained and competent to do their jobs. One relative said "My relative needs a special medical procedure and a doctor from the hospital and a nurse came to train certain staff to be able to do it. That's such a relief for me to know its being done properly."

One relative told us they had experienced problems with their family member's frequent urine infections and had to stress to care staff the need for more frequent and regular drinks. Staff had taken this on board and the infections had stopped.

People we spoke with told us the meals were good and they always had something they liked to eat. One person said, "It's very tasty and I look forward to my meals," another person told us, "I think the cook is very good here. I've not been disappointed yet." Another comment was, "When you're sitting around all day you look forward to your meals and they're very good."

We observed lunch in the dining rooms and meals being served to people in their bedrooms. The food was well presented, warm and appetising. The portions served were large; some people told us the portions were too large. There were several people needing their meals in their bedrooms but there was only one care worker serving the meals in bedrooms upstairs and some people needed full support with their meals. We saw that one person who required a protective apron was not offered one. Some people waited a long time for their meals. Sponge and custard desserts were served from a cold trolley, so for people having meals in their rooms the dessert could be cold by the time they were ready to eat it. Most of the people we spoke with told us they had enjoyed their lunch.

Some relatives we spoke with told us the home would provide them with a meal if they wanted to spend a meal time with their family member. They valued this service and they told us that when they had eaten the meals they were good.

People who used the service that we spoke with told us they thought they had enough drinks throughout the day. We saw that there were jugs of squash available in the communal lobby area and in people's bedrooms. We saw that some people, including people who spent all their time in their bedrooms, would not have been able to serve themselves with squash as the jugs were too heavy. We saw that some people asked care workers for a warm drink during the morning and afternoon and they were given warm drinks. However, other people who were not able to communicate were not offered drinks at the same time. Three people told us they regularly asked for a cup of tea in the afternoon. One person said "There's always tea there if you want it. You just have to ask." One relative said "I don't like sitting in the lounge and getting my family member a cup of tea when I visit, because other people don't get one and that doesn't feel right to me. Se we go to my relative's room."

We saw that some people had purchased fridges for their bedroom and kept snacks in them. One person said "My family bring me treats in because I don't always eat everything at mealtimes." We saw that one person had a lot of snacks in their bedroom. They told us they liked snacks.

We used SOFI during lunch. We continued to observe how staff supported people throughout their meal. The nurse sat with one person we observed and encouraged the person to eat their lunch. However as soon as the nurse moved away the person became agitated and began throwing cutlery across the dining area. The agitation escalated and the person began grabbing at other people's meal. Another member of staff brought yoghurt to the person and gave assistance. Again as soon as the staff member had moved away the person began spitting the remains of the sweet out of their mouth. This went un-noticed by the staff that were present in the dining room. This meant the person's needs in relation to receiving adequate nutrition were not met.

We spoke with the cook about people's likes and dislikes regarding the food choices. The cook told us that they were informed of this when people were admitted into the home. The information also provided the kitchen staff with any special diets or supplements required to boost people's nutritional intake. We looked at the menus which were well balanced and we saw the food looked nicely presented to encourage people to eat who had poor appetites.

Our observations over lunchtime showed people's experience could be improved. Most people were wearing blue plastic aprons. Some people were not asked if they wanted to wear the apron to protect their clothing. The dining room was so congested with wheel chairs and

Is the service effective?

people in profile chairs it made it difficult for staff and people to move around. Some people who were sat at the farthest away from the entrance had to wait for up to 30 minutes after finishing their meal to leave the dining room as they could not get past others who were still eating. The meal times we observed were disorganised and was not a pleasant experience for people who used the service.

The menu for lunch was not displayed on all tables. The cook told us it was on the wall outside of the dining room. When we looked at it the print was far too small for people to read it and it was not at a height that many of the people living at the home could have seen it.

We looked at staff records used to record supervisions these showed staff had not received supervision (one to one meetings with their manager) as described in the supervision policy. The policy said 'staff should receive formal supervision once every two months'. On the staff files we looked at regular supervisions were dated 2010. The registered manager showed us another file with more up to date supervisions which confirmed that most staff had received one recent supervision. Staff we spoke with told us they felt supported to do their jobs and the registered manager was very approachable. They told us if we wanted to discuss something or organise supervision they only had to ask.

The registered manager had commenced annual appraisals, and showed us a schedule that told us when appraisals would be completed. Annual appraisals provide a framework to monitor performance, practice and to identify any areas for development and training to support staff to fulfil their roles and responsibilities. Staff we spoke with said they received formal and informal supervision, and attended staff meetings to discuss work practice.

The registered manager told us that the nursing staff attended specific training which ensured they could demonstrate how they were meeting the requirements of their nursing qualifications. For example nurses working at the home had recently completed syringe driver training and they received regular updates regarding end of life care from the local hospice.

Staff had attended training to ensure they had the skills and competencies to meet the needs of people who used the service. The records we looked at confirmed staff had attended regular training in areas of health and safety, moving and handling and fire training. We were informed that staff were booked on refresher training provided by the local authority in the role of the alerter for safeguarding adult. Most of the staff who worked at the home had also completed a nationally recognised qualification in care to levels two, and three.

We spoke with the registered manager about the training that staff had received to ensure they had the skills and knowledge to meet the needs of people living with dementia type illnesses. He told us that some staff had received dementia awareness training but this was an area that required further development. The training plan showed that only one nurse and two care staff had completed dementia awareness training. Staff had not received training to help them understand behaviours that may challenge others. From our observations staff did not demonstrate that they were able to offer any interventions to divert people who became agitated. For example one person continuously shouted for assistance and a drink. The person was waving their arms to attract the attention of staff. We saw that staff offered minimal assistance when passing. One staff member of asked if they wanted a drink but then did not return with the drink for the person. Another staff offered a drink which was fruit juice but did not stay with the person who then threw the drink across the lounge. Fifteen minutes later a staff member sat with the person and talked to them which helped the person become less agitated.

Staff we spoke with told us the training was good. However all told us they would like to receive training in dementia awareness to be able to fully understand people's needs who were living with dementia type illnesses.

We found the home did not lend itself to people at the home with a dementia type illnesses. Corridors and doors were all painted the same colour which meant people would find it difficult to locate a bathroom or toilet. Handrails were the same colour as the walls making them hard to see for people who were visually impaired. Signage around the home was poor for bathrooms and toilet; some had a very small picture of a toilet. Bedroom doors were not personalised, very few had their names on them, just the bedroom door number. We did not see any sensory areas, sensory displays, reminiscence areas, rummage boxes, posters/ pictures, photo boards or resources that would make the environment more appropriate, accessible and enjoyable for people living with dementia.

Requires Improvement

Is the service effective?

Best practice guidance the Environmental Assessment Tool' from Kings fund 2014, suggests that having different colours on walls and doors makes it easier for people living with dementia to locate things.

We saw there was a courtyard space outside that had potential to be an attractive and safe place for people to sit in and walk around during good weather. One relative said "I was very disappointed with the courtyard last summer. There were no colourful flower pots and only a few chairs out there. Hardly anyone came out to enjoy the sunshine. I'm sure there just weren't enough staff to help people get outside." Another relative said they had spoken to the owner of the home about the fact that only a few people used the courtyard in the summer. The owner had replied that most people did not like sitting outside. One person who spent most of their time in their bedroom room said "There's one thing I would like and that's to get out in the garden in summer. I can see it from my room if I stand by the window, but I can't stand up very well and it's not the same anyway, is it?"

Staff we spoke with had a good understanding of the Mental Capacity Act .The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including balancing autonomy and protection in relation to consent or refusal of care or treatment. Staff we spoke with were knowledgeable about this aspect of caring for people.

The MCA includes decisions about depriving people of their liberty so that if a person lacks capacity they get the care and treatment they need where there is no less restrictive way of achieving this. The MCA Deprivation of Liberty Safeguards (DoLS) requires providers to submit applications to a 'Supervisory Body' for authority to do so. As Greasbrough Nursing Home is registered as a care home, CQC is required by law to monitor the operation of the DoLS, and to report on what we find. The provider had reviewed people and was aware of the need to make some applications and was liaising with the supervisory body to determine when to submit the applications. The registered manager had submitted one application, which was waiting to be processed to ensure the person was not deprived of their liberty unlawfully.

We also found best interest discussions had taken place or been documented for some people who lacked the capacity to make decisions. However these had not always been completed appropriately as the decisions had not been clearly documented to ensure best interest decisions were assessed following the legislation. The registered manager assured us this would be rectified and any future decisions required would have clear documented evidence of how the decision was made and why.

Requires Improvement

Is the service caring?

Our findings

All of the people who lived at the home and the relatives we spoke with told us that the care staff were kind, compassionate, caring and respectful. People were very complimentary about the care staff. One person told us, "All of the carers here are lovely." Another person said, "The care workers here work so hard. They do 12 hour shifts and they're usually still smiling at the end of the day." Another comment was, "I've got nothing but admiration for these staff."

A relative we spoke with told us, "They try to be very reassuring for my relative and they help me too because I need support." Another relative told us, "We are very lucky to have these carers. They couldn't be kinder."

We observed most care interactions that were kind, friendly, respectful and patient. We saw care workers assisting people with their mobility needs without rushing and explaining what they were doing when transferring people to arm chairs. We saw care workers speaking kindly to people when assisting them with their meals. We saw care workers reassuring a person who was becoming distressed. We heard a nurse reassuring a relative, in a professional manner that care staff would carry out the revised care interventions they had agreed.

One relative told us they had recently had discussions around end of life care for their family member and that staff had been very kind and compassionate over this. They said "They (the staff) are just brilliant and it feels like they're part of the family."

People told us their privacy was respected and that care workers always knocked on their doors before entering. People we spoke with told us their dignity was respected and care interventions were carried out behind closed doors. However we observed some people's dignity not maintained for example, one person sat in the lounge was pulling their skirt up showing their continence wear. We saw no member of staff go to assist this person to maintain their dignity.

We saw many people who lived at the home who were well dressed and well presented. However we saw some people had food stained clothes and faces covered in food. We saw people had breakfast food stains on their faces when they came into lunch. Staff had not thought to clean their faces to maintain their dignity. One person we spoke with on the first day of our inspection wore food stained clothes and slippers. We had mentioned this to staff during our inspection. However, when we saw the person the next day at 10am they were wearing the same clothes. Staff had not assisted the person to wash or change therefore not maintaining their dignity. We asked if the person could be washed and changed. When we next saw them they had on a different top, however, their slippers were still covered in food debris, it was not clear if the person had received a wash.

We saw several notices in different people's bedrooms, written by relatives, explaining they would be taking laundry home, or giving instructions about care of their family member's clothes. One person who lived at the home said, "If there's one thing I'd criticise here it's the washing and ironing. Sometimes my blouses are so badly ironed I can't do up the buttons." One relative told us they regularly checked their family member's wardrobe and drawers because they sometimes found other people's clothes in there.

We spent one hour undertaking observations in the main lounge area of the home. We found some interactions were good but others were not person centred, for example one person became very anxious and we saw that staff asked what the problem was but only spent time to ask the question and did not stay with the person to try to calm them. The activity co-ordinator spent time trying to distract the person and gave them a drink. This appeared to calm the person down. Another person tried to stand up and walk several times during our observations, but was told to sit down by staff passing through the area. Staff did not offer to guide the person therefore restricting their movement. After lunch we observed two people asking staff if they could go outside for a cigarette. Staff replied, "Give me five minutes." Fifteen minutes passed and in this time another member of staff was asked to take them outside but replied, "I am busy with (another person)." The two people were eventually taken outside for their cigarette.

We also observed that if people asked for a drink they were given one. However, for people who were unable to ask they were not given a choice and they did not receive a drink. We also found peoples likes and dislikes were not

Requires Improvement

Is the service caring?

always recorded. There was a pen picture completed in each plan of care, however these were more about peoples medical conditions rather that what they liked and what choices they would like to take.

This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 10 (1) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

People who used the service and their relatives we spoke with told us that the manager and staff were very approachable. They also told us they thought staff listened to them and would carry out care tasks the way they wanted. One person we spoke with said, "I'm very independent and I like to do as much as I can for myself. They (the care staff) let me do that and just help me with the few things I can't do, like reaching my feet."

One relative said, "It's taken a while, but I think the carers know how to deal with my relative now. They've listened to my advice and I think it's working better now." A relative we spoke with was pleased that care staff had listened to them in regards to the care required and delivered. Another relative told us that after deterioration in their family member's condition, care staff had provided a new bed with rails and alarms, which was alleviating some of the previous problems.

All of the people we spoke with, including relatives, told us that staff would call a doctor if they or their family member was ill. One person said, "I was poorly before Christmas and they called a doctor straight away. I got some antibiotics and I felt much better for it." Another person told us they had regular visits from a podiatrist.

All of the relatives we spoke with told us the staff contacted them promptly and kept them informed if their family member was ill and needed a medical visit.

Some relatives we spoke with told us they had been fully involved in the care planning for their family members. One relative said, "I think I know everything I need to know about my relatives care and I've been involved all along." Another relative told us that although they had not been involved in care planning for their family member, they had been told they could see their care plan at any time and make comments.

Several people we spoke with chose to spend time in their bedrooms. One person said, "There's not much going on in the lounges, so I prefer to stay in here." Another person said, "I've got all my knitting and puzzles and books here, so I don't need to go out of my room. I'm not sure I'd find anyone to talk to anyway."

There was not much evidence of regular activities at the home, particularly for people living with dementia type illnesses. We saw a poster in the lobby advertised a baking class on Tuesdays, daily reminiscence sessions and talking newspapers. None of the people we spoke with could recall anything about the talking newspapers or reminiscence sessions. Some people and their relatives were able to recall evening activities such as entertainers and a Christmas party. Some people told us they enjoyed a twice weekly visit to the local church. One person said, "But they (the staff) need to have enough people to take us over there." People also told us that there was a church service at the home once a month, which many people, attended. None of the people who chose to spend time in their bedrooms could recall staff talking to them about preferred activities.

Relatives we spoke with told us they were made very welcome by staff when they visited. Several relatives told us they had not seen many activities taking place. One relative said, "I think there could be a bit more stimulation, especially for those folk with dementia. They just sit and go to sleep really." One relative said, "I always take my relative to their bedroom when I come because there's not much going on in the lounge and we can talk a bit better in the bedroom."

During our inspection we saw that a large group of people, predominantly people living with dementia type illnesses were sitting in the entrance lounge area, a large number were also sleeping. There was no stimulation or activities for people who sat in the lounge during our inspection. One the first day of our inspection a day time television talk show was on the television, no one appeared to be interested in the show. Although on the second day of our visit there was a film that people were watching. However, this was on very loud and one person said, "This is too loud although I like the film I am going to my room." Two people we spoke with had chosen to sit by the ground floor lounge windows. They told us they liked "to watch the traffic go by."

We saw that the care workers were very busy providing the personal care needed, but there was little time for social interaction with people who used the service. We noted that on the day of our visit, staff told us they were short staffed, so a member of the housekeeping team was supervising a large number of people in the entrance lounge area, from the reception desk. People we spoke with all told us they would like more activities. One person

Requires Improvement

Is the service responsive?

said, "The odd game of bingo would be good." Another person told us, "I have been asking for two days for someone to cut my nails and I am still waiting, it would be nice to have your nails done."

We discussed activities with the registered manager who said there was an activity co-ordiantor but they did other duties as well as activities. We did not see them delivering activities during our inspection. We did see an hour's cookery class but this was delivered by the cook. This was attended by four people who said they enjoyed it. The registered manager following our visit has introduced additional activities, 24 hours a week. This was in order to be able to provide individualised activities to meet people's needs.

We looked at the care and support plans for four people. We found that the records did not reflect that staff were effectively meeting people's needs. For example one person's nutritional care plan said the person should be offered frequent snacks and drinks between meals. Throughout our observations during the morning of the first day of the inspection we did not see any evidence that staff were offering snacks as described. We looked at their food and fluid charts and these were blank where entries should have been written regarding snacks.

We looked at the tool used to assess if the person should be referred to the dietician and found that from the 21 January 2015 (47.12kg) to 4 March 2015 the person had lost 6.7kg (41.6kg) of weight and was assessed as being at a very high risk of being malnourished. The last three evaluations on the nutritional care plan stated that if the person lost any significant amount of weight they should be referred to the dietician. This had not been actioned.

We looked at this persons care plan in relation to managing their behaviour. It stated that they could become agitated and lorazepam could be given to help the person's agitation. We looked at the medication administration chart (MAR) and found lorazepam was not listed as one of the medication prescribed. We spoke with the registered manager about this and he told us that diazepam had been prescribed instead of the lorazepam and the care plan needed to be updated to reflect the change. The MAR confirmed that none had been given during the cycle of this month's medication administration. The manager felt that the person did not require the diazepam. However from our observations throughout the first day of the inspection the person was extremely agitated which could have been managed differently to improve their emotional wellbeing.

Another person's care plan said the person suffered with anxiety and was living with dementia. The care plan stated orientate to time, date and place. There is no guidance for staff on how to alleviate their anxiety. The care plan also stated that they wander into other peoples rooms but did not give instructions on how this was best managed. This meant the person could distress other people who used the service when they entered their rooms, causing a possible incident that could be avoided.

We found there was very little information in the care plans on how to manage people's behaviour that could challenge. Redirection or diversion methods were not in the plans to show how to best meet people's needs. This meant people could be anxious and distressed and staff were unable to relieve this. Stimulation and activities were also not used to alleviate peoples' anxiety.

We found staff completed a body map when a person sustained an injury or a sore was noted. However, these were not updated with progress or outcome of injury or sore. For example one person's body map dated 12 November 2014 it said 'red areas on bottom'. There were no other updates or evaluation to tell us that the sore had healed or if it had deteriorated or if professional advice had been sought. This did not evidence people's needs were being met.

This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 (1) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that there had been resident and relatives meetings which were held regularly. This meant communication was being considered and improved to seek the views of people and their relatives.

Family members said they were welcome at the home at any time during the day or evening. Relatives we spoke with said they were able to stay until their relative went to bed and spend time with them once they were in bed if they wished. No one we spoke with said there were any restrictions on when they could visit.

Requires Improvement

Is the service responsive?

A complaints process was in place. However, we found that not all concerns had been recorded. The registered manager had dealt with a number of minor concerns and relatives told us they had raised issues that had been dealt with. Some relatives told us their issues had been listened to and acted upon. One relative told us they had complained to the manager about their family member's personal hygiene and this had been addressed. Another relative told us they still had a concern on-going with the registered manager. We discussed this with the registered manager who though this had been resolved. However we found insufficient records had been kept of the concerns, or of any action taken and outcomes to show people had been listened to and issues resolved.

Requires Improvement

Is the service well-led?

Our findings

People who used the service and their relatives we spoke with all knew the names of the senior managers and told us they were all approachable. People and their relatives were complimentary about the managers and the open door policy. One relative said, "I do speak my mind and I know someone will listen to me."

Relatives told us that they knew about the monthly relatives meetings and some relatives had attended occasionally. One relative said, "He (registered manager) has an open door policy, so we don't need to go to relatives meetings. We just sort stuff out as we go along."

At the time of our inspection the service had a registered manager who had been registered with the Care Quality for three years. There was also a newly appointed deputy manager in post who had commenced in January 2015. There was also a new head of care in post. These were new posts as the service had been without a deputy manager for two years. The new posts would ensure the registered manager had support and be able to fulfil their role as the registered manager.

Some relatives could recall filling in surveys, but could not recall any changes made as a result. We saw the last survey, which was July 2014. The registered manage told us one was due to be sent out again. The surveys from last year gave mostly positive comments. The negative comments were all regarding activities, people had written that there was lack of activities and stimulation for people who used the service. We found at our inspection a lack of activities, therefore people's views had not been listened to or acted on.

A large amount of people sat in the main entrance lounge at the service. This was a busy thoroughfare with a lot of pace and noise. This environment was not conducive for people living with dementia type illnesses. The registered manager and provider told us the people choose to sit in this area. We saw evidence people liked to sit together but no one gave a preference to this particular lounge. It appeared it was easier for staff to have everyone sat together in this lounge as it was easier to monitor. There were other options available that provided environments that were less hectic and busy that would better suit people living with dementia. Nursing and Health Dementia Care Survival guide states good practice for people living with dementia is that they prefer less noisy environments, staff should try to cut out extraneous and sudden unexpected noise, which was difficult when it is the main entrance to the home. The providers monitoring systems had not identified the improvements that could be made to the environment for people living with dementia to promote people's well-being.

There were systems in place to monitor and improve the quality of the service provided. We saw copies of reports produced by the manager and the provider. The audits included infection control, environment, and yearly quality audits. However, the systems were not always effective. For example, they had not adequately monitored infection control as we found areas that required a thorough clean. The audits did not give adequate detail to be able to identify areas that required improvements. The yearly audit covered all areas of the service but this was in limited detail, these should be carried out more frequently than a year to ensure any issues are identified and rectified to ensure people are kept safe.

Accidents and incidents were monitored by the manager. However, we identified this was not effective as they did not pick up issues we identified. For instance, we found that a high number of incidents in January and February occurred at night when staffing numbers decreased. The times of the incidents had not been monitored to determine any triggers or themes which could be addressed.

The recruitment policy was out of date as it still included the CRB check rather than the DBS check. The manager told us that they were in the process of reviewing all of the policies. The supervision policy was not being followed as staff did not receive supervision at the frequency described.

This was a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with spoke highly of the registered manager they told us they felt listened to and involved in the running of the service. They said there were regular staff meetings

Requires Improvement

Is the service well-led?

to ensure any new information or changes were communicated to all staff. Staff told us they had received supervision and an annual appraisal, although they thought these were not up to date.

Although staff praised the registered manager they said he was very busy and was not always available as a manager as regularly he worked covering shifts. Staff did acknowledge that now the deputy manager was in post this should improve.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **People who used the service were not always protected against the risks of receiving care and treatment. Because the delivery of care did not always meet their needs. Regulation 9 (1) (a) (b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider did not have an effective system to regularly assess and monitor the quality of the service provided. Regulation 17 (1) (2) (a) (b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **People who used the service were not involved in making decisions in their care and treatment or able to express their views. People's privacy and dignity was not maintained. Regulation 10 (1) (a) (b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **People were not always protected against the risk associated with infection prevention and control. Because the systems in place were not effective in ensuring the service maintained standards. Regulation (1) (2) (h)**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not ensure at all times that there were sufficient numbers of suitably qualified and experienced staff to meet people's needs. Regulation 18 (1)