Elder Homes Bingley LLP

St Ives Disabled Care Centre

Inspection report

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Ratings

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

Overall summary

This inspection took place on 27 and 28 May 2015 and was unannounced. At the last inspection on 26 and 27 November 2014 we found six breaches in regulations which related to staffing, care and welfare, nutrition, respecting & involving, records and quality assurance. We requested an action plan from the provider detailing how improvements would be made but did not receive one. At this inspection we found improvements had not been made.

St Ives Disabled Care Centre provides nursing and personal care for up to 60 people with

physical disabilities; the majority of people using the service are under pensionable age. The manager told us there were 43 people using the service when we inspected, which included two people who were in hospital. The home is a converted listed building and is located on the St Ives Estate close to Bingley. Accommodation is provided on four floors, there are single and shared rooms and many have en-suite facilities. There are three communal areas on the ground floor and there is also a lounge on the first floor.

The home had a registered manager who left the organisation in March 2015. A new manager started in post on 22 April 2015 and was present during this inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

Summary of findings

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.

Although people told us they felt safe we found people's safety was compromised. People were not kept safe from harm as staff had not received up to date training in safeguarding and allegations of abuse were not always acted upon. We made safeguarding referrals to the local authority safeguarding team.

People told us there were not enough staff and this was confirmed in our observations. Although we found a small number of rooms were clean and well maintained, the majority of the home was dirty and there were insufficient domestic staff on duty to keep it clean. Infection control practices were not always followed which meant people were not protected from the spread of infection.

We found the home was not well maintained and the décor in places was shabby. Although some rooms were comfortably furnished and clean, many had stained carpets and damaged furniture. Systems in place to check and respond to environmental risks were not effective which meant health and safety and fire safety issues were not always addressed. We reported our concerns to the fire officer who visited and took action.

We found people had access to health care services, although we were not assured these were always accessed in a timely manner. Although we found people received their medicines when they needed them, the handling and management of medicines was not always safe.

Recruitment processes were not robust as thorough checks were not always completed before staff started work to make sure they were safe and suitable to work in the care sector. Staff training was not up-to-date which put people at risk of unsafe or inappropriate care.

Most people spoke positively about the staff who they felt were kind and caring and we saw some positive interactions. Yet we also saw practices that showed a lack of respect for people and compromised their dignity. People's care was not always planned or delivered in a way that met their individual needs and preferences.

There was a range of group activities and outings provided, however, these appeared to benefit only some of the people and others told us they were bored. People gave mixed feedback about the food but were generally satisfied. However, we found people's nutritional needs were not assessed and monitored to ensure they maintained a stable weight.

We found the home was disorganised and chaotic with inadequate communication systems which meant senior staff were not always aware of what was happening in the home. Although the home had quality assurance systems in place these were ineffective and had not addressed the issues we identified at this inspection, many of which were similar to those we found at the previous inspection in November 2014.

Overall, although we found significant shortfalls in the care and service provided to people. We identified ten breaches in regulations – regulation 18 (staffing), regulation 19 (recruitment), regulation 12 (safe care and treatment), regulation 15 (premises), regulation 13 (safeguarding), regulation 11 (consent), regulation 9 (person-centred care), regulation 10 (dignity and respect), regulation 16 (complaints) and regulation 17 (good governance). The Care Quality Commission is considering the appropriate regulatory response to resolve the problems we found.

The overall rating for this provider is 'Inadequate'. This means it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made
- Provide a clear timeframe within which the provider must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the

Summary of findings

service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. We found staff had not been trained in safeguarding and abuse was not always recognised and acted upon appropriately.

People told us there were not enough staff to meet their needs or to keep the home clean.

Recruitment procedures were not robust and staff had been employed without their suitability being fully explored.

The environment was not clean, secure or well maintained.

People's medicines were not always handled and managed safely.

Is the service effective?

Inadequate

The service was not effective. People told us new staff were inexperienced and we found staff induction and training was not up to date.

Not all staff had received training in Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and care records we saw showed a lack of understanding of this legislation.

Although people said they enjoyed the food, mealtimes were not adequately spaced and people's nutritional needs were not monitored.

Access to health care services were in place but were not always sought in a timely way.

Is the service caring?

Inadequate

The service was not caring.

Although some people praised the staff and we saw some staff interactions were warm and friendly, we also observed practices which showed a lack of respect for people and undermined their privacy and dignity.

Is the service responsive?

Inadequate

The service was not responsive. Care planning was incomplete, not up to date and did not provide staff with the information they required to meet people's needs.

A range of group activities and outings were provided but benefitted only some people, others told us they were bored.

People knew how to make a complaint however we found complaints were not always recorded or addressed.

Is the service well-led?

Inadequate

The service was not well led. People were not protected because the provider did not have effective systems in place to monitor, assess and improve the quality of the services provided. This was evidenced by issues identified at this inspection, many of which had been raised at the previous inspection in November 2014.

People's feedback was not consistently sought, valued or acted upon.

St Ives Disabled Care Centre

Detailed findings

Background to this inspection

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

This inspection took place on 27 and 28 May 2015 and was unannounced. On the first day three inspectors and an expert by experience with experience in care services visited the home. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day there were two inspectors.

Before the inspection we reviewed the information we held about the home. This included looking at information we had received about the service and statutory notifications we had received from the home. We also contacted commissioners from the local authority and the clinical commissioning group, the local authority safeguarding team and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We usually send the provider a Provider Information Return (PIR) before the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We did not send a PIR to the provider before this inspection.

We spoke with 21 people who were living in the home, four relatives, eight care staff, five nurses, two domestics, the cook, three activity staff, the maintenance person, the manager and two area managers.

We looked at eight people's care records in detail and others to follow up on specific information, seven staff files, medicine records and the training matrix as well as records relating to the management of the service. We looked round the building and saw people's bedrooms, bathrooms and communal areas.

Inadequate

Is the service safe?

Our findings

At the previous inspection in November 2014 we found a regulatory breach in relation to staffing as there were not always enough staff to meet people's needs and the system used to calculate staffing levels was not reliable. At this inspection we found similar concerns.

People we spoke with who lived in the home raised concerns about the staffing levels. One person said, "There are not enough staff and they don't have any rapport – it's just a job." Another person told us, "There are not enough staff on at night. They don't seem to be qualified or to be able to speak English." Another person said, "They need more staff, especially at night. They are supposed to have male or female staff at night but sometimes there are only males. I pressed the buzzer and nobody came." A relative we spoke with said, "They are always changing staff and there are too many young girls who are inexperienced."

We asked the manager how staffing levels were calculated. They told us there was a dependency tool but they had not been shown how to use it. The manager said the usual staffing was two nurses and eight care workers on duty from 8am to 2pm; two nurses and six care workers from 2pm to 8pm and one nurse and four care workers from 8pm to 8am. Three of the staff we spoke with told us they did not think there were enough staff on duty in the evenings to meet people's needs. They explained on the first floor ten people needed assistance from two staff to meet their moving and handling needs. In the evenings there were three staff allocated to this floor so if two were assisting one person this only left one staff member available to support all of the other people. This meant people often had to wait until two care staff were available to attend to them. One person said, "I get really fed up having to wait for staff. The staff are nice but there aren't enough of them. Sometimes they come in and turn the buzzer off and say we'll be back in five minutes, but it is always longer than that." Another person said, "I can wait 15 -20 minutes to get off the toilet. If it gets to 30 minutes I phone reception to tell them to send someone to assist me."

We observed there were insufficient staff to meet people's needs in a timely way. For example, at 10.05am we saw one person in a communal area waited 25 minutes for assistance from staff to use the toilet and by the time the staff member arrived the person said they had been incontinent.

We found there were insufficient domestic staff to keep the home clean. One relative told us, "The staff have improved and the new manager is good, but there are not enough domestics and it has become dirty." On the first day of our inspection there were two domestic staff on duty. One was covering the laundry duties as the laundry person was on annual leave and the other was cleaning the home. On the second day three domestics were on duty although one left part way through their shift. One of the activities staff and a care assistant had also been asked to cover domestic duties. Staff told us they had been short of cleaners for six or seven weeks because of long term sickness. The manager told us staff had been off sick since before they started working in the home on 22 April 2015 and this was confirmed by the duty rotas we saw. This meant no action had been taken to make sure there were enough domestic staff on duty to keep the home clean. The domestic staff hours were further reduced as the manager told us there were no laundry staff at weekends or after 11am during the week, so laundry tasks had to be completed by the domestic and care staff at these times. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the recruitment records for seven staff, some of whom had been recently recruited. We saw staff had completed an application form and had been checked with the Disclosure and Barring Service (DBS) before they started work at the home. However, we found thorough employment checks had not been carried out. For example, we saw on one application form the applicant had only given the years, not full dates, of their previous employment and there were no records of their interview. This meant any gaps in their employment were not clear and there was no evidence their employment history had been checked. We found references obtained for one applicant had been sent to the referee's home addresses rather than the registered managers of the care services they had previously worked for. For three other staff the references had been provided by the manager of St Ives, who had worked with the staff for the same previous employer. When we asked the manager why references had

not been obtained from the registered manager of that service, they told us they had requested references but had not received them. There was no evidence on the files to support this.

In one file there was only one reference, we asked the manager where the second reference was and they told us they would look for it. On the second day of our inspection, a second reference was produced. We saw this had been written by a nurse who was in the home completing their induction training. We asked this nurse when they had written the reference and they had been asked to write it that day as they had been told a previous reference they had written had been lost. The reference was dated 23 April 2015 and the manager had signed it stating it had been received on 24 April 2015.

In another file there were no references and on the application form there was only a name for the second referee. We asked where the references were and on the second day of our inspection we saw the details for the second referee had been added to the application form and the manager had written that the verbal reference had been requested that day. We also saw a written reference from one of the nurses who was working at St Ives who had worked with this staff member at their previous care service. The reference was dated 23 May 2015. However, we saw the nurse had left that care service on 23 March 2015. This meant they had no knowledge of the person's most recent practice. This meant thorough independent checks of people's care practice were not being undertaken to ensure they were suitable and safe to work with people who may be at risk. This was a breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked around the home and found it was not clean. Some carpets were covered in bits, were visibly stained and two rooms smelt strongly of stale urine. Some surfaces were covered in dust and there were dirty blinds and dirty commodes. We also saw a 'V' shaped pillow with faeces on it. The plasticised cover was split, meaning it could not be cleaned effectively. The manager agreed the home was not clean and said they had been shocked at the poor standard of cleanliness describing the home as, "Mucky."

We saw an incontinence pad had been disposed of in a general waste bin in a communal area together with a pair of disposable gloves. We brought this to the attention of a senior carer who said these items should have been disposed of in a clinical waste bin. When we looked in the laundry we saw there were six bags of soiled laundry in red bags and a duvet that was wet with urine on the laundry floor.

We saw the staff policy on uniform, appearance, footwear and jewellery stated staff should not wear rings with stones in or false nails. We saw staff wearing rings with stones and one staff member with long false nails.

We looked at the infection prevention audit that had been completed by the Bradford infection prevention team in February 2015 and the service had achieved 94.74% compliance against their standards. We saw the service had been given some actions to complete. For example, blinds to be cleaned, replacement of a carpet, notices to be put up and a foot operated bin for domestic waste in the laundry. When we looked around the building we saw none of these actions had been addressed. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found some rooms were clean, well maintained and comfortably furnished; however these were in the minority. Overall the décor was shabby. We saw the paint was peeling off the outside windowsills and furniture in bedrooms which was damaged or broken. Many of the carpets in people's rooms were worn and /or stained. Communal rooms were untidy and disorganised, which we saw caused problems when people and staff were trying to manoeuvre wheelchairs. The manager told us they had identified areas for improvement but acknowledged there was no written plan or timescale for this refurbishment to take place.

We found systems in place to check the safety and maintenance of the building were ineffective. For example, we found two windows without restrictors on them. One of these windows was the size of a door and led out onto a flat roof. Yet the maintenance records we reviewed stated checks had been carried out and restrictors were fitted on these windows. We raised this with the maintenance person and when we visited on the second day the restrictors had been fitted.

On the first day we saw a final exit door from one of the fire exits was not secure and this meant people could enter or leave the building unseen. When we arrived early in the

morning on the second day we checked this door which had a keypad lock fitted and found it was open. We discussed this with the manager at the end of our visit who told us they were unaware of this.

We asked two of the night care assistants what they would do in the event of a fire. They were unable to give us an account of the evacuation procedures and told us they had received no training about fire safety. We asked these staff and the nurse in charge how many people were currently living in the home and they were unable to tell us. This meant in the event of a fire there was no assurance staff would take the correct action.

We saw some fire doors were not closing securely into the door frames, fire doors wedged open and various items being stored at the bottom of one of the fire exits. The maintenance records showed the fire alarms could not be heard in various parts of the building and this had been reported to the manager weekly since 1 May 2015 but had not been addressed. The records showed six emergency lights had not been working since 8 May 2015. We looked at the fire risk assessment dated 11 August 2014 which stated there were 48 rooms and the service could accommodate 48 people. The service is registered to provide accommodation for 60 people. We saw the risk assessment had identified a number of areas for improvement, but could not see what had been completed. We contacted the fire authority and they visited on the second day of our inspection and informed the manager they would be taking action regarding the emergency lighting, fire alarm sounders and fire risk assessment.

We noted there were additional heaters in some of the bedrooms and the hot water in some bedrooms was in excess of 50 degrees centigrade. We spoke to the maintenance person about this and they told us there were four boilers that served the home with hot water and central heating, but one of these was not working. We found areas of the home were cold during our visit. We asked to see the Gas Landlord Safety certificate during and after the inspection. This was not provided. This was a breach of Regulation 15 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although people we spoke with told us they felt safe in the home, we found people's safety was at risk as staff had not received up to date safeguarding training and safeguarding incidents were not always identified and acted upon.

The manager told us safeguarding training was updated annually, however, the training matrix showed 44 out of 58 staff listed were overdue safeguarding training and had not received an annual update. Two care staff had not received training for over two years, one since 2012 and the other 2013.

The manager told us there had been two safeguarding incidents since the last inspection, both of which had been referred to the Local Authority safeguarding team and the Commission had been notified. However, the manager was unable to find any evidence to show that one of these incidents, which had been reported in March 2015, had been acted upon or investigated. We found another incident where a person reported they had called for staff assistance at night and no staff had attended and as a result the person had been incontinent and had to change their own bed. We discussed this with the manager who was not aware the incident had occurred. This had not been referred to safeguarding or investigated. We saw the call bell in this person's room was broken and their daily notes showed it had been broken since 16 May 2015. We asked this person how they summonsed assistance from staff if they were in their room. They said, "I just shout help, but if it's me they don't come, they don't like me." We asked the manager about the call bell and they said they had only been made aware that day (the second day of our inspection) that the call bell was still broken. We referred this incident to the Local Authority safeguarding team. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found people were not always fully protected against the risks associated with the unsafe use and management of medicines. Most medicines were stored safely in locked cupboards and trolleys. However, we saw medicines in one person's bedroom which were not locked away. The person was not in the room and door was unlocked which meant anyone could access the room and the medicines. We saw a self-medication assessment which stated this person was responsible for keeping their medicines secure but this had not been reviewed since 30 April 2013. Medicines must be kept securely at all times in order to protect people living in the home against the risks associated with the unsafe storage of medication.

We found medicine administration records (MAR) were well completed, which showed people were receiving their medicines as prescribed. We found protocols were in place

Inadequate

Is the service safe?

for 'as required' medicines which gave guidance to staff about the circumstances in which these medicines should be administered. However, there were no clear instructions on the MAR for thickening agents which were prescribed to be used 'as directed'. We checked the care plan for one person who was prescribed a thickening agent; the nurse told us they had 'two scoops' but there was no reference to this in their records. We saw another person's care plan showed they had thickened fluids, yet there was no thickening agent prescribed on their MAR or in stock for this person. We carried out a stock check of controlled drugs and found these were correct and the records were accurate. The nurse told us that no one was given their medicines covertly.

We asked the manager about medicine audits and they showed us a weekly audit sheet dated 21 April 2015 which showed five people's medicines had been checked and no issues had been identified. We asked the manager for copies of other medicine audits but these were not provided.

We asked the nurse if there had been any medicine errors or incidents and they said there had been none in the last six months. However, one person described to us a 'near miss' which had occurred four to five months ago when they had been given another person's medicines, but realised the mistake the nurse had made and were told to spit them out. We discussed this with the manager and area managers who were unaware this incident had occurred. The manager agreed to investigate this further. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

At the previous inspection in November 2014 we found a regulatory breach in relation to nutrition. Some people said they did not always get enough to eat and the arrangements for providing people with snacks overnight were not adequate. We observed meal times and found there was a lack of consideration and respect in the way some people were supported to eat and drink. At this inspection we found although some improvements had been made, there were still concerns.

People we spoke with gave mixed feedback about the food. One person said, "Food is very good but not spicy enough for me. The kitchen staff are great and they let me make my own meals. If you don't go to the dining room, they bring your meal to the room without asking. They do try and match your preferences." Another person said, "I don't like spicy food so they make me a snack for lunch and dinner at night. I can do things myself but they help me if I want them to." A further person said, "The food is monotonous but we do get a choice. It's always hot or you can have sandwiches." Another person told us, "Food some days is nice, some days not but it is hot and presentable." Another person said, "The dining room is too crowded but you can have it in your room. We have a choice but the food is not as good as it was before."

One person told us that since the last inspection there was always a bowl of fruit in the dining room, which they said this was good. They said there was a good choice of food and they could have something different to the menu whenever they wanted. We saw there was a hot water boiler in dining room for people to make their own drinks, however this was broken and staff said it had been out of use since the week before the inspection.

We found there was a flexible approach to breakfasts and saw people coming to the dining room for breakfast until late morning. Although this was positive in that it allowed people choice, we saw it also meant for some people there was a gap of less than an hour between breakfast and lunch. We spoke with the cook who acknowledged this was an issue. They said lunch could be held back if people had just had breakfast but said this then had a knock on effect for tea which was served at 4.30pm. We saw records were kept to show who had been served their meals but these did not include times. The records showed on one day one person had not had breakfast or lunch and on another day another person had had no lunch or tea. We asked the manager how these records were monitored and they said there were no checks made of these records.

We observed a staff member during the morning helping people with breakfast. We saw the staff member assisted one person to eat but broke off to give breakfast to another person who came into the dining room, leaving the first person with porridge all around their mouth. When the staff member had given the second person their breakfast they went back to assisting the first person to eat but paid the person no attention talking instead to other people who were in the room. Eventually the staff member turned their attention to the person they were assisting to eat saying, "You have two more" followed by, "Last one, fine" at which point they walked away again to get someone else's breakfast leaving the person with porridge all around their mouth and chin. When the staff member had brought out the other breakfast they then wiped the person's mouth but carried on a conversation with another person while doing this. We then saw the staff member go behind the person's recliner chair and without speaking pulled the chair backwards out of the dining room, talking over the person's head to another person, saying, "I am just taking (the person) to the TV lounge."

The food served for lunch looked hot and nutritious. The menu was displayed and showed a choice, although people told us they had to choose what they wanted the previous day. The cook told us they had held a meeting with people to discuss their likes and dislikes and this information had been used to plan the menus. We asked the cook how kitchen staff knew which people were on special diets and they told us there used to be a list in the kitchen but it was out of date and they did not have a current one. One person told us, "They don't understand my dietary requirements, I gave the kitchen staff a list of what I could eat but they don't read it."

We observed lunch and found it was not a sociable or pleasant occasion due to the cramped conditions in the dining room. We saw staff struggled to fit wheelchairs around the tables and staff who were assisting people with their meals found it difficult to find space to sit down. The cook offered the most conversation with people although

there were care staff present as well. We saw one person told the cook they liked cheesecake but not the biscuit base and the cook offered them a portion with the biscuit removed.

We observed one staff member in the dining room assisting a person with their meal and there was limited interaction with the person. We heard the person say they did not like salmon but they had to repeat it twice before the staff member took any notice. The cook then intervened and offered an alternative choice.

We saw in a report completed by the organisation's compliance team dated April 2015, six people's care records had been audited and identified significant weight loss over the previous four months. The manager told us as a result of this audit they were monitoring everybody's weight weekly for a period of four weeks as they felt some of the information recorded about people's weight loss was incorrect. This was confirmed by one of the nurses we spoke with who said they would review people's weights after the four week period and determine then if dieticians, GPs or the speech and language therapy (SALT) team needed to be involved. However, we questioned the accuracy of the weekly weight records as we saw one person was recorded as having gained over 10kgs in a seven day period and another had lost over 6kgs in the same timeframe. When we looked at people's care records and spoke to staff we found there was not a consistent approach to managing people's nutritional needs and responding to weight loss.

For example, we saw one person's care plan identified in January 2015 they were losing weight every month and needed careful observation and recording of their weight. The next time their weight was recorded was April 2015 when a 3.8kg weight loss was identified and the most recent weight record on 19 May 2015 showed the weight had remained the same. The records stated the weight loss was to be reported to the GP, however, there was no evidence to show this had been done. We asked one of the nurses on duty if this person was having their food and fluid intake monitored and they told us they were not. We found there was a food intake monitoring form in place, however, staff were not reviewing the information or using it to make an assessment as to the adequacy of this person's diet on a daily basis. The manager told us the nurses were responsible for monitoring and assessing the food and fluid charts, yet when we spoke to one of the nurses they told us it was the senior care staff who were responsible. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people we spoke with raised concerns about the skills and competencies of the staff. They said there were a lot of new and inexperienced staff who they felt did not understand their needs. One person said, "We are looked after well but you need to tell them your care needs. Staff know what they are doing except the new ones. It's been topsy turvy for a while." Another person said, "The staff are kind and caring but the experienced staff have all gone. It takes time for the new ones to learn the routines and they are too young."

The manager provided us with a copy of the training matrix and told us they were in the process of rolling out a new one. The matrix provided information on how often training should be updated and identified any training which was overdue. The matrix showed mandatory training for staff in many key areas such as moving and handling, infection control, health and safety, safeguarding and first aid, was refreshed every twelve months and was overdue. For example, the matrix showed 28 out of 58 staff listed had not received practical moving and handling training in the last twelve months and 45 out of 58 staff had not received infection control training in the last twelve months.

Three of the night care workers we spoke with told us they had not received any induction training. When we looked in their files we saw two induction records were blank and there was no induction record in the third file. This meant staff had not been given basic training before they started working in the home. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Staff we spoke with said they had received online training in the Mental Capacity Act 2005 (MCA) and DoLS. However, the training matrix showed 50 out of 58 staff listed were overdue the twelve month refresher training. This included 17 care staff and a nurse who had not received any training in MCA and DoLS. We asked the manager if anyone at the home had a DoLS authorisation in place and they said no. We saw MCA and DoLS assessments in some people care records we reviewed and found the completion of these assessments

showed a lack of understanding of the legislation. For example, one person's MCA assessment stated they lacked capacity but this was a general statement and not decision specific. This person also had a DoLS assessment which showed they had no capacity, were subject to constant control and supervision and were not free to leave. It was not clear from the record what decision was reached as a result of the assessment, however, we found this person was subject to a number of restrictions such as bed rails and a lap belt in their wheelchair, which suggested a DoLS application may be required. When we raised this with the manager and area managers they said they knew nothing about this situation. For another person the DoLS assessment stated they had capacity, were free to leave and were not subject to continuous control and supervision. However, we questioned the accuracy of this assessment as the person was physically unable to leave or move around without staff assistance and while technically they may have been free to leave they could not go home without a complex care package being put in place and within a very short time of meeting this person they told us they wanted to go home.

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

Care records we saw showed health care services had been accessed such as the tissue viability nurse, GPs and dieticians. However, we were not assured that health care support was always accessed in a timely way. For example, we saw one person who was losing weight had been seen by the GP three times but there was no evidence to show their weight loss had been discussed with the GP. Another person's notes showed they had been refusing their medication and highlighted this was to be discussed with the doctor, although the doctor had visited there was no evidence to show this particular medicine had been discussed with them. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service caring?

Our findings

At the previous inspection in November 2014 we found a regulatory breach as people were not always supported in a way that respected their dignity. At this inspection we found similar concerns.

Most people we spoke with described the staff as kind and caring and spoke positively about them, although other people were not as satisfied.

One person said, "I like it here, they look after me well and we have a laugh." Another person said, "I love it here, they are a good bunch of staff and they made me feel welcome. They have helped me tremendously – it's a darn good place." A further person said, "Staff are really good with residents. They helped me with my rehab, both physical and mental. They were outstanding – over and above. They need more rest and need more older staff.' Another person said, "The staff are blooming good – and they take a lot of rubbish from some people. It's absolutely lovely and they can't do enough for you." A relative said, "Care is very good and the staff are good. I would recommend St Ives to anyone."

Two people were less positive about staff. One person said, "I keep myself to myself. Some talk down to me, particularly (name of staff member)." Another person told us, "I'm not allowed to talk to you. I got into trouble last time for saying the wrong thing." A relative said, "(My relative) is happy here and doesn't want to move but they are not helping (my relative) with feeding and (my relative) keeps losing weight. They are good at bringing the doctor when needed."

Although we observed some staff were considerate and respectful in their interactions with people we saw other practices which demonstrated a lack of respect and undermined people's dignity. For example, staff told us blinds in some people's bedrooms were broken and would not close and we saw this when we looked round. This meant the blinds could not be closed to preserve people's privacy or to darken the room if people went to bed before it was dark. We saw laminated notices in some people's bedrooms giving staff instructions about the person's hygiene regime, their position in bed and instructions about changing equipment. This information should be in people's individual care plans and it should not be necessary to have this type of information on display.

We saw one room where there had been a problem with the roof and water had come down the wall into the bedroom. We saw the person had been moved to another room whilst repairs were undertaken. However, the majority of their personal possessions such as books, videos and vinyl records had been left in their original room. They had not been covered up and were thick with dust. When we asked how long this person had been moved out of their original room staff told us it had been 10 months. This person's relative told us, "They moved X out of their room a long time ago as there was a burst but they didn't move their things. They are still in there being damaged as the builders are using it as a store. I have mentioned it but they have done nothing."

While we were in the coffee lounge we saw a staff member change the channel on the television without any consultation with the people who were sitting in this room. We saw a staff member sat on the work top, where people were partaking in a baking activity. On another occasion we saw a staff member chastise one person for swearing, yet said nothing when another person swore and was aggressive towards another person in their presence.

The home had a tannoy system which they used to summon staff. We heard this in use throughout our visit. It was very loud and intrusive in the communal areas of the home. The manager told us it was like being at a train station.

When we looked around the building we saw some bedrooms had shared en-suite toilets which could be occupied by people who had bedrooms on either side. We found some of the en-suite doors had no locks which meant occupants of both rooms could access the toilet at the same time or could walk through the toilet into the other person's bedroom. This compromised people's safety, privacy and dignity. We asked the manager if there were risk assessments in place to show how these risks were being managed and were told none had been completed.

Some people told us their independence was not always promoted. One person told us, "They do everything for us rather than with us. I make my own tea and coffee but they won't let me decant the milk myself. They should let you do it yourself if you can." Another person told us they were not happy and were waiting to be moved so they could have more independence. They explained that the location was an issue as they needed taxis to get about.

Inadequate

Is the service caring?

Although some people had taken volunteer roles in the home, we found they were not properly supported in those roles; as a result they were dealing with situations which we observed caused them anxiety and which also compromised the confidentiality of other people living in the home. It was not clear if the process of selecting volunteers had been equitable. One person also expressed concern about how these roles had been decided and said, "They need to share out the jobs like (volunteer role)."

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

At the previous inspection in November 2014 we found a regulatory breach in relation to care and welfare as people's care was not always planned and delivered in such a way as to meet their individual needs and preferences. At this inspection we found similar concerns.

The manager told us they had identified shortfalls in the care documentation and had put processes in place to ensure the care plans were up to date and reflected people's needs and preferences. They said this work was ongoing and approximately 75% of the care plans had been done.

We found, although there was detailed information about people's needs in some of the care plans we reviewed, information was missing and it was often difficult to determine people's current needs as the files contained out of date, and sometimes contradictory, information. For example, one person's file contained care plans dated June 2013 which stated the person was no longer on a **percutaneous endoscopic gastrostomy (**PEG) feed and could eat a soft/pureed diet, yet an undated nutrition plan showed they were having a PEG feed overnight as well as pureed food. A PEG is a feeding tube which goes directly into the stomach and is used to provide nutrition when a person is unable to take adequate nutrition orally. This person also had a pressure ulcer which had been seen by the tissue viability nurse; however, it was difficult to determine the current treatment regime from the records as there were wound care plans dating back to 2012. There was no information regarding the correct setting for this person's pressure relieving mattress. When we checked the mattress it was set to 90kgs, although the weight records showed the person weighed 67kgs. This meant the mattress was not set correctly and therefore would not be working effectively to relieve pressure and aid the healing process.

We looked at the care records for one person who had recently been admitted. We saw this person on several occasions throughout our visit and it was evident staff did not know how to meet this person's needs. The care records gave little guidance to staff in how to support this person and the daily records showed staff were struggling to manage this person's needs. We considered their placement was not appropriate. We discussed this with the manager who agreed and said they felt the person should not have been admitted to the home as their needs were not being met and this was also affecting other people in the home. On the second day of our visit the manager told us they had arranged for health care professionals to visit that day to review the person's placement.

We found care was not personalised to meet people's individual preferences or needs. For example, we saw one person's care plan showed they did not like to eat in the dining room and preferred to eat in their own room. We saw this person had their breakfast in the dining room at 11am and was back in again at 12 noon for their lunch. We saw they were assisted with eating their meal and ate only a few spoonfuls and refused anymore. We saw evidence of medical intervention to address this person's weight loss; however, there was no evidence to show staff had considered more basic issues such as the person's stated preference not to eat in dining room, gaps between meals or unhappiness with their current circumstances as contributing factors to the person's weight loss.

Another person's records showed they had an occupational therapist (OT) assessment in December 2014 which stated they had to wear a night resting splint during the day for twenty to thirty minutes to build up tolerance for night time and this would be reviewed by the OT in a few weeks. There was no other information to show why the splint was needed or of any review. When we discussed this with the manager they said they did not know anything about it.

One person using the service told us, "We are getting a lot of new young staff; I have to tell them how I like things done. We have care plans and they should be looking at those to find out what people need."

We spoke with one person who told us ideally they liked to shower twice a week, but this did not always happen. They showed us the shower room they used and the shower chair. They said there was not a lot of room to manoeuvre in this bathroom and the shower chair they used was a 'tight fit.' We spoke to two care workers who told us the shower chair was not comfortable for this person and was not appropriate for their posture and size. We looked at this person's personal hygiene records and saw over a 24 day period they had only been showered four times. We asked the manager and area manager if there were any problems getting suitable equipment for people and they told us

Is the service responsive?

there was not and they would arrange for an assessment to be completed. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw an activity board in the main reception area which offered day trips and holidays. We spoke with activity staff who told us regular trips were arranged. They said the home had access to the organisation's minibus twice a week and showed us leaflets of places they had visited.

One person told us, "We go on holidays and trips and I like the cinema room. I've been to the Lakes, Blackpool and abroad but I prefer it in this country." However, another person said, "There is an activity board but nothing goes to plan. We have residents meetings but nothing changes." Another person said, "We get a questionnaire asking what we'd like to do and they've arranged a trip to Castleford for me soon." A relative said, "They (the staff) really try – they offered to take (family member) to a car museum."

We saw five people taking part in a baking session and there was lively conversation and people appeared to be enjoying themselves. We saw another activity staff member spend time with one person showing them how to use a computer. There were five other people in the room who were not engaged in any activity and although the television was on we observed nobody was watching.

We spoke with another person who told us they regularly went out and we saw this person went out on both days of our visit.

However, we found activity provision focused predominantly on group activities and trips out and people said it was the same group of people who went out each time. We saw people sat around with nothing to do and people told us they were bored. One person we spoke with in the afternoon said they were going to go and lie on their bed until tea as there was 'nothing to do'. We asked people what they did during the evenings and they told us apart from the television or going on the computer there were no activities.

We saw in one person's records they loved horses and it had been agreed in June 2014 that they would start visit the stables as a starting point to going out more often. There were riding stables on the St Ives estate in close proximity to the home. There was no evidence in the care records to show this had happened. We looked at this person's activity records from January 2015 and found no evidence of a trip to the stables, although the person had visited a donkey sanctuary.

We looked at the complaint records and found only one complaint had been recorded since the last inspection. The record showed this complaint had been acted upon and resolved to the complainant's satisfaction. The manager told us no other complaints had been received. They told us minor concerns were not recorded as complaints as they were usually dealt with straight away.

Our discussions with people showed they knew how to make a complaint and in some cases had done so, yet we found people had raised issues which had not been reported, recorded or addressed.

We spoke with one person who told us they had asked for a new bed as they found their mattress uncomfortable and for a new carpet because theirs was heavily stained and unsightly. One of the domestic staff also told us they had made the same request but nothing had happened. We spoke to the manager and area manager about this, they told us this had not been reported to them.

Another person said, "I usually complain to (staff member) and he is good but (another staff member) has been really good to me. I have problems with my bed as I have (a medical condition) and I'm waiting for them to sort it out." A further person said, "You complain to (deputy manager) or (manager) and they sort it out – but not always."

We spoke with one relative who told us they had raised concerns about their family member's belongings not being moved with them into a new room but nothing had been done. We saw another relative had raised a number of concerns in May 2015 which included the commode not being emptied by staff. We visited this person's room at 9.45am and found the commode had not been emptied and when we went back almost four hours later the commode had still not been emptied. This meant people's complaints had not been taken seriously and acted upon. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At the previous inspection in November 2014 we found a regulatory breach in relation to good governance as the quality assurance systems were not always effective in identifying shortfalls in the service and risks to people's health, safety and welfare. We had requested an action plan from the provider to show how improvements were going to be made but this had not been received. At this inspection we found similar concerns.

The home had a registered manager who had left the organisation in March 2015. A new manager had started in post on 22 April 2015. They had not applied for registration with the Commission and told us they would not be applying until the service was stable. The new manager had started to make some improvements and to address issues with staff, however, we were concerned that the improvement plan in place was not robust and did not encompass all the areas of concern we identified during our inspection.

We found the home was disorganised and chaotic and poor communication systems meant it was difficult to obtain clear information. For example, staff were not clear how many people were using the service. The care staff told us there were between 40 and 50 people, the night nurse told us they thought there was 47 or 48 people and then had to count them on the handover sheet where it was determined there were 41 people. We found the manager and senior managers were not always aware of incidents that had occurred in the home such as accidents and complaints. We found information we requested from the managers was not always provided and resulted in us making further requests following the inspection.

We requested reports of quality monitoring visits undertaken by the provider since our inspection in November 2014 and saw reports of visits in December 2014, March and April 2015. The reports identified continuous shortfalls in the service provision, particularly in the compliance manager's report which was conducted over four days in April 2015.This report was very comprehensive and identified non-compliance across all the domains audited.

The manager showed us an improvement plan dated 29 March 2015 which showed the actions being taken to address the issues identified. The timescales for the actions to be completed had all passed, yet the manager confirmed many of these actions remained outstanding. We also found that some of the actions which were signed off as completed were not. For example, the plan stated accidents and incidents were now being reviewed. We found no evidence of this and questioned if all accidents and incidents were being reported due to the low numbers recorded in the accident and incident log. For example, six accidents in January, none in February, six in March, two in April and none in May 2015. There was no analysis of the accidents and incidents. We found one accident related to a staff member who had fallen down some steps and the only action recorded was a reminder to the staff member to be more vigilant in future. We discussed this accident with the manager and senior managers who said they were unaware this accident had occurred.

The improvement plan stated that the call bell systems had been checked and any shortfalls had been rectified. We looked at the maintenance records dated April 2015 which identified 33 discrepancies with the call bell system and showed 17 call bell leads were needed and 13 nurse call boxes. We asked the maintenance person if these were now in place and they said no they were still waiting for them to be delivered.

We looked at care plan audits and found the most recent ones were dated November 2014. There was a tracker dated 20 May 2015 which identified four care plans to be reviewed each week, none had been done.

We found systems in place to gain feedback from people who used the service were ineffective. We asked the manager and senior managers if satisfaction questionnaires were sent out. They said they were but were not able to confirm when they were sent out or to find any surveys to show us. We asked the manager about residents meetings and they said the previous manager had planned one for 30 May 2015, but they did not think anyone knew about it as there had been no posters so they were going to arrange one for the end of June. We saw there was a poster in the dining room advising residents meetings would be held on 19 May, 21 July, 15 September and 24 November 2015. We asked to see the minutes from the last residents meeting. The manager gave us minutes dated 21 April 2015. People we spoke with confirmed residents meetings were held but did not have much confidence that they

Inadequate

Is the service well-led?

brought about any changes. One person said, “There used to be residents meetings but I’m not sure that there still are.” Another person said, “We have residents meetings but nothing changes.”

Five staff we spoke with told us staff morale was low. They said some staff had been ‘sacked’ and others were leaving. One person using the service told us, “The old carers are going as they don’t like the way senior managers treat them.”

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

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not protected from abuse and improper treatment as systems and processes were not established and operated effectively to investigate any allegation or evidence of abuse. Regulation 13 (1) & (3).

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 Service users were not provided with care and treatment in a safe way as the management of medicines was not safe and proper; and the risks in relation to the spread of infection were not assessed, prevented, detected or controlled. Regulation 12 (2) (g) (h).

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 Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed and had not received appropriate support, training, professional development to enable them to carry out the duties they were employed to perform. Regulation 18 (1) (2) (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment All premises used by the service provider were not clean, secure or properly maintained and had not maintained standards of hygiene appropriate for the purposes for which the premises are being used. Regulation 15 (1) (b) (e).

This section is primarily information for the provider

Enforcement actions

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 Service users were not treated with dignity and respect and their privacy was not ensured. Regulation 10 (1) (2) (a).

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 The care and treatment of service users was not appropriate and did not meet their needs or reflect their preferences. Regulation 18 (1) (a) (b) (c).

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 Systems and processes were not established or operated effectively to assess, monitor and improve the quality of the services provided or to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. Accurate, complete and contemporaneous records were not maintained in respect of each service user, including a record of the care and treatment provided to the service user and decisions taken in relation to the care and treatment provided. Regulation 17 (1) (2) (a) (b) (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Recruitment procedures were not established and operated effectively to ensure that persons employed

This section is primarily information for the provider

Enforcement actions

are of good character and have the qualifications, competence, skills and experience which are necessary for the work to be performed by them. Regulation 19 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The registered person had not established and operated effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity. Regulation 16 (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The registered person had not ensured that they had obtained the consent of the relevant person to care and treatment, and where the service user was 16 or over and was unable to give such consent because they lacked capacity to do so, had not acted in accordance with the Mental Capacity Act 2005. Regulation 11 (1) (2) (3)