Cookridge Court Limited

Cookridge Court & Grange

Inspection report

Iveson Rise
Cookridge
Leeds
LS16 6NB
Tel: 0113 267 2377
Website:

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Ratings

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

Overall summary

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, and to pilot a new process being introduced by CQC which looks at the overall quality of the service. This inspection was part of a pilot where we tested all the key lines of enquiry within our current inspection methodology.

The inspection visit was unannounced. At our previous inspection of April 2013 we found the service to be meeting the requirements of the Health and Social Care Act 2008

Cookridge Court and Grange is situated in the Cookridge area of Leeds. The service is registered to provide accommodation for up to 96 people who require personal care. The accommodation is situated over three floors that are serviced by passenger lifts. All bedrooms

Summary of findings

are single rooms with en-suite facilities. There are several communal and dining areas and the home has an enclosed garden area. At the time of our visit there were 89 people living at the service.

The registered manager had registered with the CQC in April 2014. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. Prior to our visit we were made aware that the registered manager had resigned from their post and was working their notice period. On our arrival at the service we were told a decision had been taken for the manager to take leave rather than complete their notice period.

Before this visit we had received information of concern about the implementation of a new medicines system, management arrangements, staffing levels and morale. We used this information to inform our planning for this visit.

There were not enough staff to meet people's needs in a timely way. People told us staffing levels impacted on the care they received and the time they received their medicines. On the day of our visit people did not have a morning drink as there were no staff available to them. People told us staffing levels were reduced at weekends.

People were not always protected against the risks associated with the unsafe use and management of medicines. Although the provider had taken steps to address concerns following a transfer to a new pharmacist, people were not always receiving their medicines at the correct time or in accordance with the prescriber's instructions. Staff did not have protected time to administer medicines and often had to leave the medicines round to complete other tasks. This increased the risk of mistakes and lengthened the time of the medicines administration rounds.

The building was well designed and maintained. However, the call bell system had not been working properly which meant people were at risk of the system not registering their call if they tried to call for assistance. The provider brought in a maintenance company to repair the system and put risk assessments in place to ensure people were checked on a regular basis. The service was clean. We identified some poor practice around storage of equipment but this was addressed during our visit.

Risks to people's health and well-being were identified and care plans put in place to help people manage these risks. However, we found care plans were not always followed. One example included a person who was not supported to use a falls monitor to help manage the risks around them falling.

Staff had not all received sufficient training and support to allow them to undertake their role. Some senior staff had not received training to administer medication; most staff had not had Mental Capacity Act (MCA) training. All staff told us they had not had supervision to support them in their role.

People were supported to maintain a balanced diet. People told us they were satisfied with the quality of food. However, we found the mealtime experience varied on different units.

People's health needs were monitored and where necessary referrals were made for specialist health support.

People who used the service and their relatives told us staff were caring and they were treated with dignity. However, this was compromised as staff did not always have time to provide timely care interventions. Our observations showed that where time allowed there were positive relationships between staff and people who used the service. However, this was not consistent.

Information was gathered about people that allowed staff to better understand their individual wishes and preferences. This included consideration of end of life care.

People who used the service were not supported to engage in meaningful activity. Where activities were offered they did not take into account the differences in people's gender or their individual choices.

The service had not followed the provider's complaints policy and procedure. This meant complaints had not always been recognised or recorded to improve the quality of the service provided or to allow the provider to monitor issues at the service.

Summary of findings

The service did not have satisfactory management arrangements in place. The lack of monitoring by the provider had led to a decline in the quality of the care provided that had been allowed to continue. This had led to low staff morale and a high staff turnover that further impacted on the quality of the support provided to people who used the service. Although a new regional support manager had started work at the service they had not been in post for long enough to start to have a sustainable impact on the service.

We found different breaches of the Health and Social care act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate 

The service was not safe.

There were not enough staff to provide support to people who used the service. This meant people had to wait longer to receive support with their personal care. People told us their medicines were often late as a result of poor staffing. On the day of our visit people were not supported to access a morning drink as staff were not available to serve them from the drinks trolley.

People were not always protected against the risks associated with medicines. People were not always administered their medicines at the prescribed time or in accordance with the prescriber's instructions.

Although risk assessments and associated care plans were in place to minimise the risks to people's health and well-being these were not always followed by staff. This meant that people were not enabled to use aids to help keep them safe.

Although one person was being deprived of their liberty to promote their safety and had appropriate authorisations in place, other people were being prevented from moving from their unit by measures in place to prevent another person from leaving the service. This meant the service was not always meeting the requirements of the Deprivation of Liberty Safeguards.

Is the service effective?

Requires Improvement 

The service was not always effective.

A lack of staff training meant there were not always sufficient numbers of qualified staff on duty to administer medicines effectively. Staff had not received Mental Capacity Act 2005 (MCA) training making it difficult for them to act in accordance with the principles of the MCA.

People who used the service were supported to maintain a balanced diet; however, people's experience of mealtimes differed from unit to unit within the service.

Care records showed people had access to relevant healthcare professionals to support them with their health needs. People we spoke with confirmed this.

Is the service caring?

Good 

The service was caring.

People who used the service and their relatives told us staff were caring and they were asked to share their likes and preferences to help staff meet their individual needs.

We observed staff treating people with respect and ensuring their privacy when providing support.

Summary of findings

The service considered people's end of life care wishes as part of their care planning. This allowed people to express their wishes for staff to understand some of their care needs in advance.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff did not always have sufficient time to respond to people's needs in a timely way.

People did not have access to meaningful occupation and activities. On the day of our visit two out of 89 people participated in the planned activity. Other people were left in lounge areas with the television on in the background. One person told us they did not think activity plans considered their interests and hobbies.

Complaints were not acknowledged, recognised or handled in accordance with the provider's complaints procedure. This meant the quality of care did not improve after people had cause to raise concerns.

Is the service well-led?

Requires Improvement

The service was not well led.

A lack of effective management at the service had led to a decline in the quality of support experienced by people who used the service and low staff morale.

The provider had failed to monitor the quality of the service to identify issues that people who used the service, their relatives and staff had been trying to raise. Where staff had raised concerns they had not been valued or supported to improve the situation for people who used the service.

Although a new regional support manager was in post they had not had sufficient time to identify all the issues at the service or to effect change.

Cookridge Court & Grange

Detailed findings

Background to this inspection

The inspection visit was carried out by four inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience of providing care to older people.

Before our inspection we reviewed all the information we held about the service. We considered the nature of safeguarding alerts that had been made which included concerns regarding the management of medicines, and any other information that had been shared with us. We were not aware of any additional concerns from the local authority, local Healthwatch or commissioners. We asked 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. This was not submitted by the requested date. We addressed this with registered manager before they left the service who told us this was an oversight and agreed a revised date to forward the completed document to us. This was submitted after the agreed date and was only received two working days prior to our visit. We reviewed the information provided to inform our planning.

We used a number of different methods to help them understand the experiences of the people who lived at the service. We used the Short Observational Framework for Inspection (SOFI) in communal areas on the three floors of the service during the morning. SOFI is a way of observing care to help us understand the experiences of people who could not talk with us. We also spoke with the area manager, two maintenance staff, the head chef, one housekeeper, four care workers, the activities co-ordinator, four people who used the service and one relative, who was a regular visitor.

We also looked around the premises, including peoples' bedrooms, bathrooms, toilets, communal areas, the kitchen, laundry and outside areas. We observed staff interactions with people who lived at the home and looked at records. Six people's care records were used to pathway track people's care. Management records were also looked at, these included; five staff personnel files, policies, procedures, audits, accident and incident reports, specialist referrals, complaints, training records, staff rotas and monitoring charts.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Inadequate

Is the service safe?

Our findings

There were insufficient numbers of suitably qualified staff on duty to meet the needs of the people who used the service. Without exception, everyone we spoke during the visit with told us the service was short of staff. Comments from people who lived at the service and relatives included, "There's only one on doing breakfasts this morning, it's difficult for them. There used to always be two on, or even three", "The major problem here is there are not enough staff" and, "The staff have been very busy lately, they seem to be short-staffed."

Relatives told us staffing was further reduced at weekends with one relative telling us, "It's like the Mary Celeste in terms of staff at weekends. There's no one about to ask anything." We checked the rotas for the week prior to our visit. These confirmed reduced staffing levels at weekends. During the week the care staff available on a morning across the whole service ranged from 15 to 17. On the weekend this reduced to 11. Likewise on a night during the week there were usually nine staff on the duty rota. This fell to six on the Saturday and five on the Sunday of the week prior to our visit.

Most people told us they were happy with the care provided at the service and their care, treatment and support needs were being met. However, other people and staff told us they felt the care provided for people who lived at the service had deteriorated over the past year. One relative told us they had recently noticed staff turnover was high and there had been a lot of new faces around. They said, "There have been a lot of staff changes; a lot of good staff are leaving. That's not good for old people. They get used to a familiar face; it's all about trust." The regional manager confirmed some staff had left the service and that one staff who had submitted their notice to leave had agreed to rescind their resignation after speaking with the regional manager.

One staff member told us, "When I started here a year ago this unit had two seniors and four care assistants on duty. Now it's often half that. There are only three care assistants on here today." Another staff member said, "Staff are shattered, we do three 12 hour shifts in a row and often don't get a break." A third staff member said, "We're a bit rushed off our feet."

The lack of staff available impacted on the serving of morning drinks on the ground floor. We observed the morning drinks trolley arrive from the kitchen at 10.50am. People still had not received a drink at 11.50 am. We were told the staff member who usually served drinks was on leave. People who used the service were asking when they would be served hot drinks. We observed a relative tell their family member, "I don't think you'll get a cup of tea before dinner."

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the report.

Medicines were not managed safely and appropriately. Staff told us the medicines rounds took several hours to complete. On the day of the visit we found the morning medication round on the ground floor was completed at 11.20am. This meant the lunchtime medication round on this floor was started later than usual. We spoke with one person who was sat in the dining room after breakfast. They said, "I'm supposed to have my medicine after breakfast, that's why I'm waiting here. If I miss it they might leave it in my room for me or I'll have it at dinnertime." We observed that peoples' bedrooms were not locked. This meant there was a risk people might take medicines left out for other people.

On the ground floor we found people who lived at the service were given their medication in room number order; starting at room 1 and finishing at room 32. This method of administering medication was not person-centred or responsive to people's needs. It also may not account for specific administration requirements, such as medication which should be taken on an empty stomach. This meant people's symptoms may not be well managed.

We observed staff whilst they administered medication at lunchtime on the middle floor and in the afternoon on the ground floor. The lunchtime round was completed at 3pm on the ground floor to account for the delay in the administration of morning medication. Staff told us they did not get protected time to administer people's medicines. This increased the risk of errors in administration as staff responsible for the administration of medicines were called from their task to attend to other issues. We saw this happen on three occasions on the ground floor.

Inadequate

Is the service safe?

We saw one person was prescribed an antibiotic to be taken 'before or two hours after food'. There were no arrangements in place for the person to have their medicines before food. This meant the person's medicine may not have been effective as it was not administered in accordance with the prescriber's instructions. On the day of our visit this medicine was administered two hours after the person had eaten; however, this was only because of the delays in the medication rounds.

We completed an audit of people's medicines and found discrepancies between records and the amount of medicines in stock. This was made more difficult as staff had not carried forward the amounts of medicines that transferred from one Medication Administration Record (MAR) period to the next. The provider had arranged for a manager from another service to attend the service on the day of our visit to complete a medication audit. They had highlighted this issue as part of their audit on the day. During our visit staff were working with them to rectify records and provide an accurate record of medicines in stock in order for more accurate monitoring to take place.

During our inspection the service was visited by the clinical care homes pharmacist. They explained they had been closely involved in the service following concerns that had been raised about the transfer of medicines to a different provider that had led to a series of errors and concerns. They explained the provider and pharmacist had been asked to complete a significant event analysis to make sure lessons were learned and to prevent any repeat in the future. They explained the provider had taken appropriate action when the concerns were raised stating, "I do not think they could have done any more to rectify" (the issues); however, they told us they would continue to provide support until they felt medicines at the service were managed safely without the need for additional support.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the report.

Staff told us the service had been built and opened in 2008.We found it had been well designed to meet the needs of the people who lived there. We saw the premises and surrounding grounds at the service were well maintained. However, we found people who lived at the service were being put at risk due to an intermittent software fault with the home's call bell system. Staff we spoke with told us this had been an issue for, "A few months." They told us people who lived at the home might press their call bell and it would not sound or their call bell would sound when it had not been pressed. Staff said it varied which room or rooms were affected each day. They said they believed an external company used by the service had done a report but they had not seen it. This showed us the provider had not responded appropriately to ensure people were kept safe. When we asked the area manager about this they told us staff at the service checked people in their rooms more frequently, however we did not hear or see any evidence to confirm this was the case.

On arrival at the service the following day the provider showed us evidence they had arranged for the maintenance company to attend the service the previous evening to complete a full maintenance check on the call system. This had identified one bedroom where the call bell was not always working effectively. The provider had completed a risk assessment and check sheet for staff to complete to ensure this room was checked more regularly until the system was repaired.

People who lived at the home were cared for in a clean, hygienic environment. We noted some issues on the first day of our inspection including the storage of moving and handling slings, towels and cleaning mops. One member of domestic staff told us they thought the standards of cleanliness varied between units due to the staff who worked there. The issues we raised had been addressed before we left on the first day. However, we found the three clinical waste wheelie bins stored outside the building, adjacent to the car park, were not locked and not secured. This showed us the provider was not aware of their responsibilities regarding the safe storage of clinical waste. We asked the provider to make improvements to the storage of clinical waste.

In the care plans we looked at we saw mental capacity assessments had been carried out. However, none of the staff we spoke with were aware of their responsibilities under the Mental Capacity Act 2005 (MCA). The MCA and Deprivation of Liberty safeguards protect the human rights of people who may lack the mental capacity to make particular decisions. This includes decisions about depriving people of their liberty so that they get the care and treatment they need where there is no less restrictive

Inadequate

Is the service safe?

way of achieving this. The regional support manager explained the provider was aware that staff required MCA training. Following our visit they provided details of the training planned for all staff employed at the service.

We found the doors to the ground floor residential unit were locked. Staff told us this was to protect one person on the unit was at risk of getting out of the service. They said, "The doors always used to be open and people could come and go as they pleased." When we asked the team leader on the ground floor about this they told us this person had been assessed as needing to be cared for in the Iveson Unit, which was more secure. They said this person's move had been delayed as their funding and finances needed to be sorted out. They said the person's dementia was progressing and their social worker and community psychiatric nurse were involved. This person's inappropriate placement within the unit meant the movements of all the people who lived on the ground floor unit of the home were being restricted.

One person on the Grange unit was the subject of a Deprivation of Liberty Safeguard (DoLS) authorisation. This meant the person was prevented from leaving the unit for their safety but this arrangement had been assessed and agreed by the local authority. All appropriate paperwork was in place with a review date for the arrangement to be reviewed.

People we spoke with all told us they felt safe living at the home. All of the staff we spoke with told us they knew how to recognise and report abuse. All staff had completed safeguarding training.

We looked at the recruitment records for five staff members. We found recruitment practices were safe and relevant checks had been completed before staff worked unsupervised at the home. We spoke with one member of staff who had been recruited since our last inspection. They confirmed that they had not been given a start date until all their pre-employment checks had been completed. This showed us the provider had taken steps to protect people who lived at the home from staff who were known to be unsuitable to work in a care home.

Where there were risks to people's health and well-being due to their medical condition risk assessments were in place to minimise the risk of harm to them. This included people who had risk assessments and care plans in place to reduce their risk of falling or of choking on food. However, these were not always followed. We noted in one person's care records they had been referred to the falls team following a high number of falls. Their risk assessment stated they were to wear a falls detector at all times. We noted the person was not wearing this at any point during our visit. Staff we spoke with told us the person did not always want to wear the falls detector that was worn round their wrist. This was not recorded within the person's risk assessment and we did not observe staff encouraging the person to wear their falls detector at any point during the day.

Requires Improvement

Is the service effective?

Our findings

Staff training at the service did not cover all of the subjects required by staff to carry out their roles. For example, insufficient staff had been trained in medication administration to cover medicines rounds on all of the shifts. We found there was a medication round on each of the three floors at the service, four times a day. We were told the service's pharmacy had recently trained three staff who worked at the service and assessed their competency in medication administration. However, the service did not have enough staff in place that were competent to administer medicines. This meant staff who were trained and competent had to administer medication in more than one unit if there were insufficient trained staff available.

None of the staff we spoke with knew about, or thought they had received any training in, the Mental Capacity Act 2005 (MCA). Only two staff members we spoke with said they had heard of the Deprivation of Liberty Safeguards (DoLS). These safeguards provide a legal framework to ensure that people are only deprived of their liberty when there is no other way to care for them or safely provide treatment. One staff member said, "I went to a talk about DoLS and another one about dementia awareness." However, they were not able to tell us about the content of the training. Another staff member told us they had, "Not really heard of the Mental Capacity Act." This showed us staff had not received appropriate training to meet the needs of the people who lived at the service.

When we asked staff about training, supervision and appraisal at the service their feedback was mixed. Most staff told us they had not had regular supervision or appraisal. One care worker told us, "I turned up for my full day annual update recently. There was only me so it was cancelled." Another care worker said, "I've not had a supervision or appraisal since I started here nearly a year ago." The first care worker added, "Neither have I and I've been here nearly 18 months." This showed us staff who worked at the service did not receive regular supervision and appraisal and had limited information about training and development opportunities.

We spoke with the regional support manager who confirmed there had been a lack of supervision and training updates. At the time of our visit the training matrix was not available for the service. The regional support manager explained they had arranged for the provider to update this to allow them to prioritise refresher training for staff. They submitted a training matrix to us following our visit. This confirmed a need for medication and MCA training as well as refresher fire safety training to ensure all staff were up to date with fire safety procedures.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the report.

People's nutritional needs were being met. We saw the menus offered variety and choice and people with specific nutritional needs, such as soft, pureed or fortified diets, were catered for. People we spoke with all told us the food at the service was good and they got a choice. One person told us, "You get a real selection of food and it's very good. I think I'll be putting weight on." Another person told us, "By the time you have eaten two hot dinners and all the snacks you are heaving."

We spoke with the cook who confirmed they were aware of those people requiring additional support to maintain their weight as well as any other nutritional requirements. They explained how they fortified food for those people requiring additional calories. There had been a recent change to the mealtime arrangements with the main meal of the day changing to the evening. Staff told us this was done to encourage people to eat more in the evening as people had been faced with a full dinner following a large breakfast.

When morning drinks were not served on the ground floor we heard people in the lounge asking when a cup of tea was coming. When we asked people whether they could get drinks for themselves during the day one person said, "I think you would have to ask the staff first." This showed us people who lived at the service did not always have access to snacks and drinks.

We observed the lunchtime service on all three floors of the service. One the ground floor people appeared to enjoy the lunchtime experience. On the Grange unit some people ate very little at lunchtime. Music was playing throughout but the CD was sticking causing the music to jump and repeat causing some people irritation. One person was struggling with soup and a sandwich and seemed overwhelmed. Staff did not sit with the person whilst they were eating but approached them at intervals to prompt them to eat. They later broke the person's tuna mayonnaise sandwiches into

Requires Improvement

Is the service effective?

their soup without asking if this was acceptable to the person. This made the food unappetising and was not eaten by the person. The person's care records showed they were at risk of malnutrition and needed support to maintain an adequate calorie intake.

Care records showed us people had access to health care professionals when they needed them These included GPs, district nurses, community psychiatric nurses and social workers. One person's care records included a recent copy of a referral to the continence advisor. When we asked people about access to external healthcare professionals one person told us, "A lady came out when I had an upset tummy recently; it was all sorted out very quickly." Another person told us they had an appointment to visit their GP on the evening of our visit and would be escorted by a family member to attend the surgery. This showed us people using the service received appropriate additional support when required for meeting their care and treatment needs.

Good

Is the service caring?

Our findings

Our observations showed most of the interactions between staff and people who lived at the service were positive, with no negative interactions. During our visit all five members of the inspection team observed good interactions between staff and the people who used the service. Feedback from people who lived at the service about the staff was all positive. Comments included, "I love it here. They do good" and, "They are all nice, everyone is smashing." A third person told us, "The home is a building, the soul is the staff."

People and staff we spoke with confirmed people were treated with respect and their privacy and dignity was maintained. One person told us, "I struggle to get dressed myself so the staff help me." People we observed in the communal areas looked clean and well cared for. This showed us that despite low staffing levels staff had taken the time to support people with their personal appearance.

Records showed people's religious and cultural needs were considered as part of their assessment. People who used the service and their relatives were asked to share life histories. This helped staff at the service to better understand people to provide individualised care. However, people were asked about their marital status rather than asking who was important in the person's life. This may have made it more difficult for people to share their sexuality or other information regarding their diversity.

From our observations and from speaking with staff, people who used the service and relatives we found most staff knew people well and were aware of people's care and support needs. We observed staff members consistently calling people by their preferred names; staff knew people's preferences. One person told us they liked to sit in a particular seat in the lounge and the care staff made sure they sat in the right one. We observed a staff member speaking very kindly and gently, with patience to a person living with dementia; they showed them affection in an appropriate manner by touching their hand and asking them if they would like a hug before giving them one.

People we spoke with told us they got choices about their daily life at the service. One person showed us their bedroom and said, "I've got my own bedding from home and my own chair; it's just like home from home." At breakfast we saw the tables in the dining rooms were set with tablecloths, milk jug and sugar bowls. Menus were put out on the tables to inform people what was for lunch. We also heard care staff telling people what was for lunch and asking them what their preferences were. This showed us people were respected and involved in their life at the service.

We observed people who lived at the service were given options about immediate personal or social care decisions. However, we did not always see evidence of involvement in care planning or long term care discussions in the care records we examined. When we asked people about their care plans nobody knew what these were. One person told us they had been asked, "A lot of questions" when they had moved in to the service. They told us they could not recall anything since then. However, one relative we spoke with told us they had been involved in, and contributed to, their family member's care plan.

No visiting restrictions were reported by visitors or people who used the service with the exception of one relative who thought that meal times were, "No go" times because they would interrupt staff's work. Pets were made welcome providing they were well behaved and on a lead in communal areas.

The service considered people's end of life wishes as part of their care plan. One relative of a person who used the service told us they had been involved in the care planning for their family member and this was reviewed from time to time. They told us this included end of life planning. This meant staff at the service were aware of people's end of life wishes and could provide the appropriate support as required. We saw some people had a 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNACPR) instruction in their care records. This showed people's end of life care had been discussed with their GP though it was not always clear from the records that family members had been consulted where people did not have the capacity to contribute to the decision regarding their DNACPR.

Requires Improvement

Is the service responsive?

Our findings

People's care records had been reviewed by staff on a monthly basis. However, we found some people's care records had not been completed accurately. One person's Malnutrition Universal Screening Tool (MUST) had not been completed fully. This meant staff were not able to check records of the person's weight in order to monitor their risk of malnutrition. Another person's records stated they had not had any falls during the review period when there was evidence within their care records that they had experienced falls.

One relative of a person who used the service told us there had been occasions when their family member had been incontinent as staff had not had time to assist them to use the toilet when they asked for support. This had resulted in the person limiting their fluid intake despite being at risk of urine infections and requiring additional fluids, as they did not want their dignity to be compromised.

We saw one person had a short term care plan in place, following a recent un-witnessed fall which had resulted in a fractured wrist. This care plan had been put in place to direct staff in the management of this person's altered mobility following their fall. This provided appropriate guidance to staff for them to provide appropriate mobility assistance during the person's recuperation from the injury, as their capabilities had changed. This care plan had been regularly reviewed and updated as the person had recovered from their injury.

One relative told us staff had identified their family member was struggling more with their care needs and thought this might be due to dementia. They explained they were referred via their GP to the appropriate service and following a diagnosis of dementia they attended a meeting with the staff to talk about their family member's changing care needs. They explained their family member now had more dedicated staff time in the mornings.

We saw activities for the week on display in the reception area and on notice boards throughout the service. Activities included 'pets as therapy' (an external company who visited the service with anilmals for people to pet and handle), games, art and one to one activities. The notice showed that at 10am on the day of our visit there was baking on one of the units and in the afternoon there was a singer on another unit. We observed two people joined in the baking. We did not see other people engaged in any activities facilitated by staff.

We found one of the activities co-ordinators at the service had recently given their notice and was on sick leave. When we asked people who lived at the service whether they had access to individual and meaningful activities they told us they did not currently have access to activities. One person told us,"It seems to be quiet with activities at the moment; we just sit on the terrace when we can. It's been raining recently though." Other comments included, "We always did have a lot of activities"; "There used to be a man who took us out on trips, he's not here anymore though", and, "I've not seen any activities going on for two to three weeks." A male person who used the service told us, "There are no hobbies that apply to me in here." This showed the activities offered did not take into account the needs and preferences of all people who used the service.

During our visit we heard call bells going off for long periods. One relative we spoke with, who said they visited every day, said they had also noticed this. When we asked people about using their call bells we got a mixed response. Comments included, "They're there straight away if you need them", and, "I've never needed to ring my bell."

A relative and one person who used the service told us their family did their laundry rather than use the laundry service at the home. The relative said, "When my mother first came into the home a lot of her clothes went adrift, and they were not cheap clothes. Now I take them home and do them for her, it's got that worry out of the way." This showed the service had not taken the necessary steps to protect the belongings of the person and this had led to their family member taking on responsibility for laundry.

One relative of a person who used the service told us they had complained to the registered manager several times about various aspects of the care at the service. When asked whether they had submitted their complaints in writing they said, "No, only verbally and I was not happy with their response." We did not see any evidence to show whether verbal complaints, comments and concerns made by people who lived at the service, or their relatives, were logged and acted upon. Staff told us they did not have any method for recording minor concerns which may be brought to their attention.

Requires Improvement

Is the service responsive?

We checked the complaints records at the service. There had been one recorded complaint in 2014. From speaking with people who used the service and their relatives it was clear staff at the service had not been following the provider's complaints procedure. In one person's care records we found an entry explaining their relative had raised a concern they had not been wearing a medicine patch prescribed to help them manage their pain relief. This was not recorded in the complaints register. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the report.

When we asked staff how people who used the service had been encouraged to share their views about their experience one staff member told us, "People are well looked after but you don't have time to listen to them." The new management team confirmed people had not been given the opportunity to share their views until the weeks immediately prior to our visit. The regional support manager told us they had arranged a meeting when they had started in their role that had taken place the week prior to our visit. They told us 26 relatives had attended and the meeting would be used to start to improve communication between the provider, people who used the service and their relatives.

Where people had moved from other services we saw assessments had taken place. Where people had been admitted to, and discharged from hospital we saw documentation within their care records showing information had been shared to provide continuity of care and treatment for people who used the service.

Requires Improvement

Is the service well-led?

Our findings

The registered manager at the service had been in post for seven months and had recently handed in their notice. The week prior to our visit we were told the registered manager was on sick leave. On our arrival at the service we were told a decision had been taken for the manager to take leave rather than complete their notice period and so would not be returning to the service. As the registered manager was still registered with CQC at the time of our visit their name will appear on this report.

People who used the service and staff told us the registered manager had not been visible to them whilst they had been working at the service. People who used the service were unable to recall the registered manager's name or tell us they knew of them. One relative of a person who used the service told us they had made an appointment to meet with the registered manager when they first started in their manager role. They told us they were kept waiting for 45 minutes after the agreed appointment time and when they did introduce themselves to the registered manager they did not know who their relative was. It was agreed the registered manager would contact them to arrange another meeting but this had not happened.

One staff member told us, "Morale is low, the staff here used to be so happy. We need a good manager. (The manager before last) was dedicated to the job and their door was always open. (The most recent manager)'s door was always closed." Another staff member said, "The home is not well-managed, we don't feel supported. A lot of staff are leaving or looking for other jobs." A third staff member said, "You can't talk to anyone, you're just a number." This demonstrated to us that the leadership and management at the service and the provider was failing to support and value the staff that worked there. The regional manager told us the provider had recognised this was an issue and they had been appointed to address these shortfalls.

Staff told us the arrangements to cover the registered manager when they had previously been on leave had not provided consistent support for the staff. One staff member told us there was a different manager for each of the 16 days the registered manager was on leave. Another staff member told us, "No-one has been introduced; we do not know who's who."

The regional support manager had been in post for three weeks prior to our visit. They told us they had been employed to provide support to several of the provider's services but would be based at the service until new management arrangements were in place. Interviews were planned to recruit a new service manager who would be required to register with the CQC. A relative was very positive about the new regional support manager stating, "The new manager is straight forward, honest , upfront, and has trust. After five days in post she arranged a relatives' meeting where she was under attack and handled it very well." A staff member also told us, "(The regional support manager) seems a lot nicer, with a good approach and she explains the situation."

Staff we spoke with told us they were not clear about the provider's expectations of them. They told us they did not feel well supported by the registered manager or the management of the company at provider level. They told us their views were not taken into consideration. One staff member told us, "No-one told you where we were going and what we needed to achieve." Another staff member said, "Communication is poor and we do not get any feedback about the home." There had been no regular supervision or staff meetings to support staff in their role.This showed us the provider's management did not support learning and development. Nor did they promote an open and fair culture. Staff we spoke with told us, "Staff will be hesitant to speak with you because the managers will pull you in and ask you what's been said." Staff told us they were afraid to speak out as the provider did not want, "An embargo or a bad report."

We spoke with the regional support manager about staff meetings. They told us, "We had a staff meeting last week and no-one turned up, I don't know why. Staff get paid for attending staff meetings and training." The lack of attendance at the meeting reflected the poor morale and lack of engagement of staff in the running of the service.

The deficiencies we found during the visit showed us the service was failing to ensure the consistent delivery of high quality, person centred care for the people who lived there. One relative told us they had been sent a questionnaire from the provider. They gave some feedback and as the survey form offered a telephone call back option they checked this to request further contact. However, they were not contacted.

Requires Improvement

Is the service well-led?

Although the provider had a system in place to monitor the quality of the service provided, this was not effective. The registered manager was required to provide a monthly 'quality indicator' report to the provider detailing information relating to the management of the service and analysis of any incidents or accidents. The report for May 2014 identified nine accidents. Copies of accident and incident forms showed there had actually been 61 recorded incidents during May 2014 of which 46 were un-witnessed. This meant incidents and accidents had not been appropriately analysed and reported in order to identify trends or minimise further risks to people who used the service.

We raised this with the area manager and asked what the provider did to make sure the quality monitoring information submitted to them was correct. They told us all accidents would be in the Datix incident reporting system, however this would be dependent on them being inputted into the system. They told us they would be reliant on the manager to check this was done. This meant the provider was not monitoring the quality and effectiveness of their managers or their quality monitoring systems. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the report.

We spoke with a visiting health professional who told us communication and working relationships with the visiting district nursing teams and GPs were poor. The regional support manager confirmed this was the case and they had arranged an initial meeting with the district nursing team to start to improve relationships.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The registered person had not taken appropriate steps to ensure that at all times there were sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity. Regulation 22.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The registered person did not protect service users against the risks associated with the unsafe use and management of medicines, by the means of appropriate arrangements for the obtaining, recording, handling, using, safe keeping and safe administration of medicines used for the purposes of the regulated activity. Regulation 13.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered person did not have suitable arrangements in place to ensure that people employed for the purposes of carrying on the regulated activity were supported to enable them to deliver care and treatment to service users safely and to the appropriate standard by – (a) Receiving appropriate training, professional development, supervision and appraisal. Regulation 23 (1)(a)

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The registered person did not have effective systems in place to monitor the quality of service delivery. Regulation 10 (1) (a) (b) (2) (iv) (v) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints The registered person did not have effective systems in place to identify, receive, handle or respond appropriately to complaints. Regulation 19.