Four Seasons Homes No. 6 Limited

Birkin 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?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Inadequate**

Overall summary

This inspection took place on 11 and 12 February 2015 and was unannounced. The service provides accommodation to up to 42 older people who have nursing or care needs. The home is set over three floors; two of which providing nursing care support, the other providing care in a residential setting. At the time of the inspection there were 37 people living at the service, 26 of which required nursing care.

There has been a history of non-compliance with this service since September 2014 when we served compliance actions in relation to infection control and staffing numbers. At this inspection we found the provider had not taken steps to meet the requirements of the compliance actions, and we found further breaches of regulations.

At the time of our inspection the service had not had a registered manager in post since 8 March 2013. The service was being managed by the organisation's regional support manager who had been appointed to the home as an interim manager since December 2014. A registered

Summary of findings

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 a legal responsibility for meeting the requirements in the Health and Social Care Act and associated regulations about how the service is run. The regional support manager and regional manager were in attendance during the inspection.

People and relatives told us that they felt safe living at the service; however the service was not always safe. Staff demonstrated an understanding of what constituted abuse and how to report any concerns. The service had safeguarding procedures in place and was working with the local safeguarding team to ensure people were protected from abuse.

There were not enough staff on duty to meet people's needs. Some people did not receive food or drink during the first morning of our inspection because there were not enough staff to ensure this happened.

There was a formal tool in place to assess the number of staff required to fully meet people's care and support needs. This was based on the dependency needs of people assessed by senior staff. We found that some staff lacked the skills and competencies to assess people's needs accurately; therefore the information used to complete the staffing levels tool was not accurate.

Staff told us they had completed an induction training programme, which included shadowing experienced staff, but the service did not have a completed induction programme to show us at the time of the inspection. Mandatory training had been provided but staff one to one meetings with their manager and appraisals were not up to date to show that staff individual training and development needs had been discussed. There was a training programme in place and staff were kept updated with refresher training. However we found that some staff did not have the skills and competencies needed and did not apply their training in practice. Although this had been identified by the manager there was no records in place so show that the staff were being supported to improve their skills. We found that some people were living with dementia and staff had not received any training to increase their understanding of this.

People told as that they had some difficulty understanding the staff whose first language was not English. They said that communication could be an issue at times. Relatives also told us that communication could be improved. The service was taking action to address these issues and there was a programme in place to support staff with their communication skills and to improve their language and writing skills. However this was only starting on the day of the inspection, even though the some of the staff had been employed for up to four months.

Staff did not follow infection control measures when changing people's dressings, such as, wearing protective aprons when carrying out these procedures. There were insufficient supplies of disposable gloves in people's rooms to ensure that these were easily accessible at all times. Staff were not handling soiled linen in line with infection control procedures. People did not have individual hoist slings to reduce the risk of infection.

Risk associated with people's care and support had been assessed, however in some cases the moving and handling risk assessments did not have full guidance about how these risks could be minimised. People had access to equipment to meet their needs. There were environmental risk assessments in place to help make sure the premises were safe, and systems in place to ensure that staff knew what to do in the event of a fire.

Accidents and incidents were recorded and some action had been taken to reduce the risk of further occurrence, however the events had not been analysed to look for patterns and trends to help reduce further occurrences.

People's medicines were not always stored safely. There was an over stock of some medicines which had not been returned to the pharmacist. Medicine records were not being completed properly to confirm people had taken their medicines. We observed medicines administration and found that medicines were being given to people safely.

There were insufficient details and information about obtaining people's consent and involvement in their care planning, including assessments of people's mental capacity and making decisions in people's best interests. Care plans recorded that people had given their verbal consent, such as, for the use of bed rails but there was no record to show how this decision was made.

People did not always receive a diet that met their needs, or protected them from risks associated with not eating

Summary of findings

or drinking enough. Records did not confirm that one person was receiving a diabetic diet even though they were. People who needed their food and fluid intake monitored did not have records in place to show this had happened.

Systems in place to monitor and check people's health care needs were not effective. Pressure ulcers had not been assessed correctly to ensure effective action was taken in a timely manner. Staff did not have a full understanding of how to assess and complete the documents to assess people's skin integrity. People had been referred to the appropriate health care professionals, such as dieticians and tissue viability nurses, but there were delays in referrals which impacted on people's health.

People and relatives told us the staff were kind and maintained their privacy and dignity. They said the staff were always caring. Staff supported people to go where they wished within the service. People and relatives told us that they were able to visit at any time.

People's needs were assessed before they came to live at the service; however records did not confirm how people were involved in their assessment or that people were consulted about how they wanted their care to be delivered.

Not all care plans had a full personal history of the person to give staff a full understanding of what was important to them. Care plans and risk assessments had not always been updated to reflect people's changing needs.

People and relatives told us that they had the opportunity to voice their concerns. A customer satisfaction survey had been sent to people last year and results had been summarised, however there was no record to show how people using the service had been advised of the outcomes, or what, if any, action was needed to improve the service.

We were told by the regional support manager that there were monthly residents meetings, which also gave people the opportunity to give feedback, however there had not been a meeting since August 2014. There were dedicated staff hours for activities and people told us that they enjoyed the singing and the local church visits, but would like the opportunity to go out more.

There was information on display to advise people how to complain but this was not in any other format to support people who may be partially sighted. Not everyone had access to a copy in their room and the complaints procedure did not include the full information about who people could contact outside of the service if they were not satisfied with the outcome of a complaint. People and their relatives were confident in how to raise issues, although some relatives were not aware who the manager of the service was.

The service was not well led. There were systems in place to monitor the quality of care and some of the shortfalls in this inspection had been identified by the regional support manager but there was a lack of action to ensure that these shortfalls were being addressed to improve the service. Staff told us they did not feel supported. The staff were not aware of the visions and values of the organisation or involved in the continuous development of the service.

The providers were not able to produce all of the documents needed for the inspection and records were not always easily accessible. Records were not always accurate and up to date, and records such as food/fluid charts had not been completed properly and there were gaps in the recording in the medicine records. There were limited systems in place to measure and review the delivery of care to people.

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 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. There were not enough staff to provide safe and effective care to people. Risks to people were not managed to ensure people's safety.

The storage and disposal of medicines was not always safe. People received their medicines when they needed them. Staff did not follow robust infection control procedures putting people at risk of acquiring infections.

People had the equipment to meet their needs which had been regularly serviced, however there was no system in place to make sure pressure relieving mattresses were set at the right levels for individuals.

Is the service effective?

Inadequate

The service was not effective. People received care and support from trained staff, however not all staff had the competencies and skills to ensure people's health care needs were fully met.

The requirements of the Mental Capacity Act 2005 were not always followed. Decisions made on behalf of people were not made in accordance with the legislation.

People had access to a variety of food and drink. However the systems in place to monitor people's health and nutrition were not always completed correctly to ensure that their needs were being met.

Is the service caring?

Requires improvement

The service was not always caring.

People and relatives told us that the staff were kind and caring but very rushed as there was not enough staff on duty. Staff said that the care became more task orientated due to the lack of staff. Relatives said that communication could be improved as some of the staff did not speak very good English.

Staff had been trained in how to respect people's privacy and dignity, and understood how to put this into practice.

Staff supported people to make decisions about their care and encouraged them to remain independent.

People's privacy was respected and family members were able to visit at any time.

Summary of findings

Is the service responsive?

Requires improvement

The service was not responsive. People told us that due to the lack of staff they had to wait sometimes for staff to respond to their calls. Care plans were not always up to date or reviewed regularly. Care plans did not always contain sufficient information to enable staff to deliver care in a responsive and personalised way.

People were encouraged to take part in the planned activities and told us they enjoyed the entertainment. However some people said that they would like the opportunity to go out into the community but there was no transport available.

Complaints had been logged and responded to appropriately and people and their relatives told us they would raise any issues with the staff. There was a complaints policy and procedure in place but there was no other format for people who had impaired vision.

Is the service well-led?

Inadequate

The service was not well led. Action had not been taken to address previous breaches of regulation. Systems for monitoring the quality of care provided were not effective and not used to make improvements to the service. Records were not always completed or accurately maintained.

There was a lack of continuity in the management of the service and a lack of leadership. Staff views were not sought by the provider. Some relatives did not know who the manager was and staff told us they did not feel supported by the manager.

People had completed a quality survey last year and this had been summarised but people had not been made aware of the outcome of what improvements had been identified or made.

Birkin 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 was 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 11 and 12 February 2015, and was unannounced. It was carried out by two inspectors, a special nurse advisor and an expert by experience. A special advisor is someone who has clinical experience and knowledge of working with people who are receiving nursing care. An expert by experience is a person who has personal experience of using services or caring for someone who uses this type of care service. The expert by experience had experience of older people's services.

The unannounced inspection was carried out as a response to concerns raised by relatives, a whistle blower, a GP practice and the local safeguarding team. A Provider Information Return (PIR) was not requested due to the short notice. 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.

Before the inspection we looked at previous inspection reports and notifications received by the Care Quality Commission (CQC) and information from the local authority and safeguarding team. A notification is information about important events, which the provider is required to tell us about by law.

We spoke with staff members, which included three nurses, care staff, the regional support manager and regional manager. We looked around the communal areas on all three floors in the service. We spoke with 20 people who were receiving care and treatment and four relatives.

During the inspection visit, we reviewed a variety of documents. These included ten people's care plans. We viewed four staff recruitment files; the staff induction and training programmes; staffing rotas over four weeks; medicine administration records; risk assessments; minutes for staff meetings and residents' meetings; and some of the service's policies and procedures.

Inadequate

Is the service safe?

Our findings

People told us that they felt safe living at Birkin Lodge. One person said: "My possessions are safe and I have no reason to think otherwise". "I like it here, I feel very safe". Although people told us they felt safe living at Birkin Lodge, and relatives we spoke with at the time of the inspection said they did not have any concerns about the safety or welfare of their family members, we found the service was not always safe.

At the last inspection on 11 September, 2014, we asked the provider to take action to make improvements to staffing levels. The inspection report stated that people were not receiving their personal care until late morning, call bells were constantly sounding and staff and relatives were saying there was not enough staff on duty. This was a breach of Regulation 22 of the Health & 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. Following the inspection the provider sent us an action plan to tell us the improvements they were going to make, which they would complete by 14 December 2014. However, this had not been achieved at the time of this inspection. There were still insufficient staffing levels and people and relatives were still raising their concerns with regard to the lack of staff on duty.

People and relatives told us that there was insufficient staff on duty. They said: "The staff are kind, but sometimes they are too busy and will not give tea when we ask". A staff member said: "I will be happy if our residents receive better care than what we give now, some of them do not get washed till late due to shortage of staff, call bells are not answered promptly". "There is not enough staff on duty especially on the middle floor where there are 19 people with sometimes only two care staff on duty".

There was not enough staff to meet the needs of people. Through our observations and discussions with people, we found that there were not enough staff with the right experience or training to meet the needs of the people living in the service. Staffing levels were assessed using a dependency tool to establish the number of staff required on duty. We requested the staff rotas for the last four weeks at the time of the inspection. The regional support manager could not produce a copy of the rota at the time of the inspection as the computer system was not working.

We received the rotas by email for the 4 weeks commencing 12/01/2015 to 02/02/2015 and found that the number of staff on duty varied each day. For example on Tuesday 13/01/2015 there were 9 staff on duty from 07.30 till 12.00, 10 staff from 12.00 to 13.30, 8 staff from 13.30 to 18.30, 7 staff from 18.30 to 19.30, and 4 night staff. The care analysis from the assessment tool stated that 10 staff should be on duty in the morning, 12 staff on duty for the afternoon and 4 staff awake at night, which did not match with the actual number of staff on duty. There was no explanation as to why these levels changed each day or how they were in line with the staffing analysis identified in the staffing dependency tool to ensure that staffing levels were sufficient to meet the needs of the people at all times. We discussed the rota with the regional manager who was unable to confirm why the numbers of staff varied and why the levels were lower than they should be.

At the time of the inspection there were two newly appointed nurses on duty who had been identified as requiring clinical support from the clinical support facilitator. The regional support manager told us that they were supporting the nurses; however there was no written records to confirm this. The deployment of staff did not include a skill mix of experienced staff to meet people's needs as two new staff were in charge.

At 09.15 am three people were calling out to have their breakfast. One person said they were so hungry they 'could eat a spoon' and another said they 'could eat their sheet'. The staff responded and served the people their choice of breakfast. They then made sure that everyone had received their breakfast. People told us that they had to wait as staff were always so busy.

Staff told us that there was not enough staff on duty to fully meet people's needs. They said they were not able to complete the required checks on people, such as to record what people had to drink or when they needed to be repositioned in bed or to make sure they were safe. On the first day of our inspection we observed that staff did not respond to people's call bells promptly. We also observed that some people did not get their 11 am drinks as staff were still providing personal care. Morale of staff was low and they told us they were felt they were not supported by the management team as they had reported the lack of staff to the regional support manager but no further action had been taken.

Inadequate

Is the service safe?

The provider had failed to ensure that there were sufficient numbers of staff to meet people's needs. This is a continual breach of Regulation 22 of the Health & 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..

We discussed staffing levels with the regional manager who took action to address the staffing shortages and arranged for an additional two members of staff to be on duty each morning and afternoon. On the second day of the inspection we saw the extra staffing was in place. The call bells rang occasionally and not for long. Staff told us that they were now less stressed because more staff were on duty and they could provide the care people needed. People had received their personal care and breakfast by 11 am. We saw people eating in their bedrooms and no one was calling out for food.

At the last inspection on 11 September, 2014, we asked the provider to take action to make improvements in infection control procedures. The inspection report stated that people were not always cared for in in a clean environment and, at times, there were unpleasant odours of urine. This was a breach of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following the inspection the provider sent us an action plan to tell us the improvements they were going to make, which they would complete by 30 November 2014. However, this had not been fully achieved at the time of this inspection as there was still unpleasant odours present. There were also were further issues with regard to infection control procedures.

Staff were not upholding infection control measures as they were observed not wearing protective aprons when changing dressings. Staff told us that plastic aprons were not available and on most days they run out of gloves and aprons. Staff were also seen supporting people to eat without using disposable gloves. This was not good practice to ensure that the risk of infection was kept to a minimum.

Staff were not handling soiled linen in line with infection control procedures, such as bagging soiled laundry, wearing protective aprons or using a trolley to take soiled linen to the laundry room. They said there were not enough trolleys to make sure that soiled linen was transported properly.

People who needed support with a hoist for their mobility or sliding sheets to help them move in bed, did not have their own individual hoist sling or slide sheet. Staff were observed using one sling and sliding sheet for several people. This practice was not in line with safe infection control procedures to make sure people used their own individual sling or sliding sheet to reduce the risk of infection.

On the ground floor by the nurses station there was a strong unpleasant odour in the corridor. The cleaning staff quickly addressed the issue by cleaning the areas concerned. However on the top floor of the service there was an unpleasant odour which was consistent throughout the inspection. The regional manager stated that the service was in the process of having a complete refurbishment and this would include the replacement of carpets and flooring. Apart from the cleaning schedule, which did not seem effective on the day of the inspection, there were no other measures in place to manage the odour until the flooring was replaced.

Some areas of the home had not been cleaned properly. We saw that one person's commode had not been cleaned and had traces of faeces in it. It was left in their room with no lid, this was pointed out to staff but an hour later it had not been cleaned.

People were not always protected from the risk of infection because appropriate standards of hygiene had not been maintained. This is a continuous breach of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014..

The chef and kitchen assistant demonstrated their knowledge and awareness of food hygiene and infection control procedures and how to prevent the risk of infection. Records were kept of fridge temperatures, the kitchen had been cleaned in line with the cleaning schedules, food was stored appropriately and the service had received a five star rating from environmental health, which is the highest rating.

Inadequate

Is the service safe?

Risks associated with people's care and support needs had not been properly assessed to protect them from receiving unsafe or inappropriate care. One person's moving and handling risk assessment noted that they had mobility issues and balance difficulties; the assessment stated that 'they needed assistance of one carer to get in and out of bed. This may vary at times, mobility is poor and two carers are required'. The person was at risk of falls as there was no other guidance for staff to show them how to support and move this person consistently and safely.

Relatives, visitors and staff told us that people had to wait sometimes up to 10 minutes after knocking on the front door to enter the service. On arrival at the service at 8 am we had to wait over 5 minutes for the door to be answered. We were told by the regional support manager that some relatives were aware of the security number to enter the premises. There was no risk assessment in place to assess if giving out the front door entry code was safe or whether people living at the service had agreed to this arrangement. This meant that people were at risk of visitors entering the service without staff knowing who was in the premises.

The provider had failed to ensure that suitable risk assessments were in place and this meant people were at risk of receiving unsafe or inappropriate care. This is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014..

People had access to equipment to meet their needs, such as wheelchairs, hoists, pressure relieving mattresses and cushions. There were records to show that most equipment was regularly checked and serviced and environmental risk assessments were in place. However we found that there was no system in place to monitor that the pressure relieving mattresses were at the right level for the individual person. Some staff were not aware what the settings should be to make sure the equipment was set correctly to prevent the risk of pressure sores.

Checks were being made at the service to ensure that people were protected from the risk of fire, such as the testing of fire bells and evacuation drills. However on the first day of the inspection it was noted that a hoist was kept along the corridor on the top floor completely blocking the fire exit. This had two potential risks; trips and fall as well as being an obstruction to the fire exit in the event of fire. This was pointed out to the regional support manager; however action had not been taken to move this hazard as on the second day of the inspection as the hoist remained in the same place.

The provider had failed to ensure that people were protected against the risks associated with unsafe premises. This is a breach of Regulation 15 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People and their relatives felt medicines were handled safely. One person said: "I just take it. I trust them to give me the correct medicines and I take it." However, there were shortfalls in the management of medicines. Some stocks of medicine had not been returned to the pharmacy for two months. We observed that when staff opened the controlled drugs cabinet stock fell out as there was insufficient room to store the medicines. The clinical room on the ground floor was also overstocked with bandages and non-adherent dressings. Items such as tins of food thickener, nutritional supplements and old medicine records were not stored appropriately and there was items in black bags which should not have been stored in the clinical room. The room should be kept clean and tidy at all times to reduce the risk of infection.

Some people required pain relieving medicines and anxiety medications on an 'as and when' required basis. Records confirmed that people were receiving their medicine, however there was no further information on the back of the medicine administration record to show how effective the medicine was, to make sure it was working for the purpose it was prescribed or when it should be reviewed.

We observed staff giving people their medicines. They demonstrated good practice in medicine administration by carefully ensuring that the right person received the correct medicines and they waited patiently for each person to take their medicine safely. The nurse administering medicines gained consent from each person before giving them their medicine and waited patiently whilst they swallowed it to make sure they received their medicine safely.

The provider had policies and procedures for ensuring that any concerns about people's safety were reported. Staff explained how they would recognise and report abuse to their manager. Staff had received training in safeguarding

Inadequate

Is the service safe?

adults. They were aware of the whistle blowing policy and the ability to take concerns to agencies outside of the service if they felt they were not being dealt with properly. People told us they would raise concerns with staff if they needed to. People were protected from discrimination because staff knew people well. One staff member knew the sexual orientation of a person they supported and told us they had received training in equality and diversity, which was part of the induction training for all staff.

When a health care professional had raised concerns about a member of staff the manager from another service within the organisation had carried out an investigation and followed disciplinary procedures. Appropriate action was taken to monitor the staff member's practice to reduce the risk of on-going unprofessional behaviour and to ensure that people remained safe,

There was an on-call system to support staff twenty four hours a day and this was being covered by the regional manager and regional support manager. Staff were aware of the on call arrangements and told us that when they called the on call manager there was always a response to support them with their concerns. There were contingency plans in place in the event of an emergency, such as fire.

Inadequate

Is the service effective?

Our findings

People and relatives told us they were satisfied with the care being provided at Birkin Lodge although, at times, they had to wait for staff to attend to their needs. People said: "I am happy here" "they call the doctor quickly when I am not well". One family member said: "I am happy with the care provided to my relative".

There was a staff training programme in place for all staff. The majority of training was e learning (completing a training session on a computer) with some practical courses. such as moving and handling. Staff confirmed they had completed an induction training programme, which included reading relevant documents, shadowing experienced staff and training courses. We did not see a completed care staff induction record during the inspection as the regional manager told us that staff had taken their records home. Staff felt that the e learning training was sometimes not sufficient. One member of staff told us they needed more training to administer medicines as they did not feel they were confident, even though they had received some training.

Records showed that training had been provided to staff in key areas, including medicine management, fire safety, health and safety, equality and diversity, infection control and food hygiene. However, there was no clinical training programme in place for the nurses. We spoke with a recently recruited nurse who told us that they had completed induction training but could benefit from more training and guidance. We found there were shortfalls in their knowledge to demonstrate they fully understood how to assess pressures sores and provide the appropriate treatment. Staff competencies were not being assessed or monitored by senior staff to ensure they had the skills and knowledge to perform their role.

The nursing staff told us they did not feel their training needs were being addressed appropriately and they needed more training to enhance their practice. One nurse had not received any training in wound care, and had received one day training on care planning and how to take people's bloods. Another nurse said: "I need training on wound management, nutrition, care planning and catheterization". A third member of nursing staff told us that they wanted to learn more, improve their knowledge, acquire more skills and experience on nursing related issues.

There were no systems in place to support staff development through the use of regular staff supervision and annual appraisals. Staff one to one meetings were not up to date and staff had not received an annual appraisal to discuss their learning and development needs.

The provider had failed to ensure they had suitable arrangements were in place to enable staff to be supported to deliver care and treatment to services users safely. This is a breach of Regulation 23 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had received Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training. The Mental Capacity Act aims to protect people who lack mental capacity, and maximise their ability to make decisions or participate in decision-making. Staff understood the importance to support people to make decisions about their care; however, there was a lack of records to show how people had been assessed to make decisions in their best interests. The regional support manager told us that a best interest meeting had taken place to support one person but there were no records to confirm this.

Some people had (DNAR) 'do not attempt cardiopulmonary resuscitation' forms in place, however not all of the forms had been completed properly or showed that the person was in agreement. One form showed that the person had the mental capacity to make their own decisions, however there was no record of their involvement and a relative, rather than the person, had signed the form. As there were shortfalls in the recording on these documents, people's last wishes may not be upheld.

People told us that the staff always asked for their consent before they carried out their day to day care. However, records documenting decisions in relation to people's care were not always kept to show how the decision was made. One person used bed rails to reduce the risk of them falling out of bed. We noted in one care plan it stated this person had verbally agreed to this, but there was no record to confirm how this decision had been made. One person had moved rooms three times but there was no information to say how or if they had been involved in making this

decision. The same person had fallen, which led to the decision to use an infrared sensor in their bedroom. There was no information to show if this person had consented to this decision or whether they had the capacity to do so.

The provider had failed to ensure that people's rights were protected because suitable arrangements were not in place to show that assessments of people's mental capacity were completed. This is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care plans included risk assessments for pressure care, falls, personal safety and mobility and nutrition. Records also showed that people had regular access to healthcare professionals, such as GPs, physiotherapists, and chiropodists. However, we found that proper steps were not in place to ensure that the planning and delivery of care met people' needs and ensured their safety.

We discussed the management of wound care with the nurses on duty as we noted that two waterlow assessments had not been completed correctly. (A waterlow chart is completed to assess the risk of pressure area development). We showed them how to calculate the scores to accurately complete the waterlow assessment. Once this had been completed they realised that the assessment had been calculated incorrectly previously. We had concerns that the staff did not have the skills to assess people' skin integrity and complete the documentation correctly to reduce the risk of people developing pressure ulcers.

Some people were at high risk of developing pressure ulcers and some had developed pressure sores. We found that some staff did not have the knowledge and skills with regard to pressure ulcer management. This lack of knowledge had led to the incorrect grading of a person's pressure ulcer. There was no written guidelines or instruction on how to manage this wound. There was no wound care plan or care plan update to note changes in the skin integrity. There was no clear instruction on how to manage the wound. This meant that appropriate actions were not taken in terms of managing the wound.

There was a delay in seeking advice from the tissue viability nurse with regard to one person's pressure ulcer. The ulcer was identified on the 14/01/2015 but they were not seen by the doctor until 06/02/2015. The doctor advised a referral was to be made to the tissue viability nurse, however this referral was not made until four days later, and at the time of the inspection the tissue viability nurse had not visited the person. This did not demonstrate that specialist advice was requested in a timely manner when dealing with a high level grade of pressure ulcer.

There were some actions taking place to prevent pressure ulcers, such as the provision of pressure relieving air mattresses, profiling beds and turning charts were in place to record when a person's position had changed. However, there were some omissions in these records to confirm people had been moved every two hours as stated in their care plan. One care pan showed that a person should be re-positioned every two hours however on some days there were only five entries on the position chart. One chart showed that the a person had not been moved since 12.00 and the next entry was 22.40, and there were no further records to confirm this person had been supported to change position for over 11 hours. The level of the air mattresses need to be set for each person to reduce the risk of them developing pressure ulcers. There was no system in place to check the effectiveness of the air mattresses to ensure they were at the correct setting for individual people to ensure the equipment was working properly.

Another person had a grade two pressure ulcer. (ulcerated area of skins caused by irritation and continuous pressure on part of the body which are graded on the severity of the damage to the skin on a scale of 1 to 4). The staff had not made sure there was an ongoing review of the wound, there were no dressing charts, no wound care plan and no current wound pictures to compare with the initial pictures to determine whether the wound was healing or deteriorating. There were re-positioning charts in place for this person but we could not accurately say they were being moved safely and consistently as the charts had not been completed by staff, to confirm the person had changed position. This meant that the person was at risk of developing further skin damage due to the lack of effective wound management.

The provider had failed to ensure that the delivery of care and treatment was provided safely to meet people's individual needs. This meant people were at risk of receiving unsafe or inappropriate care. This is a breach of

Inadequate

Is the service effective?

Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that the food was good and they had choices. They said there was always a choice of two main dishes but if neither of them were wanted the chef made something else, such as an omelette or sandwiches. People chose to eat in the dining room or their rooms, and staff respected such decisions.

Records from care plans viewed showed that two people had lost significant weight in the last three months. They had been seen by their GP and had been referred and seen by the dietician for support. People were weighed monthly and their weight was recorded. The nurse on duty told us about the management of weight loss. They said "If a resident loses weight we will inform the GP and refer to the dietician". Some people were prescribed food supplements to enhance their dietary needs. Staff were aware of people's special diets and had received training in diabetes to support people and their related dietary needs.

.Some people were at risk of malnutrition and dehydration so what they ate and drank was recorded and monitored. Staff had recorded the amount of fluid people had taken, but these amounts were not totalled to show what they had taken over a specific period of time. There was no written guidance available to staff to tell them what the safe amount of fluid people should take was and what action staff should take if the amount fell below this. We observed that people had to wait for their breakfast and the mid-morning tea/coffee had not been served to people on the top floor. People were not always protected from the risks associated with dehydration because staff were not monitoring their related fluid intake effectively.

One person was receiving a soft diet and there were food and fluid charts in place to record if they were receiving the correct amount of food and drink. A relative told us that they had spoken with the manager to make sure they were having milk shakes and they were told that this was the case; however the food chart did not reflect this information to confirm staff were providing the person with their preferred drinks, which would encourage them to maintain a healthy diet.

We observed that when people needed help with their eating staff supported and encouraged them to eat their meals. People told us they enjoyed the food, which looked appetising, was hot and well-presented. Special diets such as 'a soft diet' were catered for. This information was recorded in the person's care plan with a list of their specific likes and dislikes. However in one person's care plan it was noted that they were a 'diet controlled diabetic', however records of people's dietary needs which were kept in the kitchen stated that this person was on a 'regular diet'. This meant that the person may not be receiving the required diet to support them with their medical condition.

The provider had failed to protect people against the risks of inadequate hydration due to the lack of accurate monitoring of fluid intake records. This is in breach of Regulation 14 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014..

Requires improvement

Is the service caring?

Our findings

People and relatives told us that the staff were kind and caring, but very rushed. Staff told us how they offered people choices but sometimes their choice was compromised due to lack of time to spend with them, which resulted in the care becoming more task orientated than person centred. One person said: “The staff were kind and caring” and “The staff are wonderful”.

A relative told us how they visited their relative daily to support them with their food and said their relative was now doing well and had got out of bed recently for the first time since the New Year. Another relative said they were happy with the care given to their relative. However, they thought that communication between some of the staff and people could be improved.

Some people told us that the staff, whose first language was not English, were difficult to understand and communicate with. One person said: “I don’t think they can cope with some needs because they can’t speak English very well”. Staff told us that the nurse’s communication had improved since they first started the job and we observed them speaking with people and listening to what people were saying. The regional support manager told us that plans were in place to commence additional support in verbal and written communication skills on 12 February 2015. Records showed that there was an action plan to show how this would be achieved which included one nurse attending English lessons.

Staff waited for people to consent to their care and treatment, for example when they were taking their medicines. People told us that staff routinely asked for their consent in all areas of their care, such as if they wanted a bath or what they wanted to wear. Staff supported people to be where they wanted to be and respected their decisions when they did not want to join in with the entertainment, and preferred to stay in their room.

During the inspection, staff were observed treating people with kindness, respect and empathy despite low staffing levels. Staff engaged and spoke with people in a polite and respectful manner. People told us that the care staff encouraged them to do things for themselves so they remained as independent as they could be. One staff member told us how they encouraged one person, who was able to feed themselves, to do so to maintain this independent skill. We observed staff reassuring one person, speaking with them sensitively and explaining why they were taking the lift, and where they were going.

We observed thorough the inspection that people were treated with dignity and respect. People gave us examples of what staff had done to maintain their dignity in relation to personal care. Staff had been trained in how to respect people’s privacy and dignity, and understood how to put this into practice. This included ensuring parts of the person were covered, that were not being washed and closing the door to the room where the person was receiving personal care. People’s independence was promoted.

People’s family and friends were able to visit at any time. People told us they could see their relatives in private if they wished, or in the communal areas.

Requires improvement

Is the service responsive?

Our findings

People told us that they received the care they needed, and staff were responsive to their needs but staff did not always come quickly. People said: "I've had to wait sometimes over 10 minutes to get support from staff. There is not always enough on duty".

People needs were assessed before they came to live at the service. This assessment included information about the persons care needs, religious beliefs and dietary needs. This information was then used to complete a care plan to meet people's identified care needs. People were invited to view the premises before they made their decision to move in. Some people told us that they had been consulted about their care during this process and in how the service had gathered information, which was used to plan their care.

The care plans varied in detail. Four out of the ten care plans looked at did not have a full personal history of the person to give staff a full understanding of what was important to them.

There were instances when external professionals in the different areas of expertise were involved promptly when people needed support with their dietary or mobility needs, however, there were some delays in referrals to professionals for people who needed support with their pressure ulcers. Pressure ulcers should be assessed initially to identify the level of care required to heal the wound. The assessment should be tracked by the nurses to ensure the right treatment is being provided. If the wound deteriorated then specialists such as the GP or tissue viability nurses, should be contacted promptly to further assess and treat the wound. Delay in referral put the person at risk of developing further complications and infection of the wound.

People's individual needs were not regularly reviewed. The provider had a system in place which stated people's needs would be reviewed monthly. This had not happened. Some people's needs had changed but their care plans and risk assessments had not been reviewed or updated to reflect the changes. One care record viewed noted that the person had lost weight but this did not reflect on the waterlow score risk assessment tool for pressure ulcer. This meant that this inaccurate information on this assessment increased the risks of the person developing pressure ulcers.

The provider had failed to ensure the delivery of care and treatment was provided to ensure people's health and welfare care needs were fully met. This is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had not had the opportunity to voice their views or be involved in the service as there had not been a monthly residents meeting since August 2014. We noted that there was information on the notice board to confirm a meeting had been arranged for February 2015 and relatives were also invited.

There were activities to support people to meet their spiritual and emotional needs. People had the opportunity to participate in religious activities as there were regular church visits. There were two activities co-ordinators who provided the programme of activity.

On the day of inspection, activities took place at different times in the lounge area on the middle floor, as organised by the activity coordinator. There was a tea party in the morning and those who attended enjoyed this and also joined in with the quiz. One person said 'The activities co-ordinator) was like a mum to us." Other people told us that they enjoyed the activities, especially the afternoon singing session. We observed people singing and laughing, and enjoying the music.

People who remained in their rooms told us that they were encouraged to join in the activities but some preferred not to. One person told us that the co-ordinator visited them in their room to chat or ask them what if anything they preferred to take part in. People told us that they enjoyed reading the internal newsletter 'The Daily Sparkle' which covered 'today in history' and included past events, films and a puzzle page.

The co-ordinator told us that when there was nothing planned in the activity programme people were encouraged to play board games or complete puzzles.

Requires improvement

Is the service responsive?

People said they were asked if they wanted to play the games but sometimes chose to watch television instead. People said they would like to have outings in the community; however there was no transport available.

People and relatives told us they would speak to a member of staff if they were unhappy or worried about anything and needed to complain. They felt staff would sort out any problems they had. They said they knew how to complain although some referred to the 'old manager' not the current manager.

The complaints policy was on display in the hallway and there was a suggestion box for people to use. Some people had visual impairments, but the complaints procedure was not in any other format to support them if they needed to complain. Not all people had a copy of the complaints procedure in their room for easy access. There was also limited information in the policy, to promote people's rights and choices as there was no information about the local authority complaints procedures, or referral of complaints to the ombudsman. There was also a reference to send a copy of the complaint to the Care Quality Commission, even though it is not within our remit to investigate complaints.

When complaints had been made these had been investigated and responded to appropriately

We noted that a complaint had been made during the week of the inspection. We found that this had been responded to with a positive outcome for the individual. Lessons had been learnt from a complaint made in December 2014 as new procedures had been implemented to make sure people were seen by health care professionals in the privacy of their own room. However staff felt that when they complained of the lack of staff on duty they were not listened to and there concerns were not acted upon until we inspected the service.

Inadequate

Is the service well-led?

Our findings

There was no registered manager in post at the time of the inspection. Our records showed on the certificate of registration that the name of the manager in this report left the service on 8 March 2013 but still remained on the legal register as the registered manger of the service. The regional manager told us that since that date there have been five managers of the service. At the time of this inspection a regional support manager had been in place since December 2014.

Staff were very busy and appeared stressed during the inspection, and told us they did not feel supported or motivated by the manager. They said there was a culture of "blame" in the service with poor communication. They told us the management of the service was inconsistent and it was affecting the way the service was run. The regional manager told us that they were visiting the service to speak with staff as concerns had been raised directly with them about the lack of staff on duty and the morale of the staff.

The provider had not ensured that appropriate staffing levels and infection control measures were in place. Since the previous inspection on 11 September 2014, the provider had implemented an improvement action plan, dated 5 November 2014, to address the shortfalls in staffing levels and infection control. The staffing levels timescale to be compliant was 14 December 2014. We found at this inspection there continued to be significant shortages of skilled and competent staff on duty. There was also an action plan in response to improvements required in infection control procedures. The action plan stated that the service would be compliant by 30 November 2014. However we found that this had only been partially met and further shortfalls in other areas of infection control procedures were identified during this inspection.

The staffing action plan also stated that there would be monthly reviews and audits of the staffing levels to ensure continued compliance. This audit had not taken place. The action plan stated that the manager would monitor staffing levels on a 'daily walk around' and include discussions with people. The action plan stated that the regional manager would monitor this on audit visits. The 'daily walk around' records showed that the manager was required to walk round the service twice a day. However on occasions, such as 2, 5, 6, 9 and 10 February 2015 they only completed one walk around each day. People were not being protected against the risk of inappropriate or unsafe care and treatment as the systems to monitor the quality of service were not effective.

The infection control action plan stated that the housekeeper needed to walk around each day to identify areas to be cleaned immediately, before breakfast and again after lunch. The manager was also to monitor the cleanliness of all areas by undertaking infection control audits. There were no audits in place to show this had happened.

The audit of medicines carried out on 6 January 2015 by the provider identified that there was an overstock of some medicines, but no action to resolve this issue had been taken because during this inspection we found there was still an overstock of medicines. The audit also stated that there was a shortfall in recording and updating people's care plans when blood tests had been carried out to confirm the dosage of warfarin medicine (a drug used to prevent blood clots which may cause vein blockages, heart attack and stroke). These tests must be carried out regularly to ensure people received the required dosage of medicine as the dose can vary from week to week. At the time of the inspection it was noted that the warfarin care plans were not in place to ensure that people were receiving the correct dose of medicine and that this was being managed safely.

Accidents and incidents were reported, recorded, and some action had been taken, such as the supply of a pressure mat for one person who had fallen. We noted that the quality audit form dated from January 2015 to June 2015, had been started, but the quality audit for falls, mobility and safe use of bed rails, had not been completed, despite the fact there were 11 falls recorded in January 2015. There was no further information to confirm what, if any, action was taken to reduce the risks to people and identify any patterns or trends which should be addressed to make sure people were safe.

There was a lack of leadership in the service to make sure staff had a clear understanding of their responsibilities. Staff were not clear about their roles and responsibilities. The care staff were not aware of who was in charge in the absence of the manager and told us it would probably be the senior nurse on duty. Staff told us they were not encouraged to raise concerns with the regional support manager as their door was always "closed" and they were

Is the service well-led?

not confident their concerns were listened to. Staff we spoke with said: "My manager is always blaming me and is not very supportive, no supervision. I am always being told off for writing rubbish". "The new manager is always in the office, just bringing paper work, no communication, and no support". "The manager is new, everyday new managers, no consistency in the management team and it is affecting us" "It is very hard and stressful to work here, it is not only me, everyone feels the same". Some members of staff told us that felt isolated and they were just told to do things and were not involved in the decisions.

The provider had carried out a customer satisfaction survey and produced a report on the outcomes in September 2014. This survey did not include health care professionals or staff. The regional support manager told us that people were informed of the outcome during residents meetings, however the last residents meeting was held on 1 August 2014. People were not aware of the outcome of the survey, or what action, if any, had been taken to improve the quality of the service. We were told by the regional support manager that there was a system in place to speak with people and give them the opportunity to give their views about all aspects of the service. This process was called 'resident of the day', when each member of staff on duty talked with the person to ensure they were satisfied with all aspects of the service being provided. These meetings were not taking place. There was no record to show that people had been actively involved in developing the service to enable the providers to come to an informed view in relation to the standard of care being provided.

Staff training was not being monitored to make sure staff had the competencies to fulfil their role. The system to provide staff support and identify their training and development needs was not up to date to identify the gaps in staff training needs.

The provider had failed to protect people and others against the risks of inappropriate or unsafe care and treatment. The service had not been regularly assessed and monitored. This is a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person using the service had developed a pressure ulcer above the level of grade 3 after admission to the service. Such an event must be notified without delay to the Care Quality Commission. We found that this incident had not been reported in line with the regulations.

The provider had failed to not notify CQC of the serious injury to any person who uses the service. This is a breach of Regulation 18 Health and Social Care Act 2009 (Registration) Regulations 2009.

We requested the staff rotas for the last four weeks at the time of the inspection. The regional support manager could not produce a copy of the rota at the time of the inspection as the computer system was not working. We received the rotas by email after the inspection and found that the number of staff on duty varied each day and the levels on the staffing assessment tool also varied from the number of staff on duty.

Care staff meetings had taken place and minutes had been taken, however records of the senior staff meeting were not recorded. Only the agenda items were available for inspection therefore there was no details recorded of the meeting to confirm what had been discussed or what action was taken to improve the service.

Food and fluid charts did not show that people were protected from inadequate nutrition and dehydration as records were not completed accurately. They were not totalled to confirm that people had sufficient amounts of food and drink to meet their needs. There was no information to show staff what amount people should be taking or what action to take should people not have enough fluids.

Some medicine records had gaps where staff had not signed to confirm the administration of the medicine. We checked the medicines and found that the balances tallied with the stock indicating that people had received their medicines correctly. However records had not been completed accurately to reflect this information.

The provider had failed to protect people against the risk of unsafe and inappropriate care arising from the lack of proper records. This is a breach of Regulation 20 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered provider had not taken steps to ensure that appropriate standards of cleanliness and hygiene were being maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The registered person had not made suitable arrangements to ensure that the premises were safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered provider did not have suitable arrangements in place to enable staff to deliver care and treatment to services users safely and to an appropriate standard including staff receiving supervision and appraisal.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The registered person had not ensured that people's rights were protected because suitable arrangements were not in place to show that assessments of people's mental capacity were completed.

Regulated activity	Regulation

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	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs The registered person had not ensured that people were protected people against the risks of inadequate hydration due to the lack of accurate monitoring of fluid intake records

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered provider did not notify CQC of the serious injury to any person who uses the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered provider had not protected people against the risk of unsafe and inappropriate care arising from the lack of proper records. Records were not accurate, were not easily accessible or up to date and in good order.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered person had not taken proper steps to ensure that each person was protected against the risks of receiving care or treatment that was inappropriate or unsafe. Risks assessments lacked guidance for staff to manage risks effectively and safely. People's health care needs were not being monitored or detailed in the care plans effectively to ensure they received the care they needed.

The enforcement action we took:
CQC has issued a formal warning to the service telling them that they must take action to assess service user's needs and plan and deliver safe and appropriate care by 06 April 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The registered provider has not taken appropriate steps to ensure at all times there are sufficient numbers of suitably qualified, skilled and experienced persons on duty to meet the need of the people using the service.

The enforcement action we took:
CQC has issued a formal warning to the service telling them that they must take action to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed to meet service users needs by 06 April 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The registered provider had not protected people and others against the risks of inappropriate or unsafe care and treatment. The service had not been regularly

This section is primarily information for the provider

Enforcement actions

assessed and monitored. There was a lack of audits to check the quality of care being provided and manage the risks relating to the health, welfare and safety of people and others using the service.

The enforcement action we took:

CQC has issued a formal warning to the service telling them that they must protect service users from the risks of inappropriate or unsafe care and treatment by having effective systems in in place to regularly assess and monitor the quality of the service being provided by 06 April 2015.