Four Seasons Homes No.4 Limited

Ivyhouse Care Home

Inspection report

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Ratings

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

Overall summary

This inspection took place on 30 September and 01 October 2015 and was unannounced. At our last inspection in February 2015 the provider was not meeting the needs of people or complying with three of the regulations we looked at. We used our powers to ensure this situation improved and that the requirements of the law would be met. The registered provider submitted an action plan telling us what they would do to address these shortfalls. This inspection identified that the provider had taken action however this had not been adequate. This inspection identified that some areas of the service had not improved and in some instances had deteriorated.

Ivyhouse provides care and support for up to 76 older people. The home had four units. Rose Unit provides residential care for up to 18 people living with dementia, Cornflower Unit provides nursing care for up to 19 people, Daffodil Unit provides specialist nursing care for up to 18 older people who are living with dementia, and Tulip Unit supports up to 12 people who have recently been

Summary of findings

discharged from hospital. The maximum stay on Tulip is six weeks. People each have their own ensuite bedroom. There are shared communal facilities on each unit, which includes supported bathrooms, a lounge and dining room. At the time of our inspection there were 67 people using the service.

There was a registered manager at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

People were not kept safe from the risk of harm. The provider had conducted assessments to identify if people were at risk of harm and how this risk could be reduced. These assessments had not all been undertaken accurately or kept under review.

People did not consistently have their needs and requests responded to promptly. Many of the people we spoke with, and our own observations identified there were not enough staff to meet people's care needs.

The majority of people had their medicines safely managed. Some individuals did not experience good medicine management when they required their medicines hiding in food, if they required the use of patches for pain relief or if they needed medicines on an as required basis.

People did not consistently receive the support they required to eat and drink enough to maintain good health and hydration. The provision of food for people who needed the texture of their diet altering or for people who needed additional snacks was poor.

Nursing and healthcare needs had not all been well assessed, planned or delivered. Some people with more complex physical health needs or people who were living with dementia had essential elements of their care omitted.

Staff were not applying the principles of the Mental Capacity Act. (2005) Records about people's Mental Health needs were not all in good order, and we observed staff working in ways that did not promote people's independence or seek their consent before supporting them.

Many of the people we met gave positive feedback about the caring and compassionate nature of the staff. We observed many staff demonstrating kindness as they supported people, and staff we spoke with showed enthusiasm and commitment. However the operation of the home did not enable staff to consistently work in this way.

People who had needs relating to coming towards the end of their life, had not all experienced good end of life planning or nursing care.

We observed occasions when people's dignity and privacy was compromised and staff did not always identify this or take action at the earliest opportunity to support the person.

People did not have opportunity to pursue activities or hobbies they had always enjoyed. People spent long periods of time alone or listening to music. People we spoke with all expressed disappointment with this aspect of the home.

There was a system in place to identify and investigate complaints. People gave us mixed feedback about how effective they had found this process.

A new registered manager had been appointed since our last inspection. They were present for the inspection and showed a commitment to addressing the numerous issues raised at this and the previous inspection. Effective systems were not in place to ensure people received care that was safe, of a good standard and which met their needs.

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

Summary of findings

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.

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.

People could not be certain their assessed needs relating to both their physical and psychological well-being would be met.

People could not be certain that adequate numbers of staff would be available to support them when they needed help.

Some individuals did not experience good medicine management but most people could be certain they would receive the right medicine, in the right dose at the right time.

People did not enjoy a home that was clean, that smelt fresh, or where good standards of hygiene were consistently practised.

Is the service effective?

Inadequate

The service was not effective.

People could not be certain that their rights would be respected. If people needed support governed by the Mental Capacity Act 2005, they could not be certain staff would apply this fully or correctly.

People could not be certain they would always have enough to eat or drink, or that the food and drinks provided would be tasty and of a good quality. People who needed additional support or monitoring of their food and drinks could not be certain this would be provided.

People could not be confident that their health care needs would be assessed, planned or delivered.

Is the service caring?

Inadequate

The service was not always caring.

People approaching the end of their life could not be certain they would receive good care that met their needs and wishes or good practice guidelines.

People's dignity and privacy was not always maintained.

Some people had experienced compassionate care from individual staff working at Ivyhouse

Is the service responsive?

Requires improvement

The service was not always responsive.

Activities that provided stimulation, and that would help to protect people from boredom and social isolation were not routinely provided.

Summary of findings

People felt able to raise their concerns, and records we looked at showed that complaints were dealt with promptly and considered with compassion for the people involved.

Is the service well-led?

Inadequate

The service was not well led.

The provider did not have effective systems in place to monitor and maintain safety and quality standards.

Ivyhouse did not have a clear vision. The provider had not ensured the registered manager understood who the service could accommodate and the type of needs the home could meet well.

Comprehensive records had not been completed or maintained for each person that was using the service.

There was a registered manager in post and the provider was meeting the conditions of registration. The commission had been notified of events as is required by law.

Ivyhouse Care Home

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 30 September and 01 October 2015. The inspection team consisted of three inspectors, an expert by experience and a specialist advisor. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. A specialist advisor is someone who has specialist clinical knowledge about the needs of the people who use this type of service

Before the inspection we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give information about the service, what the service does well and improvements they plan to make and we took this into account when we made the judgements in this report. We also checked if the provider had sent us any notifications since our last visit. These are reports of events and incidents the provider is required to notify us about by law, including unexpected deaths and injuries occurring to people receiving care. We spoke to the commissioners [people who purchase this care] and a range of health professionals who supported people who used the service. We used this information to plan what areas we were going to focus on during our inspection.

During our inspection we spoke with twenty people who used the service. Due to their specific needs some people were unable to tell us their views of the service however we observed how staff supported people. We spoke with relatives of thirteen people who lived at the home. We also spoke to the registered manager, nine members of staff and two health professionals who visited to support a people who used the service. We looked at records including parts of ten people's care plans and staff training. We looked at the provider's records for monitoring the quality of the service and how they responded to issues raised. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

At our last inspection in February 2015 we found that the systems and arrangements in place to ensure the home was clean were inadequate. The registered provider submitted a plan telling us the actions they would take to address this concern. At our latest inspection we identified that although the provider had taken action such as replacing some flooring, and furnishings we were still concerned with how clean the home was.

Comments we received from people about the cleanliness of the home included, "There is sometimes a strong smell in here", and "You do see people cleaning, but it doesn't seem to get to the root of the problem." There was an unpleasant smell in Daffodil Unit. We observed food and drink residue on furniture in people's bedrooms and communal areas of the home that had dried in place. We observed that staff did not always follow good hygiene practice such as washing their hands or changing their gloves after an activity that could spread infection. Female staff were observed wearing nail varnish which is known to prevent effective hand washing. This is a breach of the Health and Social Care Act. Regulation 15. We are now considering what further action to take and will report on this when the action is complete.

People did not always receive care which kept them safe from the risk of harm. We looked in detail at the care records for six people and we also looked at some parts of the care provided to a further four people. We noted in the case of four of the six people whose care we looked at in detail that nursing staff had not accurately assessed, planned or nursed people so they were kept safe from the specific risks associated with their condition. Essential clinical monitoring and nursing care had been omitted.

Some people's health care needs meant they were at risk of developing sore skin, falling over or becoming malnourished. The provider had identified these risks and completed relevant risk assessments. However, the risk assessments had not all been completed accurately and consequently the subsequent action to be taken by staff was not always appropriate for the level of risk the person was experiencing. Records of a person who had experienced falls in August and September 2015 contained no evidence that the person received any first aid or physical monitoring following the falls The falls risk assessment was reviewed shortly after a further fall, but made no reference to the evidence that the person's risk of falling had increased or suggested any review of the person's care plan to reduce the risk of future falls.

On one unit staff did not have up to date information about how people's drinks were to be prepared in order to reduce their risk of choking. We observed staff asking each other for information about the way people needed their drinks thickened, to ensure they did not choke or aspirate. This system of communication was not effective or adequate to manage the risk associated with people's eating and drinking. This had placed people at risk of harm. This is a breach of the Health and Social Care Act. Regulation 12.

The majority of people we spoke with raised concerns about staffing. People using the service told us, "I need the toilet, but I've not seen anyone I can ask. I really hope I can get to the toilet", "Stopping here is alright. There are good days and bad; worst days are when there are not enough staff" and "The night staff are really good they come promptly if I press my buzzer."

Relatives told us, "Staff are over stretched because of the high needs of the people being admitted", "They are all good staff, but they are sometimes short staffed. I was here Sunday and there was only two on" and "Yesterday I visited [name of person]. There were only two carers on and not four."

Staff we spoke with told us, "I'm happy enough but we are often short staffed. This means we can't spend the time we would like to with people. I've not had a lunch break today" and another member of staff told us "I often miss my breaks."

We spent time observing the running of the home and in all of the four units staff were very busy. We observed that in Rose and Tulip Units this had a particularly negative impact on the people using the service. We observed people unable to attract the attention of staff as they had no means of calling for assistance when staff were working outside the lounge they were in; people waited long periods for assistance to use the toilet and staff did not have time to offer any engagement or activities. On occasion we observed single members of staff undertaking manual handling tasks that they told us should be done

Is the service safe?

with two members of staff. Care plans confirmed this. This was because the staff could not locate a second member of staff to assist them. This put members of staff and the people they were supporting at an increased risk of harm.

In the evening on Tulip Unit we observed one person trying to support themselves to stand and walk. Another person accommodated on the unit became anxious and called out to staff as they were concerned the person might fall. We also met a relative who was raising concern as she felt her relative had waited an unreasonably long time for support.

On Rose Unit we observed people sitting for periods of up to 40 minutes without any staff contact or supervision. In the communal lounge and dining room people had no means of summoning staff. We observed people calling for help and requesting the toilet but staff were unaware of these needs as they were supporting people in their rooms or other parts of the unit.

The provider had not reviewed their staffing levels when people's conditions changed to ensure there were enough staff with the required skills and knowledge to meet people's needs. We saw that when due to a person's specific condition, staff were required to support them in pairs this had not been recorded in their care records or resulted in any review of the staffing ratio. We were informed by the registered manager and staff that the needs of people being admitted to Tulip Unit were more complex and required greater support from staff. However there was no evidence that the staffing ratios had been reviewed or calculated appropriately to reflect this. Failing to supply adequate numbers of staff to meet people's needs is a breach of the Health and Social Care Act. Regulation 18.

We observed staff administering medicines. On some occasions staff wore a tabard that made people aware they were administering medicines and did not wish to be approached or distracted. This was respected and was a way of decreasing the risk of a medicine error occurring. On the evening medicine round on Tulip Unit the nurse did not wear the tabard and we observed them regularly being interrupted. We observed one nurse administer medicines through the lunch time meal, interrupting people eating to administer their medicines. This was unpleasant for people, and an unnecessary interruption to people eating. Professional good practice guidance based on research identifies the many benefits to people of having uninterrupted meal times.

We looked at the management of medicines to see if people were getting the medicines they had been prescribed at the correct time in the correct dose. On Rose Unit most medicines had been given as prescribed. However we found that patches prescribed for the management of pain had not been managed correctly. This could reduce their effectiveness and result in people experiencing more pain than was necessary. One person was self-administering a prescribed medicine but no assessment of the person's ability to do this correctly had been undertaken. Some people needed medicines on an, 'As and when' basis. [PRN] There were not always guidelines in place to direct staff on how and when to use these medicines correctly. This could result in inconsistency or medicines being used differently to the way the prescriber had intended.

One person whose care we looked at in detail required their medicines to be administered covertly. [Hidden in food or drinks] This had not been planned or undertaken in line with good practice guidance to show this was in the person's best interest, or that all other options had been considered and discounted. This decision had not been reviewed since 2012 and it was likely that the person's medicines and condition had changed in that time. Failing to properly and safely manage medicines is a breach of Regulation 12 of the Health and Social Care Act 2008.

On Cornflower and Tulip Units the medicines audits showed medicines were well managed, and the minor issues we identified had been picked up in an audit undertaken by staff working at the home. We heard some nurses explain to people what the medicine they had was for. On Daffodil Unit we saw a nurse return on numerous occasions to support a person with eye drops. They gave people time, reassurance and plenty to drink to enable them to take their medicines. The process was unrushed and we saw the nurses often used the opportunity to enquire about the person's day or wellbeing.

Some people required the support of staff to help them move, and some people who were unable to stand required the support of a hoist to lift them. The majority of staff we observed used the moving and handling equipment appropriately and gave people an explanation during transfers and provided them with reassurance. People who did not require specialist equipment to support transfers were appropriately encouraged to be

Inadequate

Is the service safe?

independent and to stand using frames or encouraged to move themselves forward in their chair before attempting to raise themselves to standing using the arms of the chairs.

We asked people if they felt safe. Most people told us they did. Their comments included, “Yes I do, because before I couldn’t do anything for myself. The people are nice friendly people. They don’t insult anyone who comes in”, and “Yes, it’s alright.” Some people felt anxious around feeling safe and one person told us, “I don’t always feel safe. You hear the door bang and you don’t know who is coming in or going out.” Relatives we spoke with told us, “Generally I think it is good, and I don’t worry about him being here” and “Yes, It’s the way they look after her. She’s told us that they treat her well.”

Inadequate

Is the service effective?

Our findings

We last inspected this service in February 2015. At that inspection the registered provider was not complying with the requirements of the Mental Capacity Act 2005, and was not ensuring that people had adequate support to eat and drink enough to maintain good nutrition and hydration. The registered provider submitted a plan telling us the actions they would take to address these issues. At our latest inspection we identified that the provider had not taken adequate action to meet the needs of people or the requirements of the law. We are now considering what further action to take and will report on this when the action is complete.

Some of the people who used the service had needs that required staff to apply the Mental Capacity Act 2005 and the Deprivation of Liberty safeguards (DoLS.) We looked at the support given to one person for whom a DoLS application had been made and noted information provided by staff and in the person's care records was inconsistent. A formal capacity assessment for one person completed by a professional external to the home stated the person did not have mental capacity. However an assessment completed by the home's own staff stated the person did. Other records we looked at had only partly completed mental capacity assessments. These were not adequate to provide staff with guidance on how the person made decisions or the support they would require to do so.

Staff did not always ask people's permission before supporting them with routine tasks. For example on Cornflower Unit we observed staff wiping people's mouth and putting protective aprons on without asking for people's consent. We also noted that people were not routinely asked what they would like to eat, drink or where they would like to sit.

In three of the four units we observed that it was standard practice for staff to remove people's walking aids from within their reach when they sat down. Staff gave several explanations why they did this saying walking aids could present a trip hazard, that people would try and get up without staff support or that people would not require them until later in the day. Staff were unaware that this practice could risk restricting people's independence and deprive them of their liberty to mobilise when they wanted. Records showed that the provider had not applied to the local safeguarding authority for approval to support people in this way or undertaken work to identify if less restrictive options were available. Failing to uphold people's rights is a breach of the Health and Social Care Act 2008. Regulation 11.

The service had not adapted the premises to improve people's quality of life or wellbeing in line with national good practice guidance. This guidance is available to advise managers how to provide environments that aid people's orientation and enable independence as far as possible. The communal lounge areas of the home were poorly organised. Chairs lacked soft furnishings to provide comfort and support and chairs had been arranged in a style that did not enable people to interact or engage with each other. The dining areas of three of the units did not have adequate space for all the people accommodated to eat at a table if they wanted. We observed people sitting in their rooms or in lounge chairs to have their meals even though they told us this was not their preferred choice. Lighting was provided by candelabra style fittings but in each of the units the majority of bulbs were not working. When it was dark outside this standard of lighting would be poor and may increase the risk of falls and slips. Orientation boards in three out of four units had not been updated since the previous day with information about the day's menu and staff who were on duty. In Cornflower Unit this information had not been updated for three days. This did not provide current information on the events and plans for the day and could cause confusion and anxiety to people who live with dementia. Failing to adapt the environment to provide safe premises is a breach of the Health and Social Care Act 2008. Regulation 12.

People we asked gave us mixed feedback about the food. Comments from people included, "I liked the ice cream and meringue we had yesterday", "They feed you good" and one relative told us, "Apparently the food is really nice. She says it's lovely. They often bring round little treats like Wotsits." Other people told us, "Every tea time we get these same little sandwiches, they aren't even very nice", "It's not nice" and "It's soup. It's hard to say what sort- it hasn't got much taste in it."

During our inspection we observed seven meal times across the home. On the first day staff we spoke with were unaware of the lunch time menu choices until the food arrived. We heard staff say, "It looks like fish pie and meatballs, I'm not sure. I'll let you know" and, "I haven't ever seen a menu." The meal times lacked co-ordination

and we observed that people often sat at the meal table a long time before the food was served. On Cornflower Unit we observed people sit at the table 60 minutes before the meal was served and on Rose Unit for up to 45 minutes. People were often asleep or restless by the time the food was served which had a negative impact on their motivation to eat. People were not all offered the opportunity to sit at a dining table, however some people told us this would be their preference had they been given the opportunity. Staff did not promote social interaction because they frequently had to stop supporting people to eat in order to answer call bells. On Cornflower Unit we observed two people waiting up to 30 minutes for assistance with a drink which had been poured out and placed in front of them. Staff did not refresh or reheat the drink which had gone cold during this time. There were a limited range of condiments in some units and none in others. People were not offered the opportunity to wash their hands before eating and staff put plastic aprons on people to protect their clothes with no explanation or option being given. People were not supported to have a pleasant meal time experience.

People did not always have the help and support they needed to eat and drink. We observed the snacks, lunch and tea time meal on three of the units on the first day of inspection. On the first day of our inspection there were no healthy snack options provided. Some of the people who were assessed as requiring regular, high calorie snacks did not have these provided. One person had been given their breakfast at 0900 and their lunch at 1340 but had not been offered any mid-morning snack despite this being part of their nutritional care plan. On Tulip we observed the morning drinks round was running late and staff told us, “We don’t want to offer chocolate or biscuits as they won’t eat their lunch.” During our visits there were no adapted snacks offered for people who required the texture of their food to be altered.

Some people’s health needs meant they were at risk of not eating or drinking enough. Although meals had sometimes been “saved” by staff when a person had been unable or reluctant to eat, there was no evidence that staff had offered them the meal at a later time. We observed records that showed people had long gaps between drinks. Records for one person who was unable to ask for a drink or support themselves to drink independently showed they had gone over 13 hours between drinks because staff did not continue to prompt the person when they refused a drink. We observed some people had on occasions refused food and drinks for the majority of the day. There was no evidence that this information had been handed over when new staff came on duty or that there were any systems in place to identify or monitor such occurrences. People were at risk of not receiving enough food and drink to keep them well or prevent them from becoming hungry. Failing to ensure that people have enough to eat and drink and that people receive the support they need is a breach of the Health and Social Care Act 2008. Regulation 14.

We asked people and their relatives about the care they had received. We received feedback about the practice of specific members of staff, where people described care that was of a good standard, met their individual needs and was compassionate. Relatives of people particularly on Tulip Unit raised concerns which included, “My relative has experienced delays in receiving care. The nebulizer was on his eye. If the oxygen and nebuliser become dislodged they are not repositioned” and “I feel I can’t turn my back. I can’t rely on them to do things.”

We looked in detail at the health and care needs of six people and at parts of the care planned and delivered to a further four people. These included people with needs related to nearing the end of their life, people living with dementia, and people with ongoing needs such as constipation. We found evidence that only one person was having their assessed health needs well met by the registered provider.

The records of a person who had recently moved into Tulip Unit from hospital showed that instructions for staff required to keep them well, had not been followed since the person was admitted four days prior to our visit. Staff we spoke with confirmed this. The checks needed to ensure the person stayed safe had not been conducted. Failing to undertake these checks would mean subtle changes in the person’s health and well-being would not be identified and prompt action would not be taken to ensure the person’s comfort or the best possible health outcomes for them.

Records for a person who was at risk of developing sore skin stated that they needed to be turned every two hours. Records showed and discussions with staff confirmed these turns had not always taken place. Records showed that on two days at least six essential changes of position had been omitted which in turn could lead to skin damage.

Inadequate

Is the service effective?

We looked at the care given to a person who told us they were experiencing constipation. Records showed the person had a history of constipation and had received hospital treatment for this in the past. Despite this the care plan failed to make clear the treatment required. Staff had been provided with charts to record the person's bowel movements. These had not been fully completed or reviewed and we identified periods of up to ten days between bowel movements. We asked nursing staff and the home manager about this. They arranged for the person to be reviewed by the GP. Failing to go to the toilet causes people extreme discomfort and can have an adverse effect on their health and wellbeing.

The systems in place to ensure care and treatment was provided in a safe way were inadequate. The registered provider had not taken all possible action to mitigate the impact of risks people were assessed to have. This is a breach of the Health and Social Care Act. Regulation 12.

The registered provider had arranged for extensive on line training to be provided. However records showed that courses that might enhance or equip the staff team to meet the needs of the people they were supporting had not been accessed. For example records and discussions with the nurses who were providing complex nursing care to meet people's' physical and mental health needs did not provide evidence that the training provided had been adequate to ensure they had the skills and knowledge to meet people's basic needs in line with good practice.

The majority of staff had received training in the theory related to safe practices such as food hygiene but had not been provided with the practical training that would enable them to transfer the skills learnt in theory to practice. Failing to provide staff that have the skills to meet the needs of people is a breach of the Health and Social Care Act 2008. Regulation 18.

People and their relatives told us they felt staff were patient and kind and that they had the skills needed to support people. Their comments included, "Yes, I would think so. They all seem to do the job properly" and "Yes, in my observation so far." however our observations showed that staff did not always have the skills needed to meet people's health care needs, or the needs of people living with dementia.

We asked people and their relatives about the opportunities they had to access health appointments. People told us, "I do get to see the doctor, dentist, and optician. I only have to ask and they sort it out for me." Relatives confirmed that either they or staff at the home arranged medical appointments as people required them.

Inadequate

Is the service caring?

Our findings

We observed that people were not always supported in a constantly caring manner because staff were not always mindful of people's dignity. This included women being hoisted without caution paid to cover their legs and underwear or dressed with the appropriate clothing to cover their stomachs and breasts. We also observed people being cared for in bed who had become naked and uncovered. These people were visible to people walking up and down the corridor. We observed that staff did not always take immediate action to protect people's dignity when they had the opportunity to do so.

People were not always supported to maintain their independence and privacy. On one unit we observed that people's rooms were not always clearly identified. Staff told us and we saw that some people had difficulty in moving around the unit as they could not always find their way back to their rooms. People sometime became distressed because of this. This did not promote people's independence. We also observed that laundry staff and visiting health professionals had to intrude on people's privacy as they were unable to locate the person they had come to visit. Staff expressed concern that there was a risk of people receiving unsafe or inappropriate care particularly when people were dis-orientated or so physically un-well that they could not state their name. Some staff gave examples of returning from leave or rest days and of the challenge they experienced in matching people with their rooms.

People had not all been supported to undertake their personal care to a good standard. Some people and their relatives told us, "Dad is sometimes clean and shaven. But often not," and "I can't remember when I had a bath or shower, but they give me a good wash every day. It's not the same." Another person told us "I get a wash every day. What I hate is that I never feel clean after using the toilet." Some people who had food or dirty marks on their faces were not supported to remove them. We observed that these marks remained in place for the duration of our visit. Failing to protect people's privacy and dignity is a breach of the Health and Social Care Act 2008. Regulation 9.

Staff we spoke with were unclear and inconsistent in explaining how to recognise when a person was approaching the final stages of their lives. We looked at the records of four people who lived with dementia to identify the arrangements in place so they would receive the care they wanted when approaching their end of life. Good practice guidelines identify the need to undertake end of life planning as early as possible for people living with dementia, however only one of the records we looked at had a plan to support a person's end of life needs. The authority not to attempt resuscitation when a person stopped breathing was invalid for three people as records had not been completed accurately or within legal requirements. The provider had failed to support people and their families to make good plans which may result in the person not receiving the care at the end of their life that had been determined as in line with their best interest or wishes. This is a breach of the Health and Social Care Act 2008. Regulation 12.

Staff spoke affectionately about the people they supported. We observed that some staff had effective communication skills and were able to use different ways of enhancing communication by using touch, ensuring they were at eye level with people who were seated, and altering the tone of their voice appropriately. However we also observed some interactions where staff did not have these communication skills and when people were unable to answer a question they repeated the question, using a louder and harsher tone each time. We heard and observed some staff seek consent to interventions when people required support with personal care but this was not consistent throughout our inspection, or in all units of the home.

People and relatives that we met and spoke with during our inspection told us that individual staff were compassionate and showed kindness to them. Comments from people included, "It's great here," "I'm very happy," and "She's an angel." Relatives we spoke with told us, "Staff love Dad, they are very good to him, even when he isn't always nice to them." Another person said "Overall it is good here. The difference is the attitude of each of the staff. The needs aren't always met, but they do really care for him." The staff we spoke with showed compassion and spoke with enthusiasm about the people they were supporting. Staff were aware of people's family life, hobbies or interests the person had, and in some instances knew for example the occupation of a person in their earlier life.

Requires improvement

Is the service responsive?

Our findings

People we spoke with said that people were not always supported to engage in activities they had expressed they liked. Comments we received included, “Is there much to do? No.” Another person told us, “Activities are a bone of contention. There used to be lots of things to do, activities, music, entertainers, there is nothing now,” and “I feel let down on the activities. It isn’t at all like they told me when I came to look round.” A visitor said “There’s nothing much for him to do. He just sits here all day.”

We observed that the opportunity to participate in interesting activities varied between the different units and between the staff on duty. On one morning we observed people on Daffodil Unit had the opportunity to join in games and music, however, we did not see this level of activity repeated elsewhere during the inspection. Although we observed people enjoying this activity, there was no evidence that they had been consulted about the type of opportunities they would like to partake in. For the majority of the time we observed that people did not have interesting things to do. We looked in detail at the needs of some people who were cared for in bed. They had no care plan to show how their social or recreational needs would be met or how to manage the risk of social isolation. Our observations showed that a number of people were left alone in their room for long periods. Failing to provide activities to meet the needs of the people is a breach of the Health and Social Care Act 2008. Regulation 9

The registered manager was able to show us the records demonstrating the action he had taken in response to concerns and complaints. The records we viewed showed that the concerns had been investigated quickly and effectively, and the person raising the concern received a detailed response of the findings and action taken. We spoke with the relatives of two people who had raised concerns about the service. One relative told us they had met with the registered manager, but had not received feedback and the other relative told us things had improved since raising their issues but they remained frustrated as the matter had not been fully resolved. People could not be confident that their concerns would always be fully explored and the action taken to address the issues would meet their expectations.

Inadequate

Is the service well-led?

Our findings

We last inspected this service in February 2015 and raised concerns with the arrangements in place to protect people from risks relating to their health, safety and welfare. The registered provider sent us a plan of the actions they would take to resolve these issues. However, at this inspection we noted that although some action had been taken it had not been effective. The registered provider's efforts to improve the service had been inadequate and in addition, they did not have effective quality assurance systems in place. Therefore a good quality service had not been consistently delivered. We are now considering what further action to take and will report on this when the action is complete.

In recent years there had been several changes of manager which had resulted in the leadership of the home being inconsistent. Although a new manager had been recently appointed, some people told us they did not know who they were and we found that that the provider had not made arrangement for relatives to meet the new manager. This made it difficult for people to express their views about the service or influence how it was developed.

The new manager had registered with the Commission [as is required by law] and was complying with all the conditions of registration. They were knowledgeable about their requirement to inform the Commission of notifiable events as is required by law. People, their relatives and staff gave mainly favourable feedback about the management team. Comments we received included, "The unit manager of Tulip is very good. She will usually sort out issues on the same day" and "The new manager seems good. Fair."

Staff we spoke with were not always clear of the vision and direction of the unit they worked on. We noted that the registered manager and nurses working on the "Tulip Unit" were unclear of the admission criteria and purpose of this unit. Some staff told us they believed it was a rehabilitation unit to help people regain confidence and lost skills following a period of illness. Other staff described it as an assessment unit, where people's needs were further considered and assessed prior to a decision being made about their longer term support needs. The purpose of the unit had not been made clear in the providers Statement of Purpose. We noted that this had resulted in people being admitted to the unit with care needs the registered provider did not have the skills or resources to meet. This had resulted in people receiving unsafe care.

The registered provider had provided new paper recording system for staff to assess, plan and record the care they had offered each person. At the time of inspection the transfer from using one documentation system to another for each person was part way completed. The tasks had been delegated to nursing staff on each unit but no additional resources had been made available to provide protected time to enable them to complete the accurate transfer of documentation. The people whose care we looked at in detail did not all have comprehensive or accurate records of care. We found information had been omitted and transferred incorrectly. New records had not all been completed. This meant some people had no written plans of care for acute and ongoing health care needs. There was no system for formal reviews of the care plan at an agreed frequency with the person or their relative. There was no evidence that people had been involved in planning or evaluating their care when they had the capacity to do this. Our findings did not provide evidence that the provider had considered, mitigated or managed the risks associated with this transfer process.

The registered provider had undertaken a range of audits and developed action plans in response to these. We found that these had not always been effective at identifying issues. An example of this was the many issues identified during the inspection which had not been identified in the providers own audits. The registered provider had developed action plans which had not been effective at driving improvements at the required level or pace, to ensure people consistently received a good and safe service.

The failure to have in place effective arrangements to assess, monitor and improve systems and processes to keep safe the people using the service is a breach of the Health and Social Care Act 2008. Regulation 17.

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
	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment People did not benefit from a home that was clean and which smelt fresh. Staff did not consistently use good infection control practices.

The enforcement action we took:
We are considering the action we will take in response to this breach of the Health and Social Care Act 2008 and will report on this when the action is complete.

Regulated activity	Regulation
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People did not consistently receive care that was safe. People did not consistently benefit from the safe management of medicines. People approaching the end of life care did not benefit from staff who were skilled to provide this care, or from care planning that reflected their needs and wishes or good practice guidelines.

The enforcement action we took:
We are considering the action we will take in response to this breach of the Health and Social Care Act 2008 and will report on this when the action is complete.

Regulated activity	Regulation
	Regulation 18 HSCA (RA) Regulations 2014 Staffing People did not always have access to the staff they required to meet their needs.

The enforcement action we took:
We are considering the action we will take in response to this breach of the Health and Social Care Act 2008 and will report on this when the action is complete.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

People were not always treated with dignity and respect, or have their right to privacy maintained.

The enforcement action we took:
We are considering the action we will take in response to this breach of the Health and Social Care Act 2008 and will report on this when the action is complete.

Regulated activity

Regulation

Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

People did not always receive the support they required to eat and drink adequate amounts. People who required the texture of their food altering did not always have access to snacks or a choice of quality meals.

The enforcement action we took:
We are considering the action we will take in response to this breach of the Health and Social Care Act 2008 and will report on this when the action is complete.

Regulated activity

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

People did not benefit from a safe or good quality service as the registered provider had failed to put effective arrangements in place to assess, monitor and improve systems and processes.

The enforcement action we took:
We are considering the action we will take in response to this breach of the Health and Social Care Act 2008 and will report on this when the action is complete.

Regulated activity

Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

People's human rights were not consistently upheld.

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
We are considering the action we will take in response to this breach of the Health and Social Care Act 2008 and will report on this when the action is complete.