Qualia Care Limited

Duchess Gardens Care Centre

Inspection report

Lady Lane
Bingley
West Yorkshire
BD16 4AP

Tel: 01274551173

Date of inspection visit:
31 October 2017
02 November 2017
20 November 2017

Date of publication:
05 April 2018

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?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Duchess Gardens Care Centre is a converted four floor building and is registered to provide personal care and nursing to a maximum of 131 people. The home provides care for older people, people living with dementia and people with long term mental health needs. At the time of our visit 64 people were using the service and one person was in hospital.

This was the first inspection of the service since it was taken over by Qualia Care Limited in February 2017. Prior to this the service had been in administration and the last inspection had been completed in September 2015. At that time we identified three breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and assessed the service as being requires improvement in all domains and requires improvement overall. This meant the provider knew improvements needed to be made.

There was no registered manager in post. A manager had been recruited but had not made an application to CQC to be registered. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. Since the registered manager left the service in March 2017and one of the nursing staff had been acting manager until a permanent manager was appointed in September 2017.

Staff were not always being recruited safely and there were not enough of them to keep people safe and deliver person centred care. Whilst some staff were seen to deliver caring, kind and compassionate care, others were not treating people with dignity and respect. A lot of staff training was out of date and some staff supervisions were overdue.

Although staff could tell us about safeguarding procedures, we found incidents were not always being reported to the safeguarding team. Important information was missing from the emergency fire files about people's evacuation needs should an emergency arise.

People's care plans were not person centred and did not always provide accurate and up to date information about their current needs. Information was difficult to find or contradictory. Risk assessments were being completed; however, these were not always being followed or had been completed incorrectly. This meant we were not confident action was being taken to mitigate risks to people using the service.

Medicines were being managed safely. However, advice about people's healthcare needs was not always being sought in a timely way.

People who used the service made some positive comments about the meals; however, we found people's nutritional and hydration needs were not always being met. We also found people's mealtime experience

was variable depending which unit they lived on.

There were some activities on offer and trips out were being arranged

We found the service was not working within the principles of the Mental Capacity Act and Deprivation of Liberty Safeguards. People were not supported to have maximum choice and control of their lives and staff did not support people in the least restrictive way possible; the policies and systems in the service did not support this practice.

Generally the home was clean and tidy; however, there were areas where unpleasant odours were present. A redecoration and refurbishment plan was in place.

There was a complaints procedure in place and formal complaints had been investigated.

There was a lack of leadership and direction for staff, with no oversight of clinical risks or key issues for people's care. Systems and processes for monitoring the quality of the care provision were weak and there was no robust management of the service. At the time of the inspection there was a new management team in place. They had produced an action plan for improving all aspects of the service. However, it was too soon for us to assess the impact of this upon people's care.

We found nine breaches of the Health and Social Care Act (2008) Regulated Activities 2014 Regulations. You can see what action we asked the provider to take at the back of the full version of this report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still 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 this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to 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 so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Staff were not always being recruited safely and there were not enough staff to keep people safe or to provide person centred care.

Risks to people's safety were not always being mitigated and safeguarding issues were not always being reported to the safeguarding team.

Medicines were being managed safely.

Is the service effective?

Inadequate

The service was not effective.

Staff did not always have the training, knowledge or skills to support people appropriately.

The service was not meeting the legal requirements relating to Deprivation of Liberty Safeguards (DoLS).

People's nutritional and hydration needs were not being met.

Healthcare needs were not always being met.

Is the service caring?

Requires Improvement

The service was not always caring.

Whilst some staff were caring, compassionate and kind this was not consistent across the service.

Some staff were not treating people with dignity and respect.

Is the service responsive?

Inadequate

The service was not responsive.

People were not receiving person centred care which met their needs or preferences.

There was a complaints procedure in place and formal complaints had been investigated.

There were some activities on offer to keep people occupied, however, more work needed to be done to make sure these were person centred and tailored to individuals.

Is the service well-led?

Inadequate

The service was not well-led.

There was no registered manager in post.

Effective quality assurance systems were not in place to assess, monitor and improve the quality of the service. We identified nine breaches of regulations at this inspection.

Duchess Gardens 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 31 October, 2 November and 20 November 2017. The first day the inspection was carried out by one adult social care inspector an assistant inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. A paralegal from CQC was also present to observe the inspection process. On the second day the inspection was completed by three adult social care inspectors. The inspection was concluded on the third day by two adult social care inspectors.

Before the inspection we reviewed the information we held about the service. This included notifications from the provider and speaking with the local authority contracts and safeguarding teams. On this occasion we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spent time observing care in the lounges and dining rooms and used the Short Observational Framework for Inspections (SOFI), which is a way of observing care to help us understand the experience of people using the service who could not express their views to us. We looked around some areas of the building including bedrooms, bathrooms and communal areas. We also spent time looking at records, which included ten people's care records, four staff recruitment records and records relating to the management of the service.

We spoke with 10 people who used the service, three relatives, two visitors, one agency nurse, and a team

leader. We also spoke with a senior care worker, seven care workers, a district nurse, one housekeeper, an activities co-ordinator, the chef, the administrator, deputy manager, manager and operations support manager.

Inadequate

Is the service safe?

Our findings

People who used the service told us that there were not always enough staff on duty to support them. Their comments included, "There can always be more." "I don't think so they take a long time to come." A visitor told us, "I think there should be more staff in the main lounge all the time. [Name] who is blind sometimes stands up and there is no one to help her. We have to go find staff. Also [name] who is unsteady on their feet walks off on their own staff are not always around."

We observed throughout the inspection that people were left unattended for long periods of time in the lounges and dining rooms.

Only one senior care worker was on duty on the residential unit on the second day of the inspection. There were 29 people living on this unit and only this one senior care worker to administer medicines. We saw they were still giving medicines on the lower ground floor at 10:55am and still had the other floors to do. This resulted in people's lunchtime pain relief being omitted as there would not have been the required four hour gap between doses. We saw this senior care worker was regularly interrupted and broke off the medicines round to talk to other members of staff and to assist with other tasks. On the third day two senior care workers had been allocated on the duty rota to work on the residential unit. However, a care assistant was moved to provide cover on the nursing unit which meant one of the senior care workers worked as a 'hands on' carer. This meant, again, only one senior care worker was available to administer medicines.

The emergency call bell was going off on the top floor of the nursing unit on the first day of our visit. We heard the buzzer for approximately five minutes before it was answered. We asked a care worker who was with a person in a wheel chair what was happening. They told us that the buzzer had been pressed in the ground floor shower room and that someone down stairs would see to it, if not someone from the top floor would go down to investigate. We were not assured call bells were being responded to in a timely way.

On the first day we saw one person coming out of their bedroom in their nightwear and nothing else on. It was clear they were having difficulty standing and walking as they were unsteady on their feet. It was a few minutes before staff arrived and attended to this person We also heard a person shouting for someone to help them in the dining room.

One person who used the service was still in bed at 9am when we went to their room, on the first day of the inspection. They told us, "I'm bored; I've been talking to the curtains. I don't think there is many staff around." This person wanted to get up but there were not any staff available to assist them. We went back to this person's bedroom with the manager. The manager then told a care worker to help this person out of bed.

One person who used the service was sitting in the lower ground floor lounge of the residential unit at 08:55am, on the second day of our visit. They had not been shaved and did not have any slippers on. A care worker fetched their shoes at 09:10am from their bedroom and assisted the person to put them on. We asked the care worker why the night staff had not done this and they told us the night staff had been running

late. They also added the night staff never shaved any of the male residents when they got them up. The senior care worker and care worker told us they felt the night staffing levels needed to be increased by one on this unit, so people would receive more person centred care.

We heard a person shouting for someone to help them in the dining room. We went to investigate and saw a lady in a wheel chair on her own. She told us she was uncomfortable in her wheel chair and didn't feel well. There were no staff around and we had to go and find a member of staff to help her. The nurse who attended her took her out of the dining room to her bedroom. Whilst doing this the person in the wheelchair winced out in pain, when they were knocked against a dining table. (One of the inspection team moved the table to allow more space for the wheelchair to be manoeuvred.) The nurse did not slow down or offer any reassurance when the person expressed they were in pain.

We concluded there were not enough staff to keep people safe and provide them with person centred care.

This was a breach of the Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw a body map dated 30 October 2017 identifying bruising to the inside of one person's arms. We asked the care worker who had completed the form if this had been reported to safeguarding. They told us a senior care worker had been present at the time the bruising was seen and it would have been their responsibility to report to the manager who would then have informed safeguarding. We showed the body map to the manager who was not aware of the bruising and agreed this should have been referred to safeguarding.

Another person who used the service told us a male agency worker had been abrupt with them, adding they did not want a male to attend to their personal care needs. This was reported to the manager and we also referred the issue to Bradford's safeguarding team.

We saw there were safeguarding policies and procedures in place and these were also on display. Staff we spoke with were able to tell us what they would do if they thought people who lived at the home were at risk. All of them told us they would not hesitate to report any concerns to one of the nurses, manager, Care Quality Commission or the Adult Protection Unit. However, most of the staff we spoke with told us they were concerned that there were not enough staff to keep people safe and to meet their needs. However, none of the staff had reported these concerns. This demonstrated a lack of understanding of the safeguarding process. We identified concerns about people's hydration and safety needs not being met and made six individual safeguarding referrals following our inspection.

This was a breach of the Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service told us they felt safe at Duchess Gardens. These are some of the things they told us: "You feel secure." "I think it's safe." "Good security the doors are always locked you can't get out without the codes." "People can't just walk in and out there is always someone about."

'Fire boxes' were available in the nursing and residential units. These contained Personal Emergency Evacuation Plans (PEEPs). However, there were only 27 PEEPs in the nursing home file when there were actually 36 people living in that side of the building. There were 28 people living in the residential unit but there were only 24 PEEPs in that file. This meant in an emergency the evacuation needs for some people would not have been available.

One person's care plan indicated they were at high risk of falls and stated, 'Ensure wearing comfortable shoes,' We saw they were wearing slippers which were not supportive. We saw there were flat shoes in their bedroom. The two care workers on this floor were both new and were not aware of the care plan. The care worker who had assisted them to get dressed said they had put on slippers because that is what the person usually wore. On day three this person was still wearing ill-fitting, non-supportive slippers.

The same person's choking risk assessment had not been completed correctly and indicated they were at a low risk of choking. Staff had recorded this person had no swallowing difficulties, however, their medication care plan stated they should have liquid medicines due to difficulty swallowing. We saw some recently dispensed medicines had been supplied in tablet form. This was still the case when we returned on day three of the inspection. We concluded risks to people's safety were not being mitigated.

This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at the employment files of four recently employed staff and found the correct procedure was not always followed. This meant we could not be confident only people suitable to work in the caring profession were employed. For example, there was no reference on file from one person's most recent employer. In another there was no photo identification and dates were missing from one of the references and in a third only one reference was on the file.

This was a breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Two newer members of care staff confirmed they had completed an application form, attended an interview and had not been allowed to start work until all of the necessary checks had been completed.

The service is split into a residential unit and nursing unit The accommodation in both was arranged over four floors. On the residential unit there were lounge and dining room facilities on the lower ground and ground floors, with single bedrooms across all floors. The fourth floor was not in use as repairs to the roof were taking place. On the nursing unit there were lounges, dining rooms and bedrooms on three floors. There was also a shared hairdressing salon and shop.

We saw a range of checks were undertaken on the premises and equipment to help keep people safe. These included checks on the fire, electrical and gas systems. We also saw there was a redecoration and refurbishment plan in place, although this was not detailed. For example, it stated in stage two of the refurbishment to the Nursing second floor there would be a 'full refurbishment where required'. This meant it was not a specific and targeted plan which showed the provider had considered the exact areas where refurbishment was required.

We found one of the lounge areas cold and asked one of the people using the service about this. One person told us, "Yes [Name] does get cold in here, we did have a bigger heater in here but it disappeared. It lets the heat out in this room."

People who used the service made the following comments about the cleanliness of the home. "Generally speaking I don't find odours." "No Smells." "It is clean they come once a day to clean my room." "Always clean never smells" "Always clean my washing is always done as I like it."

Infection prevention policies and procedures were in place and staff told us they had received relevant

training. Disposable gloves and aprons were available for staff to use. Liquid soap and paper towels were available in bedrooms, bathrooms and toilets and hand sanitiser dispensers were available throughout the service.

Generally the home was reasonably clean and tidy; however, there were areas where unpleasant odours were present. One relative said, "Sometimes there is an odour in the lounge and hallway but it has improved."

People were positive when we asked if they received their medicines on time. People said they were given pain relief if they needed it. These were some of the comments people made; "I can't grumble I get them." "The same time every day." "I ask for pain relieve if I need it." "Early morning and pain killers three times a day. I have always been given enough to keep the pain at bay."

A visitor was happy with the way their relative's medicines were managed and told us, "They ask her if she wants pain killers. Staff tell us that she has been in pain and that they have given her pain killers."

Medicines were stored securely and only administered by staff who had received appropriate training.

Some people had medicines which were prescribed with particular instructions about when they should be taken. For example, some medicines needed to be taken half an hour before food and other medicines needed to be taken at specified times throughout the day. We found these instructions were followed. When medicines were prescribed to be taken 'as required' there were instructions for staff to help ensure these medicines were used effectively and consistently.

Topical medicines such as creams and lotions were managed safely.

Some medicines are classified as controlled drugs because there are particular rules about how they are stored and administered. We found these medicines were stored and accounted for correctly.

Inadequate

Is the service effective?

Our findings

Staff training was mostly out of date. There was 71 staff in total included on the training matrix including the home's management. Staff training was out of date for Mental Capacity Act, safeguarding and first aid. Moving and handling training, first aid, dementia awareness and medication training. Dates had been organised for this training to be up dated.

Care workers told us the 'face to face' training was very good. However, they also told us they needed more specialist training to support people they were caring for. For example, training in the care of a catheter, more training on managing aggressive behaviour and more in-depth dementia training.

Staff supervisions and appraisals were out of date. The only supervision records the manager could evidence were the most recent ones they had completed, There were no other records to review of previous supervisions or appraisals. The registered manager had placed a notice on the notice board which stated that staff supervisions would take place in September and October this year. However, when we asked them about these dates they told us that some supervisions had been pushed back to November but they aimed to have all of these completed by December 2017. At the time of our inspection 25 supervisions had been completed so far in September 2017. Supervision notes were kept in sealed envelopes within staff files.

Appraisals were scheduled to be completed in January 2018 and preparation for these was to start in November and December, but these were also currently outdated.

This was a breach of the Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

One person who used the service was receiving one to one support. We asked the agency nurse on the nursing unit if this person had a DoLS in place as they were subjected to continuous supervision. They told us nothing had been mentioned in handover. The care file showed us this person had been assessed as 'lacking capacity' 'prior to admission on 5 October 2017. However, a DoLS application had not been made

until 31 Oct. 2017.

One person's care file contained a mental capacity assessment which stated the person could not understand information in order to make decisions. Staff had recorded, on the same day, "I confirm that I have discussed my care plan and have been involved in setting goals with my named carer," in another part of the file. This showed us staff did not understand issues around consent and the best interest process.

The manager did not know who had a current DoLS in place and this information could not be found during the inspection.

This was a breach of the Regulation13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person, who had been assessed as not having the capacity to make their own decisions, had the support of a friend who had been involved in making decisions about their personal care and medication. There was no information in the care file about the friend having Lasting Power of Attorney (LPA). A LPA is a legal document that allows someone to make decisions for you, or act on your behalf, if you're no longer able to or if you no longer want to make your own decisions. LPA's can be put in place for property and finance or health and care. Without an LPA for health and care the friend would not have been able to make these decisions.

The friend had stated there were other family members who would like to be involved, however, there was no evidence they were contacted to involve them in making decisions in the person's best interest. In another part of care plan it stated the son was estranged. Care staff told us they thought the friend was the person's daughter.

The manager told us no one was receiving their medicines covertly, for example, disguised in food. However, one person's records stated the GP had advised their tablets should be crushed and given covertly [disguised in food/drink] as this person was refusing their medicines. There was no best interest decision recorded and no evidence the pharmacist had been consulted regarding the implications of crushing tablets. Crushing tablets may change the way they work. The care plan did not have any details about how the covert medicines should be administered. The agency nurse on duty told us they had added the medicines to the person's porridge but had not crushed them.

The agency nurse also told us they had given another person's medicines covertly. They confirmed there was nothing documented in this persons' care plan about this. The nurse added they had phoned one of the regular nurses who told her it was in the person's best interest to do this.

This was a breach of the Regulation11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The care files showed staff were not calculating the amount of fluid people should be receiving or exceeding on a daily basis. The Royal College of Nursing's Hydration Best Practice Toolkit for Hospitals and Healthcare recommends people having 30mls of fluid per kilogram of weight. This information was clearly printed on the fluid balance charts but staff had not made the calculations.

We saw one person who used the service sitting at the dining table waiting for their breakfast. We saw their mouth was very dry and unclean. We saw they had their own teeth and their care plan informed us they needed the assistance of one member of staff to clean their teeth. It stated, "[Name] likes to have teeth

cleaned and brushed but is not able to do this themselves." The care plan review in September 2017 stated, "Oral care to be given twice daily." When we looked in their bedroom we saw they had a new toothbrush which had not been used and toothpaste. We concluded staff had not supported them to clean their teeth. The services' policy was very clear about the importance of mouth care and the need for people to have a clean and moist mouth.

This area of the building where this person and others were sitting was very hot. We used our room thermometer and found the temperature in the lounge was around 28 -29 degrees Centigrade. We would normally expect a comfortable ambient temperature to be around 21 degrees Centigrade. We saw jugs of cordial were available in the lounge, however, no one was offered a drink during the morning until hot drinks were served around 11:30am. Again we saw the same person had a very dry mouth and lips. They were given tea to drink and drank it all, raising the beaker to their lips several times even though it was empty. This indicated to us they were thirsty yet this was not picked up by the staff. At 11:55am we noted this person's lips and mouth were dry again they were not offered another drink until 13:07pm when a carer gave them a cup of tea which was too hot. The person spat the tea out, grimaced and started to cry.

At 09:10am we saw the same person in the dining room with their head on the table. At 12:10pm they were again falling asleep at the dining room table a member of staff asked them if they were tired. They slept until their food was served at 12:49pm.

We asked the manager why this area of the home was so hot and they told us the night staff had turned the heating up. This showed us a lack of regard for people who used the service as when rooms are too hot it makes people sleepy and could be seen as a means of restraint.

On the second day of our inspection we saw the same person sitting in the lounge at 8:25am, their mouth and lips were dry. Another person who used the service told us no one had been given a drink yet and that the had kettle broken the day before. The manager came onto this unit and we asked them to look at this person's mouth and they agreed their mouth and lips were very dry. This person was given a beaker of tea at 08:45am which they drank and told us they were thirsty.

One person who was having their fluid intake monitored weighed 74kgs and based on the above calculation should have been aiming to drink 2220mls of fluid on a daily basis. One day they had only drunk 900mls yet on the same day staff had written on their daily notes, "[Name] ate and drank well." The record also showed there had been a 12 hour gap between their last drink at night and their first drink the next morning.

Another person was also having their fluid intake monitored; they weighed 52.9kgs and therefore should have been achieving a fluid intake of around 1587mls on a daily basis. We looked at their fluid intake for the four days prior to the first day of our visit and saw the following had been achieved: 850mls, 850mls, 1250mls and 1400mls. We concluded people's hydration needs were not being met.

One person's care records showed us they had lost 4.4kgs (9.7lbs) over the period of a month. We asked staff if they were having their food and fluid intake monitored and they told us they were not. Their care plan stated they sometimes needed encouragement to eat and drink. In the absence of any food and fluid charts it was not possible to establish if they were receiving adequate support at meal times. A care worker was assisting this person at lunchtime to eat their meal; however, they had to break off at one point to assist someone else.

One care worker told us. "The food is inconsistent, for example, the porridge is either runny, thick or has lumps in it. The bacon is juicy or hard like it is today." Another care worker said, "The food is not always top

notch." We tasted the vegetarian pasta on the second day, the dish was bland and the pasta overcooked.

People who used the service were asked to choose what they wanted the following day for lunch and the tea time meal. There were no pictures of the meals available to help people decide what they might like.

At lunchtime each day there was a choice of soup, sandwiches and another option. The main meal was served at tea-time.

One person was given pureed food in their room. The food was reasonably hot and had a food cover on the plate when it was delivered to their room, however, it did not look appetising and we could not identify what the food was. We asked staff what was the menu for pureed food today and they were unable to tell us. We also asked an agency nurse if they could tell us what the choice for pureed food was. They did not know either. We asked a regular staff member who thought it was vegetable soup, which it clearly was not as it had mashed potatoes on the plate. Another staff member decided to ring down to the kitchen to ask. First we were told it was corned beef stew and mashed potatoes. Then the chef rang back a few minutes later and said it was sausage casserole and mashed potatoes.

On the second day of the inspection [Thursday] we asked a care worker about the pureed diets and they told us they were made from the previous day's leftovers. We saw a plated pureed meal with brown and green 'blobs' and mashed potato. Again care staff did not know what the meal consisted of. We went to ask the chef who told us it was meat from Monday, mashed potatoes and green beans.

One person was having their food intake monitored. We saw on 1 November 2017 nothing had been recorded in relation to the breakfast or teatime meals. There were no times on the chart so it was not clear how long there was between meals. We saw breakfast and lunch were served very close together, for example, breakfast finished about 10.30am and lunch started at 12.15pm. We were concerned people's nutritional needs were not being met.

People who used the service made the following comments about the meals: "I just enjoy the food it is good. Particularly the soup today it was lovely and thick and creamy just as I like it." "I take things as they come I don't complain. I don't get a choice." "I like the food, there is plenty of choice. For example, jacket potatoes, or a sandwich, we order today for tomorrow." "I would like a change of vegetables it's always the same, carrots and sprouts. On Friday they went for fish and chips, I don't like fish so I had an omelette which was over cooked. We get tea and biscuits in a morning and afternoon and a cooked breakfast and cereal in a morning."

This was a breach of the Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we returned on day three we found night staff were giving people a drink when they got up in the morning. Generally, people looked better hydrated and fluid monitoring charts were being more fully completed. However, more work needed to be completed in this area as some people were still not meeting their target intake and some people were still not getting a drink between suppertime and going to bed.

Some people need to have their fluids thickened to a specific consistency because they were at risk of choking. One person had been prescribed thickening powder to be added to their fluids. The instructions were for it to be used 'as directed. ' The nutrition care plan stated one spoonful to be added to 200mls of fluid. One care worker said they used one scoop to 250mls and the senior care worker told us they added 1.5 scoops to 200mls to make it a 'syrup consistency.' None of the staff were sure where this instruction had

come from. This person had not been seen by or referred to the Speech and Language Therapy team since admission on 4 October 2017.

One person told us they had broken their distance glasses "ages ago" and nothing had been done about replacing them. A care worker told us it had been at least three weeks ago since the glasses had broken. The care plan did not contain any information about what staff had done to replace these glasses. We concluded people's healthcare needs were not always being met to ensure people's safety.

A care worker told us they had noticed one person, who used the service, had a swollen leg. They had reported this to a senior care worker; however, it was another six days before a doctor visited, when cellulitis was diagnosed. We concluded people's health care needs were not always being met.

This was a breach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the third day we saw information relating to thickening fluids had been added to the appropriate care files. One of the deputy managers was also in the process of writing to GP's, who had prescribed the thickeners to ask for specific instructions.

Also on day three we found the optician had visited and new glasses were on order for the person who had broken their distance glasses.

People who used the service made the following comments: "The Doctor comes every Monday. If we mention she might need a Doctor they respond well." "I think so, generally they call the Doctor if necessary." "A chiropodist comes; I am going to ask about the dentist I get to see a Doctor whenever I want." "This week I am to get my feet done and my nails trimmed."
People were confident a Doctor would be called if needed. "I tell them [staff] if I don't feel well." "I speak to the nurse and if she thought I needed a Doctor they would get one."

We spoke with a district nurse who provided support to the residential unit. They told us their usual days for visiting were Mondays and Thursdays but currently they were visiting almost daily. They also said they felt communication was improving and staff were getting better at following their instructions.

Requires Improvement

Is the service caring?

Our findings

Some staff were kind, caring and compassionate; however, this was not consistently the case across the service.

One person who used the service told us, "Sometimes on a night when staff has been on duty a long time they can be sharp but they don't mean it".

We were sat in the office next to the dining room on the first floor of the nursing unit and overheard staff speaking to people in an uncaring and inappropriate way. For example, "[Person's name] come back in, go sit in your chair, I have your pudding." This was followed by, "No you can't have it like that, sit down [person's name], behave yourself; you are messing around too much." This was followed by a command, "Stay sat." To another person staff said, "[Person's name] you need to stop doing that, it's not nice." We also heard the way care workers were speaking to people changed when another inspector arrived on the unit. This concerned us as clearly staff knew how they should be speaking with people but left to their own devices chose to ignore this.

We also heard staff talking over people who used the service to each other in a disrespectful way. For example, "He has had his; he can go." and "Start feeding her."

Staff did not always knock on people's bedroom doors before entering.

We saw some people who did not look well cared for their hair had not been brushed or combed and some were wearing clothing with food spills on it. For example, we saw one person trying to push their hair out of their eyes as it had not been brushed that morning.

People who used the service experienced different dining experiences, depending on which floor of the service they lived. On the ground floor residential unit tables were set with tablecloths, condiments, sauces, cutlery, crockery and plastic glasses. Where as in other dining rooms tables were not set to this standard which showed a lack of regard for people.

On the second day of the inspection we noted again people in the lounge had not been given a drink by the night staff. One person confirmed they had not had a drink. When one of the inspectors raised this the care worker in the room went off and made this person a cup of tea but did not offer anyone else in the room a drink. The team leader came into the room and we asked them about people getting drinks. They were very defensive in their attitude and said to the person (who was going to get a drink), "We do give you drinks don't we [Name]." We explained people looked thirsty but this still did not prompt them into getting people a drink.

On the third day we went to one person's bedroom to see if they had any shoes to wear. This was because their care plan stated they should wear shoes to reduce the risk of falls, but we saw they were wearing slippers. There were two wardrobes in their bedroom one of these did not have and 'knobs' on the doors

and the other just had one 'knob.' There were no shoes in the wardrobe we could open. In the bedroom there was an easy chair, however, the seat cover had been removed exposing bare foam and netting. In the en-suite shower room we saw this persons toothbrush and toothpaste had been balanced on the liquid soap dispenser. Their toiletries were on the toilet cistern as there was no shelf or cupboard for storage. We asked the deputy manager to look at this room with us and managed to open the wardrobe with no door 'knobs' where we found this person's shoes. The deputy manager agreed the standard of the furnishings and storage in the en-suite was not acceptable.

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

People who used the service made the following comments about the staff: "You just ask and they come and help, they speak to me politely." "If I need anything they try to help me. I get the right amount of assistance when I need it. For example, I can stand on my own but I need someone to watch me. If the nurse is calm it is usually all right if she panics it doesn't work." "They are kindness itself; I couldn't fault them they are lovely girls. They tell me what I have on I like to look nice every day. I had my hair done yesterday."

We observed some good interaction between people who used the service and staff on the residential unit (Ground Floor). For example, we saw a staff member assisted a person who was distressed and living with dementia to transfer from the dining table to a comfortable chair in the lounge area. They explained what they needed to do and chatted with them throughout the process. The person responded positively to their calm and caring approach.

One care worker was assisting a person with their meal. They thought the spoon was too big for the person and went to get a smaller spoon, covering the food with a lid so it did not go cold. The person was not particularly interested in their food. The care worker offered them a drink and they drank it all and then tried to eat some food. They ate a small amount of food with encouragement from staff.

Some care workers did encourage people to be independent, for example, we saw one person who used the service decide to set the dining table with cutlery for the next meal. Staff encouraged this and thanked the person for their help. We also saw care workers encouraging someone to transfer themselves out of their wheelchair and into an easy chair.

We saw another care worker encouraging one person to make their own bacon sandwich, giving them a choice of bread and sauces.

Visitors told us staff were friendly, but they were only offered a drink if the morning or afternoon drinks trolleys were going round

We looked at whether the service complied with the Equality Act 2010 and in particular how the service ensured people were not treated unfairly because of any characteristics that are protected under the legislation. Our observations of care, review of records and discussion with the registered manager, staff, people and visitors demonstrated that discrimination was not a feature of the service. However, we did think more could be done to support people who had specific communication needs.

Inadequate

Is the service responsive?

Our findings

The manager told us they knew the current care plans were not fit for purpose and staff were in the process of updating and re-writing them. One member of staff told us, "Paperwork has been a little rushed but we are changing everything which is a priority. Care plans are very old and these are being done, they just aren't robust enough. We've had some problems reviewing plans."

Another care plan indicated the person needed a normal diet, however, when we read the care plan reviews we saw on 18 May 2017 they needed a high protein, fortified diet. This showed us the actual care plans were not being up dated following review to give a clear overview of people's needs. It would be far too time consuming for care workers to have to read though all of the monthly reviews to get an accurate picture of people's needs.

A third person's social care plan stated, 'when upset put on classical music for her.' We saw there was no music in their bedroom and care staff not aware of this strategy. This person's communication care plan stated staff should observe their facial expression but no detail of what to look for or what it might mean.

Care staff were speaking to one person who used the service in English. Staff told us their first language was Ukraian and they could also speak Polish and Russian. They explained this person had been able to speak fluent English but as a result of their diagnosis of dementia they had reverted back to speaking their native language. The information in their care file was from their previous care home and there was no information to suggest how best to communicate with them or what alternatives could be used.

Staff were not always working in a person centred way. Night staff were assisting people to get up but not ensuring all their personal care needs were being met. For example, making sure people were appropriately dressed with their shoes/slippers on, hair brushed or combed, men shaved and given a drink.

This was a breach of the Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service told us what they would do if they had a complaint their comments included: "I would speak to staff/ manager and I would tell my relatives." "I would speak to the manager she is approachable." "You would go to the top." A relative knew there was a complaints procedure and told us, "The manager here, then I would follow the complaints procedure which is in reception."

We saw the complaints procedure was displayed in reception. The complaints file showed eight complaints had been received during January, February, March, June and July 2017. A complaints checklist was attached to the front of the file detailing what needed to be completed when a complaint was received. One relative told us, "My sister has complained twice and on both occasions it was dealt with satisfactory."

We saw the level of engagement with staff and activities varied depending on which lounge people were using. For example, we spent most of one morning in a lounge and there was very little interaction between

people using the service and staff and no activities. In another lounge we saw two care workers engaging really well with people and providing activities which people enjoyed.

People who used the service told us there were activities on offer to keep them occupied. Their comments included: "I prefer to look out of the window and see people walking past." "I do a jigsaw occasionally." "I like to bake and play bingo, I like to go out shopping and out for meals. The activities staff go with me. They take other people out a few at a time." "I can't see but they involve me. I have a radio in my room which I listen to." One person told us that they had played skittles for an hour that morning. They also said they got taken outside regularly so they could have a cigarette. Another person told us they had been singing the previous day and had played cards and dominos.

One person's visitors told us they had seen a very simple activity which involved people having bats and hitting balloons. They said people had really enjoyed this and though care staff could replicate this to provide more activity and stimulation for people.

Care workers had sat one person in front of the television, which they were not watching. They had very little interaction with staff and did not engage with anyone else in the room. Some visitors told us they had joined in the bat and balloon game and had also enjoyed it. This observation was confirmed by one of the activities staff.

Inadequate

Is the service well-led?

Our findings

This was the first inspection of the service since it was taken over by Qualia Care Limited in February 2017. Prior to this the service had been in administration and the last inspection had been completed in September 2015. At that time we identified three breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and assessed the service as being requires improvement in all domains and requires improvement overall. This meant the provider knew improvements needed to be made.

The registered manager left the service in March 2017and one of the nursing staff had been acting manager until a permanent manager was appointed in September 2017. We concluded provider oversight of the service from when the registered manager left until a new manger was appointed had been poor. This had resulted in eight breaches of regulation being identified during this inspection.

We found inconsistencies in the service between the residential unit and nursing unit. These inconsistencies should have been addressed by a robust quality assurance system which ensured all units were working to the same standards.

The manager told us that although they had only been in post a short period of time they had recognised that some of the quality assurance systems in place were not robust and had therefore started to implement new systems. For example, they told us they had started to carry out a care plan audit but had stopped the process as it was apparent many of the care plans were not up to date and did not always reflect people current needs.

We saw the provider had their own 'Quality inspection tool' which was used to assess the service against the CQC domain areas of safe, effective, caring, responsive and well-led. This document was dated September 2017 and identified the service as being 'good' in all domain areas except safe which had been assessed as 'requires improvement.' This document identified 'A DoLS log was in place which is reviewed monthly with evidence of appropriate follow up of non-allocated places.' However, we could not establish who had a current DoLS and there was no log of applications which had been made. We explored this with one of the people who had completed the audit and established the September report was a reprint of the July 2017 findings. They told us the manager at that time had shown them a spread sheet regarding information about DoLS.

We also found the acting manager had provided other information in July 2017 was not accurate. We concluded this tool was not being used effectively to ensure people who used the service received safe care.

On the second day of the inspection we spent time on the lower ground floor of the residential unit. A care worker had to go to the kitchen to get the food trolley, taking them away from their caring duties. When they started serving breakfast there were not enough cereal bowls available for everyone. A member of staff from one of the nursing units came to ask if there were any cereal bowls they could have as they had run out. A care worker told us there were not enough cereal bowls in the building to go round. They added there was

also a shortage of cups, bowls, pillows, duvets and face cloths.

Another care worker from the residential floor came down to ask if there was any spare bacon. They were told they would need to request this from the kitchen.

We also spent time on the first floor nursing unit. At 8:30am we asked one person who used the service if they had been given a drink. They told us they had not and added the kettle had been broken for 24 hours. We asked the manager about this and they told us they had meant to get one on their way into work but had forgotten.

Care workers were taken away from their caring duties to look for cereal bowls, clothing protectors and bacon. The shifts on the various units were not always being well-led and one care worker told us they did not think the skill mix of staff was always right.

Some staff told us communication was an issue within the service. For example, one care worker told us they had reported the weighing scales were broken but nothing had been done. The also said they had reported the shortage of cereal bowls to the kitchen staff but again nothing happened.

We found communication was not effective particularly handovers to agency staff. It was very difficult to get information about people's current care and treatment. One care worker also added there was not much co-operation between the day and night staff.

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

We asked people if they thought the service was well led and did they think the management were supportive. These were some of the comments people made: "We have had a change in management, would like to see them a bit more." "There has been some changes, its early days. A lot is being done to the building." "Manager is very friendly she comes to talk to me."

Staff made the following comments, "Yes I feel very well supported she's [the manager] been brilliant. We have a good support system in place here with an open door policy, unless she has a meeting and then she normally puts a note on the door to let us know." "[Name of manager] encourages people to go to her. She is focussed on making this a better home for residents and staff.] "[Name] I like her she is stern but fair. She is approachable and has an open door policy."

Head of Department meetings were held once or twice a month, attendance was good and we saw minutes dating back from April 2017. Clinical team meetings were also held regularly and actions were taken from these meetings.

Full staff meetings had been held on 4, 6 and 8 September 2017, however, prior to this the only minutes on record were from April and February 2017. Comments from these meeting minutes with actions held in September 2017 were as follows: 'Staff attitude is appalling and is going to change.' 'I can never see any staff in the lounges.' 'No staff members can tell me about DOLS.' 'We've had complaints about staff smoking and being loud in the morning'. 'There are issues with paperwork.' These observations would support some of our findings from this inspection.

Residents and family meetings had been held on 10 October 2017 when nobody attended and another was held on the 5 October 2017 when 16 people attended. All actions from this meeting had been completed.

The last record of any meetings held prior to this was the 19 July 2017 at this meeting people who used the service complained their clothing was going missing, however, there were no further actions from this meeting detailed in the minutes.

There were no minutes of any meetings with the activities team, kitchen team or the night staff. A domestics team meeting had been held on 10 October 2017 with four actions identified, all of which had been completed.

The manager told us they were now in the process of reviewing all the care documentation with the involvement of people who used the service, their families and members of the staff team. The manager told us once the care records were up to date they would be reviewed on a regular basis to ensure they provided accurate and up to date information.

They had also identified a lot of areas which required improvements and had developed their own action plan. For example, to improve the dining experience and to make sure 'lessons learnt' exercise was undertaken following accidents/incidents.

In addition the manager told us in January 2018 they were going to start a 'Resident of the day' programme. This would include a full review of the persons care records and making the day special for them. The manager confirmed they were aware more emphasis needed to be placed on providing person centred care and encouraging people to become more involved in the care planning process.

We saw accidents and incidents were recorded and an accident and incident audit was carried out on a monthly basis. The manager confirmed that they reviewed the audit results and an action plan was put in place if themes or trends were identified.

We saw the manager had reviewed how staff had provided end of life care, specifically looking at areas of good practice and areas that required improvement.

The manager told us they felt well supported by their line manager and we saw two 'Provider' visit reports. The manager also told us they had to complete and send a monthly audit report to the organisations head office to show the service was meeting key performance indicators.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The care and treatment of service users was not appropriate and did not meet their needs or reflect their preferences. Regulation 9 (1) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	Service users were not treated with dignity and respect Regulation 10 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Service users were not provided with care and treatment in a safe way in relation to assessing the risks to the health and safety of service users of receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks Regulation 12 (1) 2 (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	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 prevent abuse of service users. Regulation 13 (2) (5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Services users were not getting enough to eat and drink to sustain good health Regulation 14 (1) (4) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care 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. Regulation 17 (1) (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not being operated effectively and required documentation was not available. Regulation 19 (3) (a) and (b)

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 Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment was being provided without the necessary consent from service users and where service users lacked the capacity to consent the 2005 Act was not being followed. Regulation 11 (1) (3)

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care 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 to meet service users' needs. Staff were not receiving appropriate training, supervision and appraisal to enable them to carry out their duties. Regulation 18 (1) (2) (a)

The enforcement action we took:

Warning notice